2009 APPRAISAL REPORT ON THE PERFORMANCE OF QUÉBEC’S HEALTH AND SOCIAL SERVICES SYSTEM

BUILDING ON PRIMARY HEALTHCARE RENEWAL: RECOMMENDATIONS, ISSUES AND IMPLICATIONS

THE HEALTH AND WELFARE COMMISSIONER
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A WORD FROM THE COMMISSIONER

Appraising the performance of a health and social services system is not a simple matter. To fulfill our mission, we opted for a unique approach based on engagement, dialogue and collaboration with stakeholders and on the citizen participation that is at the very core of this endeavour. The appraisal process therefore takes a twofold approach, involving a quantitative study of performance monitoring indicators along with a series of public consultations, most prominently the Consultation Forum, designed to shed light on the results.

Primary healthcare is the object of our initial appraisal report. Improved healthcare will be built on the foundations of primary healthcare, the gateway to the system. In addition, since primary healthcare responds to the current healthcare needs of individuals, it is a means to reach a majority of those individuals in their own environment. Many commissions and study groups have addressed the issue of primary healthcare. A vast number of findings and proposals for change are available.

Based on this information, a number of experts, decision makers and citizens in addition to various groups of professional staff from various clinical settings were consulted. A range of proposals emerged. Some of these proposals were the product of consensus, while others are still subject to debate. Proposals that the overall group of stakeholders considered effective, feasible, acceptable in the current context and with a demonstrable impact were the ones selected.

The appraisal report that I am submitting contains four documents, each with a specific purpose and designed for readers with different interests and concerns. Our primary intent is to inform and offer ways to enhance the system. Admittedly, the system is so complex that it is not always fully understood. We emphasized a structured analytic approach aiming to stimulate the participation of a full range of actors in the system who can truly make a difference.

The vast scope of this subject cannot be underestimated as appraising the performance of the health and social services system in Québec is by no means an easy task. A prudent approach is advisable in order to avoid making overly hasty judgments on issues that we are only beginning to comprehend. In some cases where there is a lack of evidence, the problem has been explained and the public has been called on to examine it. Despite these situations, in many fields there is sufficient data available to formulate recommendations.

In reading this report, you will find that it contains neither ready responses nor simple targets. Instead, it calls for collective ongoing improvement of our health and social services system. The objective was not to seek out those responsible for the problems that are identified, but rather to highlight both systematised problems and promising methods for service organization. Each of us in our own way, are responsible for the effectiveness of our system and therefore it is incumbent upon all of us to contribute to its appraisal and improvement.

My confidence grew as I witnessed the collaboration fully offered at each stage in the consultation and data collection process and saw that the sources of information are indeed plentiful. There is a willingness and a strong desire within our network to work together to maintain and improve our health and social services system. In my opinion, there is a readiness for renewal and it is time to take the measures needed to meet these challenges and undergo the task of ongoing improvement.

Health and Welfare Commissioner

ROBERT SALOIS
FOREWORD

The mission of the Health and Welfare Commissioner is to provide perspective for public debate and governmental decision-making that will contribute to enhancing the health and welfare of women and men in Québec.

Each year the Health and Welfare Commissioner publishes an appraisal report on the performance of the health and social services system. For that purpose, the Commissioner has adopted a comprehensive, integrated appraisal framework and established a consultation and deliberation process for support. This approach is based on a variety of scientific, organizational and democratic knowledge development sources described in the Orientation Document published by the Health and Welfare Commissioner (CSBE, 2008).

The appraisal exercise conducted this year by the Commissioner was intended to create a portrait of the health and social services system, in particular the system delivering primary healthcare. To produce an opinion, the Commissioner drew on an impressive collection of data, including performance monitoring indicators, surveys, findings from recent scientific studies, observations and opinions resulting from a consultation process involving clinicians, experts, decision makers and managers in addition to the deliberations of the Consultation Forum composed of citizens, many of whom possess special expertise in the field of health and welfare.

Our examination has resulted in four volumes that correspond to the four functions exercised by the Health and Welfare Commissioner. These consist of: appraising the performance of Québec’s health and social services system; consulting citizens, experts and stakeholders in the system; informing the Minister, the National Assembly and the public; and making recommendations and discussing the issues and their implications.

The initial volume entitled *The Current Situation of the Health and Social Services System and its Primary Healthcare Sector* provides a portrait of the overall system with an emphasis on primary healthcare. The deficiencies observed and transformations underway are also described.

The second volume entitled *A Global and Integrated Appraisal of the Performance: Analysis of Monitoring Indicators* presents an analysis of the performance indicators for the system as a whole and analyses specifically for primary healthcare services across all of Québec and in each region of Québec. These findings led to proposals of potential solutions deserving further consideration, which we invite actors in the health and social services system to examine.

The findings and observations produced by the consultation process are included in the third volume entitled *Report on the Consultation Process Regarding Primary Healthcare* devoted to the consultation on primary healthcare. This document presents the results of the consultation process dealing with the characteristics of effective primary healthcare, actions shown to be effective in enhancing performance and the feasibility of those actions. Certain conditions linked to implementation are also described to guide any decisions that may occur regarding the adoption of certain proposals.

In the light of analysis of performance and the consultations, the present document, the fourth volume, entitled *Building on Primary Healthcare Renewal: Recommendations, Issues and Implications* serves to conclude the performance appraisal exercise. Recommendations that result from the appraisal process are presented here. Lastly, the document includes an analysis of certain implications that are to be expected and which are related to these recommendations.
INTRODUCTION

Health and welfare are fundamental; there is deep interest surrounding issues dealing with the effectiveness of our health and social services system, which is invested with the goal of maximizing the impact of the services rendered to the public and providing guidance for all partners in society that influence the determinants of health and well-being. The overall goal of the health and social services system consists of promoting health, preventing illness, maintaining and enhancing public health and welfare, and reducing inequalities between individuals or groups in Québec’s society. Therefore, appraisal of the system is crucial to ensure ongoing improvements and continual fulfillment of the public’s needs.

Interventions designed to achieve this goal are still difficult to implement and require ongoing reappraisal. Our system, like that of other western nations, is dynamic in nature with a high level of complexity. Composed of a large number of stakeholders and organizations, and providing an extensive range of social and health services, it must meet a wide variety of needs. It is also necessary to address strong demographic and socio-economic pressures, as well as changing technologies and advances in medicine and professional practices. Governmental decision-making under such circumstances requires making trade-offs among multiple objectives.

The mission of the Health and Welfare Commissioner is to provide perspective for public debate and governmental decision-making that will contribute to enhancing public health and welfare. To achieve this goal, the Commissioner carries out an appraisal of the health and social services system; consults experts, decision makers and citizens by means of the Consultation Forum; informs the Minister of Health and Social Services and the public and recommends actions to enhance the performance of the health and social services system.

Why was primary healthcare chosen as a starting point?

As many have already emphasized, it is necessary to provide support for primary healthcare and ensure that the services provided are the ones most pertinent to primary healthcare. The importance of primary healthcare as the foundation for an effective health and social services system and the crucial role of physicians' offices have emerged as the fundamental findings from the consultations carried out by the Commissioner with experts, decision makers, and citizens. These findings are also the basis for prior recommendations made by study commissions and work groups. Primary healthcare services are often the main point of contact between the public and the healthcare system and thus a logical starting point for formulating actions envisaged by the Health and Welfare Commissioner.

Furthermore, many transformations are underway in Québec, which could have major impact on access to healthcare and on the coordination and quality of services rendered to the public. In addition, there are currently a large number of studies available on primary healthcare services and on promising approaches, particularly regarding organizational models already being implemented. This context of transformation provides a unique opportunity to make an appraisal and to inform the public and decision makers about the effectiveness of the organizational transformations that have now been underway for several years. It allows us to recommend implementation or consolidation of exemplary organizational practices. The reorganization of primary healthcare services that was initiated several years ago is, however, still only in its
starting phase and the effect it has had on meeting public healthcare needs and on public health has only been partially demonstrated.

In this document, we will describe the findings of the integrated analysis of primary healthcare. The first part is an overview of how the Commissioner formulated the recommendations. The second part details the proposals for action, the expected benefits informed by domestic and international studies and experiments, the current situation and citizen concerns and lastly, those aspects perceived to be important by the Health and Welfare Commissioner. Each subsection concludes with the recommendations formulated using the information collected and a preliminary examination of certain implications linked to the recommendations. The concluding third part of the document examines the connections among the various recommendations and the potential to improve the performance of the health and social services system.
1. How Did the Commissioner Formulate the Recommendations?

A large number of parameters were taken into consideration to determine priority recommendations for enhancing primary healthcare and health and social services system performance in Québec. A description of the current situation along with analysis of the indicators and surveys were used to isolate the nature and extent of the problems affecting primary healthcare. The consultation approach made it possible to identify actions needed to enhance performance. These actions were analyzed on the basis of evaluative research from Québec and other contexts that demonstrated effective methods to improve service and the resulting potential benefits. Taken into account were the appropriateness and the feasibility of the actions as perceived by the decision makers and other network stakeholders consulted along with related issues and implications emerging from the deliberations of the Consultation Forum of the Commissioner.

The synopsis of all these elements enabled us to make choices and propose several recommendations that can be considered absolutely essential. Consequently, the strength of the recommendations made by the Commissioner stems from the integrated analysis designed to determine what is relevant, feasible and has been shown to be effective in solving the problems identified while taking into consideration issues and conditions from the general public’s point of view (see Figure 1).
Information resulting from analysis of quantitative data

The document entitled *The Current Situation of the Health and Social Services System and its Primary Healthcare Sector* presents a wide range of information intended to provide better understanding of the health and social services system in Québec. This review of the current situation based on data from a series of research documents and analytical studies as well as unpublished data comparing Québec to a number of western nations taken from a recent Commonwealth Fund survey raised several problems related to primary healthcare services.

The main findings of the review show that although the services provided are top quality and individuals express satisfaction, there is a lack of success in providing the whole population with primary healthcare service and meeting care needs. The review also confirmed that there are problems related to family doctor affiliation and as a result in gaining access to care. Québec shows a relative shortage of medical staff for primary healthcare services and lower productivity than in other contexts, despite a very comparable level of human resources. This can also be related to physician disaffection with family medicine in favour of specialized practices and hospital practice. Most family physicians also tend to specialize and reduce their area of practice and family physicians are often located in hospital institutions which are factors that increase the potential impact of these findings on the care intended for the public in Québec.

The document entitled *A Global and Integrated Appraisal of the Performance: Analysis of Monitoring Indicators* describes the performance level of the system in light of the performance monitoring indicators using a comprehensive and integrated approach. A wide range of indicators was selected and analyzed on a province-wide and regional scale in order to identify the specific sectors where there are particular problems that deserve our attention as well as the attention of the various actors in the healthcare network responsible for planning, managing, delivering and appraising health services and social services.

The provincial and regional findings from this analysis highlight the need to examine the reasons behind such gaps in performance and to reflect on possible improvements. Certain findings regarding the organization of healthcare services and social services in general suggest that those who do obtain access to healthcare receive quality services and are generally satisfied with the results. This is an extremely important point. Furthermore, the analysis conducted shows that substantial gains have been made in recent years in terms of the overall performance of the health and social services system. These gains have helped meet an increase in care needs caused by changes in health problems among the population and have helped increase capacities for both intervention and treatment.

However, other findings show that there are gaps in certain aspects of the system from both provincial and regional points of view. How care is organized requires particular attention, as does its productivity. Major variances in reaching performance guidelines, that is reference values, among regions indicate inconsistent performance and urge in-depth examination of specific modes for planning, organizing, managing and appraising the services that are at the source of such variances. The intent is to learn from these performance gaps and to discuss the most promising practices to further enhance system performance.
While many of these findings relate to a range of sectors or activities in the health and social services system, others relate more specifically to primary healthcare services. The findings show that the level of medical resources and the indicators related to the organizational climate are favourable in Québec in comparison with the rest of Canada. However, other findings rank our system less favourably in comparison with other provinces. Notable among the findings are problems of access and affiliation with family physicians and frequent use of emergency services for problems that could be treated in primary healthcare clinics, thus negatively affecting productivity indicators. Lastly, primary healthcare does not seem to be founded on a modern organizational structure in comparison with other provinces or countries, especially in terms of group medical practices and the introduction of new information and communication technologies.

**For more information**

For more details on the overall findings and information available, consult the document entitled *The Current Situation of the Health and Social Services System and its Primary Healthcare Sector* and the document entitled *A Global and Integrated Appraisal of the Performance: Analysis of Monitoring Indicators* published jointly with this document.

To consult regularly updated data tables and a wider range of performance appraisal tools, go to the website of the Health and Welfare Commissioner at www.csbe.gouv.qc.ca. It contains additional details on the indicators, such as the specific sources, definitions and data periods used in the calculations.

**Other information obtained from the consultation process**

The Health and Welfare Commissioner, under the relevant constituting legislation, has a mandate and authority to commission studies and hold consultationss. As described in the Orientation Document (CSBE, 2008), this may include consulting experts such as healthcare clinicians, researchers and analysts; political, administrative or clinical decision makers as well as the public through the Consultation Forum of the Commissioner. These consultations are inter-related with findings from each step in the consultation process helping to stimulate discussion during subsequent proceedings.

The Commissioner took an approach designed to identify the areas where strong consensus exists among the various actors consulted. Identification of such areas relate to the most important findings regarding the healthcare system and enable the defining feasible actions most likely to enhance system performance. This approach permits the integration several aspects of the context that are specific to the appraisal process and formulation of recommendations, which should lead to better implementation. The goal is to propose actions shown to be effective and feasible in relation to the characteristics of our system and which ultimately are the most acceptable in relation to the dominant values of Québec society.
The Consultation Forum of the Commissioner

The Consultation Forum of the Commissioner is composed of 27 members of whom 18 citizens provide representation of the regions and nine hold special expertise related to the field of health and welfare (see Appendix 3). The members are appointed for a three-year term. The mandate of the Forum is to provide the Commissioner with its point of view on various issues the Commissioner submits as part of a consultation. Under section 22 of the Act respecting the Health and Welfare Commissioner, the performance appraisal report must give an account of the consultation of the Forum and set out the conclusions and recommendations of the Forum on each of the matters or issues submitted to it.

In November 2007, Québec researchers and analysts with expertise recognized by their peers were invited to the seminar of experts to appraise primary healthcare services. In February 2008, decision makers from various sectors and levels in the health and social services system were invited to join the decision maker panel. These two steps in the consultation process led to identification of various aspects of the health and social services system that could have an impact on performance, and to outlining of a vision of what effective primary healthcare services should do, as well as targeting potential actions to achieve such a vision, determining the priority areas for action according to current conditions and discussing feasibility. Nine priority areas for action and 39 actions were identified. The results of these two phases in the consultation process are detailed in the document entitled Report on the Consultation Process Regarding Primary Healthcare.

The Commissioner also conducted consultations with specific groups in order to complement the information already obtained and to examine certain aspects in greater detail. As part of the complementary consultations, groups representing physicians (the Fédération des médecins omnipraticiens du Québec, local and regional general medical departments and medical clinics) were consulted. These consultations allowed the Commissioner to examine various paths of action and to discuss with the principal stakeholders from the primary healthcare system. This consultation process also confirmed many of the findings established during the appraisal process. Noteworthy findings include the problems within primary healthcare related to attracting young physicians into family practice, access to care and family doctor affiliation as well as the challenges related to the manner of organizing primary healthcare services in Québec.

Finally, the Consultation Forum of the Commissioner held deliberative sessions in June and September 2008 concerning various priority areas and actions with the aim of identifying ethical concerns related to implementation. The Report on the Consultation Process Regarding Primary Healthcare describes the overall process in greater detail and presents the results.

An Orientation Committee and a Consultative Committee on Primary Healthcare composed of Canadian and international experts were consulted in order to place the findings and recommendations from the appraisal process conducted by the Commissioner in perspective.¹

¹ It is worth noting that the committees were limited to an advisory role and committee members are not associated with the conclusions drawn by the Commissioner after the consultation process. The recommendations of the Health and Welfare Commissioner are made solely by the Commissioner and do not represent the position of those who took part in the consultation process conducted by the Commissioner.
This allowed for a more comprehensive outlook at the various aspects addressed and allowed for integrating broader lessons from contexts outside Québec.

**For more information**

For more information on the proceedings of the committees of experts, decision makers and the Consultation Forum of the Commissioner on primary healthcare, consult the *Report on the Consultation Process Regarding Primary Healthcare*. This document discusses only a few of the aspects of the consultations and the positions of the Forum related to the actions.

**Recommendations based on the synopsis of information obtained**

We have analyzed possible recommendations and paid special attention to how they are interrelated. While each recommendation offers potential benefits, the synergy obtained from implementing a coherent series of measures would likely produce even greater impact within our health and social services system. Certain recommendations are also prerequisites for the implementation of others. Therefore, we have established priorities for the recommendations whose combined action would produce benefits for the overall system and whose implementation would facilitate implementation of a wider range of measures.

Although implementing individual recommendations in an isolated manner may appear difficult, the combined influence of several factors can ensure gradual and complete implementation. By emphasizing the implementation of each individual recommendation, we will ultimately encourage implementation of the full range of recommendations. These recommendations address actions which to varying degrees are essential to the implementation of the others. However, the experience of our approach strongly suggests that the issue is not to attempt to carry out full implementation all at once, but rather to start up work on each one of the recommendations. To the extent that we maintain our resolve along with the collaboration of all the actors in the system, it is our belief that the degree of primary healthcare performance already achieved by other countries is within our reach.

**Taking into account the consequences of the recommendations**

Under the governing legislation, the Health and Welfare Commissioner is required, when issuing recommendations, to take into account the implications of those recommendations. The appraisal process for primary healthcare services that was selected takes an approach that addresses the organizational, economic and ethical aspects of the recommendations. Consequently, several implications that must be taken into account in the case of future implementation of the recommendations have been identified. The goal is not to predict the organizational transformations, or accurately model the costs or lay out all the ethical concerns related to the recommendations. Instead, the approach taken is to assign analysis and models to the organizations that hold the appropriate information and the legitimacy to design specific projects for such analysis. For the Commissioner, the essential is to highlight various potential consequences so that they will be taken into consideration when action is implemented.
There are ten interconnected recommendations from the Health and Welfare Commissioner to enhance the primary healthcare performance and its interaction with the overall health and social services system in Québec. These recommendations affect four fundamental aspects of the healthcare and social services systems: organization of care and resources; clinical practices and provision of services; the planning and management of clinical activities and funding. For our health and social services system, this involves modernizing the organization and its resources, as have several other industrialized nations, fostering greater participation by the public in healthcare, better planning, organizing and evaluating care and providing appropriate funding for primary healthcare. Achieving these goals would improve the overall system.

**List of recommendations**

1. Encourage medical group practice
2. Support the implementation of electronic medical records and Québec’s shareable Electronic Health Record
3. Increase interdisciplinarity in primary healthcare group practice
4. Explore new modalities for care delivery
5. Foster self-care practices and support the contributions made by informal caregivers
6. Ensure that individuals wishing to register with groups of primary healthcare physicians can do so
7. Review the clinical responsibilities of primary and secondary care physicians
8. Develop mechanisms for primary healthcare clinical governance
9. Introduce mechanisms for clinical performance appraisal and ongoing clinical improvement
10. Realign the mode of remuneration for physicians
2. HOW CAN PRIMARY HEALTHCARE PERFORMANCE BE IMPROVED?

Considering the consultation process, the performance monitoring indicators, analysis of the scientific documentation and international attempts at reform of primary healthcare services which have been described in this section, there is no doubt that we must pursue the reorganization of primary healthcare initiated in recent years and consider primary healthcare as a true priority within the health and social services system in Québec. This will require better primary healthcare infrastructure if the public is to experience a positive effect from the extensive resources invested. This will also require modification to service planning, organization and management as well as to the manner in which physicians and other primary healthcare professional staff work together and interact with the public they serve. Lastly, this will require mobilizing all the professional staff, revising the clinical activities they perform and adjusting the manner in which the services are funded.

The public hears about the health and social services system through written and electronic media. This situation exerts a strong influence on proposals for change and the relations among the stakeholders in the network such as the federations of professional staff, the health institutions in the network and the Ministère de la Santé et des Services sociaux. The decision makers consulted also emphasized the political context with less time between elections than the time required to implement reforms. Without strong leadership and without adoption of a long-term vision, the result may be piecemeal political action and priorities focused on the short term to the detriment of more fundamental changes.

These findings echo those of the Consultation Forum of the Commissioner, which considered it of “utmost importance that priority be truly placed on primary healthcare services”, and that primary healthcare be appropriately financed. The members of the Forum also emphasized the need for persons working in the network to take ownership of the organizational change process and acknowledge that change will take time. Furthermore, the members of the Forum consider that changes should be implemented with an eye to the long-term vision of what is to be accomplished. In their opinion, a long-term vision is the best way to respond to the challenges posed by an aging population. Such a vision will also help reestablish public confidence in the health and social services system.

In this section, we will discuss the various aspects that provide support for implementation of certain actions likely to enhance primary healthcare performance. A brief description will be provided of the results of the consultation process regarding the implementation priorities to enhance primary healthcare performance. After this the expected benefits from implementation of such actions will be presented based on documented scientific evidence. The elements to keep in mind for possible implementation of the actions deemed priorities are stated. The actions which are analyzed are grouped into those concerning the organization of care and resources, those related to clinical practices and service delivery, those dealing with clinical activity planning and management and lastly, with those involving the financing of primary healthcare.

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2 It is not possible to include all the scientific documentation used to support the actions defined during the consultation process. Only specific factual references will be mentioned. Readers are invited to consult the list of documents available on the Website of the Health and Welfare Commissioner.
2.1 Acting on the organization of care and resources

One of the main findings from the consultation process, from the performance monitoring indicators and from analysis of the scientific evidence is that primary healthcare is not optimally organized. In our review of the current situation, physicians still often work within care delivery models that no longer correspond well to the needs manifested by the population they serve and which have become increasingly complex; physicians do not have the technical support they require. Healthcare systems that have set up strong and well-organized primary healthcare services are those which have the best results for cost ratio anywhere in the world as well as the most appropriate funding.

One of the aspects requiring attention of local, regional, provincial and organizational decision makers is that the health and social services system is suffering not simply from limited human and financial resources in relation to care needs, but also from suboptimal use of professional staff skills. This is in addition to slow integration of interdisciplinary networking into medical practices and a lack of optimal coordination.

Although the indicators analyzed suggest that primary healthcare physicians and nursing staff deliver high quality care and that those using the services are generally satisfied, it must also be acknowledged that the primary healthcare network does not meet demand, and that a high percentage of the population has needs that are not met and that the wait times are long. Furthermore, the challenges of dealing with chronic illnesses and preventing health problems require a review of the manner in which care is organized if we are to achieve better coordination and provide a range of services that will handle health concerns in an overall manner.

Resulting from the consultations and the data, family medicine group practice, electronic health records and Québec’s shareable Electronic Health Record (EHR), along with interdisciplinarity practice and primary healthcare network practices, have emerged as the essential aspects requiring consolidation in order to improve primary healthcare organization and ensure adequate access to available resources.

2.1.1 Family medicine group practice

The Consultation Forum of the Commissioner highlighted how important it is for the public that fair access to primary healthcare services be available across all of Québec. It was also noted that better consistency and integration should involve sharing practices with medical clinics; many professionals currently work in relative isolation. Group practice is acknowledged as meeting the concerns raised by the Consultation Forum.

Similarly the decision makers consulted emphasized the major changes needed concerning the organization of care related to new primary healthcare models of organization, such as family medicine groups (FMG) and various forms of clinic-networks and the creation of local health and social services networks (RLSSSS). These transformations are also part of a generalized greater awareness of the importance of primary healthcare services for healthcare performance, stemming from lessons learned internationally. Encouraging group practice is one action that has obtained the approval of both experts and decision makers as much for its potential to improve care as for its response to the needs of individuals and its feasibility of implementation.
What benefits can be expected from group practice?

Perceived as the first stage in the consolidation of primary healthcare, a consensus exists on implementing greater general use of group medicine practices associated with improved healthcare system performance. By helping deal with unmet needs and improving the coordination of care, access to a primary healthcare service team reduces use of emergency services and the risk of hospitalization, and contributes significantly to building confidence with the public and the professional staff in the healthcare system. According to a recent survey, nearly one third of adults residing the Montréal area had used emergency services at least once over the last two years. The main reasons justifying the use of emergency services instead of normal primary healthcare include problems of accessibility, including the impossibility of rapid consultation at the usual service provider and the lack of access at the usual primary healthcare service provider outside normal business hours (Roberge et al., 2007).

The burden created by visits to emergency services and avoidable hospitalizations justifies the need to set up a sufficient number of family medicine groups or other authorized group models to provide the whole population with access to primary healthcare service teams. This consolidation of group practice, combined with empowerment of the public and of patients should also lead to better utilization of the available resources and allow individuals to obtain care near their home from healthcare professionals they know. As a result, coordinated team care, associated with better planning and appropriate appraisal of care, would reduce the number of short-term institutional admissions replacing them with primary healthcare service access and improved continuous care. Better planning can result in a reduction in the risks caused by undesired events during hospitalization which at as well as health problems that could be avoided add costs to the healthcare system.

Organizational models of effective primary healthcare

A study dealing with the impact of various organizational models for primary healthcare on various aspects of care experienced by individuals illustrates the positive effect of family medicine groups and of models fostering service coordination and the integration of other components of the health network on accessibility, continuity, response to individual expectations for treatment and the perceived comprehensiveness and results of the care provided. This study suggests that these models are also more in line with the organizational features identified in the pertinent body of scientific literature as the most promising. However, it also mentions that the model of those who practice on their own maintains a very high evaluation from users in terms of the care received. The distinguishing feature of group models is the ability to reach a much wider proportion of the population. Ultimately, the authors suggest that the models fostering more comprehensive care coordination and integration have the most potential, although efforts must be made to ensure that the patient-doctor relationship, a strong characteristic of solo practice, is also preserved. The study concluded that models encouraging short-term interaction, such as walk-in clinics were not effective models for any of the care experience attributes, including accessibility (Pineault et al., 2008).

Among those admitted to hospital for short stays in Canada in 2000, one out of 13 experienced an undesirable event such as an error in medication or a nosocomial infection and in one out of 152 cases, death occurred (Baker et al. 2004). Although improvements have been made since 2001, the rate of hospitalization related to health conditions that could be handled through an outpatient basis remains too high (380 per 100,000 inhabitants in 2006) (CIHI Health Indicators, 2008).
Other authorities have already made recommendations concerning group practice. The Commission of Study on Health and Social Services (2000) had recommended that the medical component of this primary healthcare network be made the responsibility of Family Medicine Groups that include general practitioners working in a group, in an office, or a CLSC with the collaboration of nurse clinicians or nurse practitioners. These groups should be responsible for a defined range of services for a population of citizens who choose these general practitioners. As a result of this recommendation, a large number of family medicine groups have been established.

In a similar direction, the Task Force on the Funding of the Health Care System (2008) recommended accelerating deployment of health clinics (either private offices, FMG, CLSC, clinic networks or health cooperatives) to guarantee that every individual in Québec has access to a family physician. Furthermore, it also recommended greater flexibility of the FMG formula to allow for participation by private offices in sharing regular working hours and nursing staff. A study sponsored by the Task Force (see box) recently highlighted the fundamental characteristics that make group practice an avenue for improving the quality of care.

Group practice as a basic model for medical practice also enjoys the support of many healthcare professional organizations and a majority of the population (Hutchison, 2004). In fact, nearly half of the residents in family medicine in Canada are headed to group practice (45%) and very few intend to enter solo practice (less than 1%) (2007 National Physician Survey, Medical Student Results). Lastly, the increasing exposure of medical and nursing students to family medicine group practice during clinical internships, in contrast to training received mainly in university hospital centres, could also encourage them to choose this type of practice for a career and thus facilitate implementation of such a model. The training received during a professional career could also facilitate transition to family medicine group practice and encourage the hiring of young physicians interested in that career thus counteracting the trend towards specialization that currently afflicts the network.

**An organizational model for the future**

A recent study (Lamarche, Pineault and Brunelle, 2007) concluded that primary healthcare organizations that achieved the best results were those that followed up on the state of health, provided access to care and coordination of care of the individuals and groups for which they assumed responsibility. They brought together physicians to practice as members of a team on a full-time basis in collaboration with nurses and other healthcare professionals in the social services and community network. These organizations are mainly funded based on the number of patients they treat and their social and health characteristics. The physicians are remunerated based on the responsibilities they assume and the time devoted to those responsibilities, and not only or mainly based on the quantity and complexity of the services provided. Each individual is affiliated with a family physician and follow-up is performed in person or by telephone 24 hours a day, 7 days a week. These primary healthcare service organizations are equipped with the diagnostic and therapeutic technologies needed to fulfill their mission. The study also recommends revising the number of students admitted to family medicine at graduation and their remuneration, and enhancing family medicine practice as part of their education.
What is the situation concerning group practice in Québec?

The current situation that we have described highlights the fact that many physicians practice on their own or in organizations in which they share only the administrative costs linked to the office without ever working in a collaborative manner. Furthermore, a significant number of physicians continue to offer walk-in service practice models with little or no follow-up and a limited range of care. Nevertheless, a significant number of family medicine groups have gradually been introduced in many regions in Québec. The establishment of family medicine groups is a real success for the system, as this type of organization achieves enviable degrees of performance in comparison with other healthcare models. For healthcare professionals, it constitutes a stimulating setting for medical practice based on a continuity of quality clinical care and health care coverage for the population (Haggerty et al., 2007; Beaulieu et al., 2006; Pineault et al., 2008).

While the FMG model has been well received by the population and healthcare professionals, its introduction has not been uniform across all regions and only one in five individuals has access to an FMG. While other organizational models with features deemed capable of improving primary healthcare quality of care are emerging in Québec (such as different types of clinic networks, clinics (integrated networks, health cooperatives), the introduction of FMG still remains the driving force for change.

For citizens, what are the issues related to group practice?

The deliberations of the Consultation Forum of the Commissioner did not allow the identification of the major problems linked to group practice. Nevertheless, the notion of a strong interpersonal link between family physicians and patients remains important in the opinion of the members of the Forum. If group practice is perceived as fostering an improved primary healthcare capacity to meet the overall needs for the populations being served, efforts must be made also to preserve personalized and inter-personal relationships in new models for care. The bureaucracy and depersonalization that go along with greater complexity in organizational models must be carefully monitored. The example of the FMG demonstrates that it is possible to preserve top quality interactions within group practice.

Key elements for the Commissioner concerning group practice

The finding that the Commissioner has been able to establish from the information available and after consulting experts, decision makers, and the Consultation Forum of the Commissioner is that the reorganization of primary healthcare medical services has not been completed. There are still too few people in Québec with access to primary healthcare and not enough people have access to primary healthcare organizations with an up-to-date support structure to treat the public. In the Government Sustainable Development Strategy, it is stated that access to basic services must be ensured according to regional and local realities (Gouvernement du Québec, 2007).

While the Commissioner does not consider that group practice improves performance on its own, it is nevertheless a foundation for a range of improvements of healthcare and is therefore considered a prerequisite for the implementation of other organizational modalities such as interdisciplinary practices, the introduction of information technologies and improvements to the quality of care. In this context and in view of the studies, international experience and the consultation process, the Commissioner recommends to the Minister of Health and Social Services that group medical practice in Québec be increased (see Recommendation 1).
Recommendation 1

Encourage medical group practice

In order to improve primary healthcare service performance and contribute to improved overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

1.1 **A target of 300 family medicine groups (FMG) be achieved** over the next few years to ensure that 75% of the public is covered;

1.2 **FMG fundamental organizational characteristics** (group medical practice, registration of the clientele, contractual agreements with CLSC, presence of healthcare professionals other than just physicians) **be maintained along with all current obligations tied to these organizational models** for care during official certification or authorization procedures;

- This will require preserving the flexibility during implementation in order to meet the specific demands of various geographic settings (urban, rural, remote or isolated) and organizational (clinic size, availability of human resources locally, specific characteristics of the local network of health and social services).

1.3 **Other authorized organizational models** with characteristics similar to FMG **be added** to extend primary healthcare services to the population overall;

1.4 **Medical students and family medicine residents be exposed to FMG practice** early in their training before and after graduation.

- This will require the collaboration of network clinical settings and institutions with teaching institutions.

What are the implications of increasing group practice?

From an **organizational** point of view, the recommendation to increase group practice requires maintaining further implementation of family medicine groups (FMG) throughout Québec. Implementation is well underway in Québec and recent years have seen an accelerating number of FMG set up each year in many regions. Consequently, a growing number of people across Québec are registered with an FMG. Just the same, achieving the objective of 300 FMG and registering 75% of the population could require adjusting the FMG formula and intensifying the effort needed to complete such a task. While the first FMG established were clinics with organizational characteristics compatible with the formula even before the current reorganization, or which required minor organizational changes for compliance, the clinics currently without FMG status might have organizational structures differing much more significantly from the FMG model.
In addition, while some characteristics of the FMG model may appear essential in relation to available studies, others could be modulated during set up based on organizational characteristics or settings of the clinics. Furthermore, progressive implementation of FMG development phases appears necessary to encourage acceptance of the model by a larger number of clinics. It should also be noted that multiple adjustments have already been made for several FMG due to specific circumstances.

From an economic point of view, it is important to note that funding the operations of family medicine groups currently represents approximately 70 million dollars of expenditure for the MSSS, or about 0.3% of total health expenditure (MSSS 2006-2007 Annual Report). Considering that 50% of FMG implementation is now complete, the total budget required for funding the model in its current or modulated formula to take into account local and organizational concerns, should be 140 million dollars annually on an annual basis. While this is a considerably large amount for the scale of the population, it appears necessary to allocate these resources to address the needs of individuals seeking affiliation with a primary healthcare group at different stages in their lives. This investment represents a little less than 20 dollars per person per year in Québec.

From an ethical point of view, few consequences have been identified during the consultation process regarding group practice. Nevertheless, observing confidentiality in group practice and developing a healthcare team that fosters a respectful, humanistic, therapeutic relationship are points necessitating special attention. While solo medical practice continues to decline, the impact of that decline on the satisfaction of individuals should be tracked since this model is linked with a high degree of satisfaction among those using it. This also means preserving strong interpersonal relationships within the context of expanding group practice.

2.1.2 Electronic medical records and Québec’s shareable Electronic Health Record (EHR)

New information technologies offer ways to store, process and analyze clinical data related to health care. They include various tools such as electronic medical files (electronic patient files), electronic health records (registers) and distance prescribing of medication. These technologies are being used in the health field in many countries.

Discussion of new information technologies has occupied a large part of the consultations and been a major topic of various commissions studying the healthcare system. Placing priority on a shareable health record was proposed along with networking all physicians working outside health and social service institutions to allow all professional healthcare staff to have access to relevant clinical data related to the health care of the population. This proposal would provide support for networking that could take the form of a partnership between the government and physicians' offices.

**What are the benefits of electronic medical files?**

Scientific documentation shows that new information and communication technologies in the field of health are effective in improving various aspects of health care quality, such as prescribing medication, prevention, managing chronic illnesses and reducing the number of unneeded tests. These technologies could also address certain aspects of the lack of coordination of care in the Québec context by facilitating the transfer of data from primary to secondary or
tertiary care following hospitalization and consultations with specialists. The expected benefits mean that it will finally be possible to bring in systems that store data on the population being served and make use of planning tools for clinical activities, reporting and performance appraisal.

### Electronic medical records and Québec’s shareable Electronic Health Record

**Electronic medical records** contain all the data that is essential concerning the patient at the clinic. In actual fact, they are the electronic versions of current paper files.

On the other hand, Québec’s shareable **Electronic Health Record (EHR)** is a file that allows healthcare professionals local and at a distance access to specific information needed for follow-up and case management of patients regardless of the location of treatment. Under the current project, the EHR does not contain all patient clinical data, but does include information related to certain specific clinical aspects such as laboratory test results, diagnostic radiology examinations and the pharmaceutical profile.

Electronic medical records, introduced into each clinic, office and institution in the network, and Québec’s shareable Electronic Health Record (EHR) with a single record per patient are complementary since one fulfills the function of care management in a local setting (a clinic) and the other, the function of liaison and the sharing of data across the whole network.

Scientific studies conducted internationally suggest that the introduction of such information systems is conducive to fostering preventive interventions (using electronic reminders), greater participation by patients in healthcare (by being able to see progress on certain health outcomes), better planning of the care provided by clinics (through better knowledge of those in the groups of clients receiving care), greater continuity of care and an improvement process for quality of care (through the analysis of the health outcomes of those treated).

These information systems also make it possible to generate data on the health of populations that currently are not fully tracked by the health and social services network because primary healthcare services are poorly documented at the present time. Aggregating such clinical data would allow for better understanding of the state of health of the population and would improve the quality of information from databases related to hospitalization, mortality, illness registry and drug use, and would also provide support for planning care and evaluating the effect of care on health outcomes for individuals.

In Québec, as elsewhere, the utilization of different components in electronic medical records has led to numerous beneficial effects on the quality and safety of primary healthcare services, including standardization of work, rapid and clear communication, strengthening of promotional activities and the prevention and reduction of medical errors. Reductions of 18% in the rate of inappropriate prescriptions that could cause undesirable side effects and 22% in the rate of treatments that were unduly extended have been observed among Québec physicians using information technology clinical decision assistance tools in comparison with those who do not use them (Tamblyn et al., 2003).

Data also suggests benefits for offices equipped with electronic medical files and other information technology tools providing support for medical practice. For example, a survey carried out in 2005 with family medicine groups using information technologies reveals that a
large majority of those using such tools for sending laboratory results considered that this facilitates information exchange and clinical follow-up (94% and 81% respectively). In addition, a pharmacotherapeutic advisor equipped with a prescribing function was installed in 58% of FMG equipped with information technologies, although only 60% of those made use of it. According to the physician respondents, the main advantages of its use were to detect interactions and drug-related allergies (86%) and prior prescriptions (72%) (MSSS, 2005).

Electronic medical records help make primary healthcare medical services more effective and also increase efficiency. When using these systems, care teams gain time by reducing the time spent filing and searching for information in paper files and reducing the number of calls to pharmacists for clarification (Ross et al., 2005; Wang et al., 2003; Miller et al., 2005). Furthermore, there are also related financial advantages, especially a more judicious use of laboratory tests and diagnostic imaging and a reduction in billing errors for medical services (Wang et al., 2003). These studies suggest that the economic benefits associated with the utilization of electronic medical files require a number of years to become apparent.

Electronic medical files for each patient are seen as offering multiple benefits. They are a means to improve communication among healthcare professionals and improve continuity of care, reduce errors in prescriptions and duplication of services, all of which improve the quality of care. Electronic medical files also lead to better understanding of care needs and provision of services thus enabling better planning and management of the services provided. These information technologies offer a response to various constraints inherent in the health and social services system in Québec. They ensure that appropriate information is attached to the records of patients, who are highly mobile within the system, following the patients regardless of the place where care is provided.

What is the status of electronic medical records in Québec

All actors consulted fundamentally agreed that the present system is far behind in terms of electronic record keeping for clinical activities. The portrait of the current situation that we have drawn, the various monitoring indicators we have presented and the consultation process with the network stakeholders confirm that Québec has fallen behind other Canadian provinces and is even further behind other countries in which physicians' offices have been making greater use of information technologies for several years already. This delay in implementation results in lost productivity, lack of knowledge concerning the clientele, and poor implementation of support efforts to improve quality of care and planning for primary healthcare services.

The percentage of family physicians who use computers for a variety of clinical and administrative tasks is lower in Québec than in other provinces and illustrates the lack of penetration of these technologies into the primary healthcare network in Québec. In fact, only 35% of physicians stated that they used software for patient scheduling, less than 10% use electronic medical records (less than 2% stated in 2007 that they used electronic medical records instead of paper files) and less than 4% made use of electronic reminder systems for recommended patient care (National Physician Survey, 2007). Québec ranks last among provinces in Canada in terms of using electronic medical records.
**Funding information technologies**

Introducing and maintaining new information technologies will incur costs. In a context in which the income of physicians can only be increased marginally - since there is a fixed overall budget for physicians - implementation of such systems may not be economically viable for many physicians' offices. In fact, within the context of primary healthcare services, the strictly economic benefits tied to information technologies may not actually accrue to physicians' offices. Like the funding of information technologies in family medicine groups, countries that have successfully introduced such technologies into physicians’ offices opted for partial public funding of the implementation and maintenance costs.

Taking into consideration administrative costs from a fee-for-service remuneration plan does not appear to prompt medical clinics into purchasing such systems. In general, those who have brought in information technologies are large-scale clinics and in many cases clinics with privately financed services (such as executive medicine, services to businesses, healthcare professionals who are not physicians) in addition to medical services insured under the public system. These types of clinics were able to carry the cost of information technologies using various methods to generate an economic return on the investment.

On an international level, Canada also has fallen behind in some respects. In 2001 only 23% of Canadian physicians stated they used electronic medical records - one of the lowest rates among industrialized nations (The Commonwealth Fund, 2008). At that time, there was 100% implementation in other countries. Progress has recently been achieved, however, in terms of laboratory test results and imaging with 27% of physicians stating that they use electronic systems to request and receive test results.

In the more specific case of family medicine groups, the most recent data suggests that three out of four FMG have access to laboratory results using information technologies (MSSS, 2008). The level of information technology implementation varies greatly from region to region which explains why in regions with several hospital centres, the workload and costs related to developing software interfaces is considerable. In Montréal, only one FMG in three uses information technology to access lab results (Idem).

As for other information technologies, penetration into clinical settings is not better. Only 11% of clinics stated that they routinely used electronic prescriptions and 8%, electronic lab test results and a little more than one in four has electronic access to test results (The Commonwealth Fund, 2006). These low rates for information technology in primary healthcare medical clinics could be explained by a lack of hardware and software among family physicians and by the lack of new technologies in clinical settings. This is less the case among young physicians. In fact, during clinical training, 75% of Canadian second year residents in family medicine used or were exposed to electronic medical records and a similar percentage expects to use them in future practice (National Physician Survey, 2007).

These gaps in the use of information technologies have consequences on the capacity of clinicians to offer the most appropriate care and to properly plan and appraise the services they deliver. In Canada, approximately one in four physicians can state being able to generate a list of patients according to diagnosis or risk factor or a list of medications for their patients (The Commonwealth Fund, 2006a). Only one in ten physicians reports having received electronic
reminders indicating a potential problem related to patient medication or the need for a patient to undergo a screening test. Only 6% of clinics are able to share records electronically with other clinics or allow patients to consult their file electronically (The Commonwealth Fund, 2006).

Concerning aspects related to preventive services, the Commonwealth Fund survey suggests that only 13% of Canadian physicians stated they could easily print out a list of patients who must be tested or receive preventive care and that only 8% of the patients received electronic reminders for preventive care or medical follow-up, which is the lowest rate among the countries compared (The Commonwealth Fund, 2006a). Increasing prevention of illness and the promotion of health in the clinical context is a major challenge due to the large volume of patients who must be seen each day. Consequently, the time devoted to prevention is limited and often subordinate to the need for immediate care. Nonetheless, these clinical contacts are opportunities to strengthen messages concerning prevention and to conduct screening tests and preventive treatments that can deter the advance of illnesses.

A local experiment: the Montmagny FMG

Set up in 2003, the Montmagny FMG has 20 physicians (13 full-time equivalent positions), 3 nurses and 12 secretaries in five service outlets. Today it makes full use of information technologies. For the physician in charge of the FMG who assumed the leadership role for the information technology project, the process required an investment of approximately six additional hours per week during start-up as well as during the first 18 months of implementation. This FMG experience revealed that there were few generalized outages of the system (defective Internet connections) affecting distant sites connected to the central server.

The experience at this FMG illustrates the potential gains in productivity for the professional staff and the expenses related to managing paper files. In fact, using electronic medical records allowed the physicians in this FMG to save approximately 40 minutes daily or three and a half hours weekly per physician by making patient consultations and daily administrative tasks more efficient. The total gain for the FMG physicians as a group is nearly 70 hours per week, or two additional virtual physicians - a 10% increase in physicians. In addition, since 2006, the FMG has ceased receiving paper laboratory reports thus freeing up approximately 20% of the time of secretaries that previously went to digitization and transcription. Electronic data transfer of laboratory results also results in a major reduction of paper use since each physician previously received approximately 30 pages of laboratory results per day (280,000 per year). Adding several document scanners gradually helped eliminate paper documents from files.

Source: Personal interview, Jean-François Rancourt, in charge of the Montmagny FMG

For citizens, what are the issues related to electronic medical records?

The members of the Consultation Forum of the Commissioner acknowledged that new information technologies offer many advantages. However, they also emphasized risks, such as data transfer to third parties with the consequences of privacy breaching and possible discrimination based on health status. As a result, they consider that a rather prudent approach should be taken for implementation of new information technologies in clinical settings in Québec.
In addition, the proposal stemming from the consultation process, which consists of using public funds to finance infrastructure in the private sector, such as primary healthcare physicians' offices, raised questions among the members of the Consultation Forum of the Commissioner. If the process does not allow networking of patient files, the members of the Forum question the ensuing advantages and do not approve in such cases of public financing of equipment for primary healthcare physicians' offices. If the government moves in this direction, the members of the Forum have identified several concerns. For example, they believe that financial participation must be conditional on strict implementation measures that would ensure system efficiency, data confidentiality and greater accountability for physicians' offices.

The opinion of the general public regarding electronic medical records

Overall, Québécois appear quite open to new information technologies. A vox populi survey conducted under the Commission of Study on Health and Social Services (2000) suggested that 80% of people were somewhat or highly in agreement with the idea of a single record being established for each patient that could be accessed online by all healthcare professionals being consulted. More recently, a survey revealed that 81% of respondents gave a favourable opinion of Québec’s shareable Electronic Health Record (EHR) and more than 80% had confidence in the confidentiality of their health data, especially data in medical clinics (85%) (SOM survey, 2007). It should also be noted that only 2.6% of 3500 users refused to take part in the first phase of the EHR pilot project launched June 9, 2008 at the Saint-Vallier FMG in the Québec region (MSSS, 2008a).

Key elements for the Commissioner concerning electronic medical records

As have previous commissions investigating primary healthcare performance, the Commissioner has concluded that introducing new information technologies is important for obtaining a beneficial impact on patient care delivery while ensuring that the risks inherent in such an approach are taken into consideration to reduce potential adverse effects. These information technologies allow for the creation of electronic medical files for each patient as well as a health information system designed to improve care (practice guidelines) and a decision assistance tool to guide clinicians in managing clinical problems. The context of expanding group practice in Québec offers an opportunity to introduce information systems.

In this context and in light of the studies conducted, international experiments and the consultation process carried out, the Commissioner recommends that the Minister of Health and Social Services support implementation of electronic medical records and Québec’s shareable Electronic Health Record (EHR) within primary healthcare physicians' offices in Québec (see Recommendation 2). As a result, the Commissioner agrees advocates that information technologies should play a major role in the reform of primary healthcare services to the extent that various issues pertaining to maintaining confidentiality of clinical data are taken into consideration.
Recommendation 2

Support the implementation of electronic medical records and Québec’s shareable Electronic Health Record

In order to improve primary healthcare service performance and its contribution to the overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

2.1 **Electronic medical files and related technologies** (electronic transmission of queries and of data, electronic prescriptions) **be implemented throughout all family medicine groups and throughout all other officially recognized models**;

2.2 **Support activities for training and introduction of information technologies in clinical settings be set up** at local and regional levels;

2.3 **A partnership between medical federations and network authorities be developed to foster the introduction of electronic medical records and related technologies into all primary healthcare clinics and offices which so request it**;

- This could be supported through financial or organizational incentives within a context of agreements stating the conditions of such incentives.

2.4 **Québec’s shareable Electronic Health Record and electronic medical records introduced into FMG and other offices be technologically harmonized** in order to foster circulation of appropriate information related to the care of persons throughout the health and social services network;

2.5 **Guidelines be instituted** in collaboration with clinics and professional orders and in line with Québec legislation governing such matters **to ensure confidentiality and protection of medical information contained in the shareable electronic health record and electronic medical files**.

What are the implications of introducing electronic medical records?

From an **organizational** point of view, the introduction of electronic medical files brings major challenges. Introducing new technologies requires time and expertise with information technologies, two commodities that are not always available within the context of primary healthcare services. This recommendation therefore requires creation of a support program for implementation of electronic medical records in clinical settings. In addition, this phase of implementation will require technical support for harmonization while regular clinical activities are being conducted. In addition, resources must be made available on a regional level to provide support for clinics during the planning and implementation phases. The result would be better consistency in the actions carried out.
From an economic point of view, the implications of the recommendation to implement electronic medical files are significant in terms of costs related to system set up and maintenance. Set up and maintenance of these information systems are very costly. For the physicians’ offices, the introduction of electronic medical records may represent several thousands of dollars of expenditure to purchase hardware, software and related technical support. In fact, a cost-benefit analysis for implementation of electronic files suggests that it could cost approximately $10,000 per physician - an amount that could vary according to the size of the clinic where implementation takes place.

Thus, for all primary healthcare service physicians, full implementation could require an investment of nearly 70 million dollars considering that in Québec there are approximately 7,600 family physicians and that only approximately 10% of them are already using electronic medical records. In addition, maintaining these systems would also involve recurrent expenditure of 10 to 20% of the expenses related to set up and would thus result in recurrent annual expenses.

On the other hand, as was highlighted earlier, full introduction of information technologies into physicians' offices could result in considerable economies for the healthcare system overall. In addition, this investment could generate new employment, particularly in the health sector and the commercial sector as well as stimulating research and development, especially in the creation of software applications, studies on appraisal and performance of the healthcare system, and on the efficiency and effectiveness of treatment and medical practices.

<table>
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<th>Costs related to family medicine group information technologies</th>
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<td>For an average FMG, the MSSS currently funds a server, 16 workstations and an operating system, certain software packages and a laser printer per site, access to a telecommunications link, technical support, costs related to information technology training and replacement of the salaries during training in information technologies. Also subsidized for FMG are use of the firewall module, the medication decision assistance tool, the module for access to laboratories and the registration module for the RAMQ. The non-recurrent budget for the initial purchase of hardware and software is $27,000 for a typical FMG. The recurrent budget for utilization of software applications is $18,000 for a typical FMG (MSSS 2008-2009 budget review). On the other hand, the MSSS does not finance the purchase of optical scanners required to convert old paper files nor the applications required for full data entry such as the patient index. It does not finance the module to access medical imaging results or the electronic billing module, the costs related to support and maintenance for the applications and costs of implementing full use of information technologies (work reorganization, training).</td>
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From an ethical point of view, our consultation approach suggests that various aspects related to a possible loss of confidence as the result of an inappropriate use of personal health data must be taken into consideration when physicians' offices integrate information technologies. Various conditions concerning the introduction of such systems have been highlighted earlier. In our context, specific rules for utilization of electronic medical files must be developed and introduced into the clinics to ensure appropriate observance of the persons rights and privacy. On the other
hand, introduction of EHR should offer individuals better access to their personal medical records and the quality of healthcare should be improved and dissemination of clinical incidents more efficient. To respond to the concerns raised within the context of the consultation process, a framework for accountability should be developed as a counterpart to financial support for implementation of information technologies.

It should be noted that, in the current situation, physicians are required under the code of ethics to maintain the privacy of information regarding their patients. The requirement is the same for electronic files as it is for paper files. The difference is mainly the speed with which sensitive nominative data can be divulged in an electronic format.

Countries that have introduced such systems provide interesting lessons concerning the measures that may be brought in to ensure data safety. However, the risk is never absent regardless of the laws and mechanisms designed to eliminate it. Nevertheless, many actors in the system feel that an electronic file is safer than a paper file since information technologies can track all those who consult a patient record. One of the initial steps in full implementation of information technologies in FMG is establishment of a secure environment starting with daily backups of data.

The obligations tied to use of electronic medical files

Under the provisions of the regulation governing patient records in Québec, the Règlement sur la tenue des dossiers du Collège des médecins du Québec, a physician utilizing electronic medical files must observe the rules and use technology to protect the privacy of the electronic data contained in the file or which is sent to other actors in the field. Use of electronic medical files is subject to specific obligations: (1) use of an electronic signature (2) use of a file directory separate from the other directories of the clinic, (3) protected access to data through the use of a security key and user authentication, (4) use of document management software designed so that data recorded cannot be deleted or replaced, (5) use of a software allowing data printouts, (6) backup copies of clinical data are maintained at a different site.

2.1.3 Interdisciplinary teams and network practice

Most primary healthcare reform proposals emphasize the importance of an interdisciplinary team approach (Shortt, 2004). This approach is based on the work of several professions, with those most often cited in the references being pharmacists, social workers, psychologists, physiotherapists and especially nurse practitioners. Various factors are acknowledged as justifying the development of interdisciplinary teams in clinical settings. These include a shortage of primary healthcare physicians, an increase in the workload of physicians, an increase in exposure to interdisciplinary work during medical training, acceptance of interdisciplinary clinical practices by physicians and openness to the notion of interdisciplinary practices among the public (Hutchison, 2004).
Within the context of the consultation process, the interdisciplinary team approach and networking took a major place and were identified as the basis for renewal of the system giving the central role to actors throughout the system beyond the resources in the health institutions. The members of the Consultation Forum of the Commissioner highlighted the importance of the role played by professional staff members who are not physicians in order to foster a comprehensive approach to healthcare. They clearly expressed the wish that primary healthcare services be delivered according to an interdisciplinary team approach.

In addition, the members of the Consultation Forum believe that medical and social concerns, prevention and cure, should be combined in primary healthcare services in the local community service centres (CLSC) but underscored the difficulty of fulfilling such a mission without the participation of physicians' offices. The members of the Consultation Forum first highlighted the importance of the "creation of multidisciplinary teams around family medicine groups (FMG) rather than relying solely on agreements signed by health and social services centres (CSSS) and local health and social services networks (RLSSSSS) with resources other than medical resources, since these are not always sufficient." However, by the end of their deliberations on the subject, they concluded that the Consultation Forum could not pronounce an opinion on the organizational model for services that should be favoured, whether strengthening the mission of the CLSC by repatriating physicians or by favouring the FMG model with the integration of many actors in the system. In addition they also emphasized that "synergy must be created that will oblige the various actors to talk with each other, and change the culture of current practices making them more stimulating and less restrictive".

An interdisciplinary team approach within medical offices based on networking of resources in the care and services network is intended to ensure close collaboration among a team of professionals and physicians to meet the needs of persons who come in for consultations. Joint efforts make it possible to optimize service trajectory by bringing together all the professional staff around a continuum of care and to foster the promotion of health and prevention of illness for individuals. The introduction of local mechanisms for collaboration among medical offices and the current services offered in the CSSS clearly became a priority that is feasible. Lastly, it seems that the training of physicians must be changed, especially to prepare them for an interdisciplinary team approach so that they will adopt a comprehensive approach to healthcare and rely more on prevention and self-care practices and accept patient empowerment. This interdisciplinary team approach should be part of university training through collaboration among the various university departments of health sciences.

**What is an interdisciplinary team approach?**

An interdisciplinary approach designates the participation of professionals from various disciplines that deliver care and services to individuals such as medicine, occupational therapy, psychology and social work. This participation relies on a significant degree of interaction and coordination of the action of various actors in the system in developing intervention and treatment plans for patients. An interdisciplinary team approach means more than the simple fact that a patient receives services from multiple providers (which is termed a multidisciplinary approach) and is based on the interaction of providers to deliver complementary services in a jointly collaborative manner. Moreover, interdisciplinary care is differentiated from the notion of multidisciplinary care that describes simultaneous participation of several disciplines in the care framework but does not call for any significant degree of interaction among the various professions.
The strong consensus on the need to increase the interdisciplinary team approach within primary healthcare services is part of an overall trend towards modifying professional practices and the division of fields of expertise. This trend can be seen in the emergence of new organizational models based on an interdisciplinary perspective (FMG, clinical networks) as well as the transfer of certain activities from hospital settings to clinical settings located in the community. The decision makers consulted underlined the high quality of the human resources, physicians and professional staff within the network ready to respond to the needs of individuals.

What benefits can be expected from an interdisciplinary team approach to primary healthcare services?

Studies available and the findings produced after analyzing the impact of interdisciplinary care in various provincial and international contexts suggest many benefits for healthcare systems. These benefits would consist mainly of an increase in the capacity of organizations to respond to the overall care needs manifested by individuals and an increase in the appropriateness of care by dint of collaboration among the various professional care providers during interaction with patients. The participation of nursing staff on medical teams has been the topic of many studies, and there is strong proof that the satisfaction of individuals regarding the care received is greater.

Lessons learned from international experience are widespread regarding the benefits of interdisciplinary team practices. The cases of health maintenance organizations (HMO) in the U.S. such as Kaiser Permanente and the Veterans Health Administration are particularly eloquent in bearing witness regarding improved quality of care and better utilization of available resources, most notably in terms of primary healthcare services provided to those suffering from chronic illnesses. In a context in which chronic illnesses such as heart disease, diabetes, joint disease and health problems related to aging are increasingly prevalent, there is a need for more interdisciplinary care to respond to the growing complexity of the healthcare needs manifested by many patients.

A recent study also highlighted its relevance within the Canadian context (Khan et al., 2008). Primary healthcare interdisciplinary teams have been associated with greater receptivity to health promotion and illness prevention efforts, better coordination of care, an approach responding to the comprehensive healthcare needs of persons and greater quality of care. Carried out from a viewpoint of increasing the efficiency of healthcare systems, this study, based on data from a scientific survey of experiences with primary healthcare, concluded that access to primary healthcare interdisciplinary teams reduces emergency room use through reductions in unmet needs and in uncoordinated care that also lessened the risk of hospitalization.

Within the context in Québec, a recent study on FMG interdisciplinary teams illustrated the feasibility of introducing interdisciplinary teams into primary healthcare medical offices and the various benefits for the care continuum (Beaulieu et al., 2006). This study revealed how the integration of nurses into FMG, along with the presence of other organizational features inherent to the FMG model, was accompanied by clinical care protocols and had positive impact on access to services, coordination of care, and the comprehensiveness of care and the knowledge of the patient by the teams providing treatment. Other authorities have also released findings and recommendations aimed at placing greater emphasis on an interdisciplinary team approach. For this purpose, the Commission of Study on Health and Social Services (2000) recommended a review of the framework for professional practice and the creation of the conditions necessary for interdisciplinary team work.
What is the status of primary healthcare interdisciplinary teams in Québec?

It is estimated that 40% of Canadians have access to a primary healthcare team defined as access to a health professional other than their doctor at their regular place of care (Khan et al., 2008). In Québec, the network has the experience of local community service centres (CLSCs) which have provided interdisciplinary medical care for many years in order to meet the health and social services needs of the populations they serve. The hospital context also benefits from the service of multiple professionals within the same institution to meet the needs of persons who are hospitalized. However, primary healthcare services remain relatively self-contained. In fact, the current situation that we have described suggests that a majority of the primary healthcare service outlets in Québec essentially offer only medical services. Nearly one physician in three works alone and only a quarter of physicians work in collaboration with professionals from another discipline. This observation can be explained by the fact that primary healthcare physicians who provide an initial community-based service very often work in a solo setting or in groups of physicians and have very little integration with institutions in the health and social services network. Moreover, the National Physician Survey (2007) reveals that medical students are not very familiar with the manner of practice of other healthcare professionals such as occupational therapists, physiotherapists, pharmacists and especially nurses and midwives.4

Gains have however been achieved in recent years. The Act to amend the Professional Code and other legislative provisions as regards the health sector, in force in Québec since 2002 contributes to interprofessional collaboration by amending the Professional Code and redefining the exercise of medical professions such as nursing, physiotherapy and pharmacy. It expands the fields of practices so that certain services are no longer exclusively reserved to physicians but may be shared among several professional orders. In addition, the introduction of FMG and integration of nurses at locations where primary healthcare services are provided has increased the number of primary healthcare medical points of service benefiting from an interdisciplinary team approach. Nevertheless, beyond the collaboration of physicians and nurses, few primary healthcare medical teams work as interdisciplinary teams outside CLSCs. In addition, these cover only a small proportion of the population for primary healthcare medical follow-up. Since FMG implementation is still only partial and because an interdisciplinary team approach is rare, there is limited interdisciplinary team practice in primary healthcare services.

In fact, the laws governing healthcare services and social services do impose limits on the funding of care delivered by professionals. These laws govern the provision of services to the public, ensuring that required medical services and services delivered in health institutions are free-of-charge, but not those delivered outside of health institutions. In Québec, the services of various professionals, such as pharmacists, occupational therapists, psychologists, dentists or social workers must be funded by complementary private insurance or by the user of the service when care is provided outside health institutions. As a result, only persons holding complementary private insurance are covered for the costs related to these healthcare services. Approximately one person in three in Québec does not have complementary private insurance. In emphasizing only the care provided by physicians or by health institutions, the Canada Health Act has profoundly affected public funding of services of other primary healthcare providers, thus placing a barrier on interprofessional collaboration.

4 For third and fourth year medical students, 23% are not at all familiar with the work performed by nurses, 16% with the work of dietitian/nutritionists, 15% with that of occupational therapists and 13% with that of social workers (National Physician Survey, 2007).
For citizens, what are the issues related to interdisciplinarity?

More widespread implementation of interdisciplinary practice in the health network, especially through mobilization of resources in the health and social services centres (CSSS) towards primary healthcare networks raises certain issues that are important to consider. It should be noted that the members of the Consultation Forum of the Commissioner emphasized that an interdisciplinary team approach in itself is desirable and should be designed according to patient needs and not according to the location where services are provided. They also agreed that a balance should be maintained between mobilization of resources towards family medicine groups and the establishment of service agreements under which resources render services inside the CSSS according to the needs expressed in the regions. Lastly, they also stated that interdisciplinary practice in primary healthcare services calls for modification in the training of healthcare workers to familiarize them with this mode of practice and promotion of a new organizational culture within the network.

Key elements for the Commissioner concerning interdisciplinarity

Interdisciplinary teams and network practice are fundamental notions for improving the relevance of care in a context in which cases of chronic illnesses and multi-morbidity are on the rise. As mentioned earlier, the care needs of persons and treatments are becoming increasingly complex and require participation of a range of various healthcare professionals more now than ever. Moreover, the context of limited resources facing the health and social services system calls for implementation of interdisciplinary teams that will allow the right professional healthcare worker to provide the right care at the right time. At the present time, primary healthcare physicians are employed in responding to all the needs of those coming in for consultations, including the services that other professional healthcare workers could deliver.

In light of the studies conducted, international experience and the consultations carried out, the Commissioner considers that the formation of interdisciplinary teams in primary healthcare settings would improve quality of care, allow for increased emphasis on health promotion and illness prevention, and fill the relative lack of medical resources that Québec is facing. In this context, the Commissioner proposes to the Minister of Health and Social Services that implementation of primary healthcare interdisciplinary teams in Québec be facilitated (see Recommendation 3). An increase in interdisciplinary teamwork within family medicine groups should be a priority for the implementation of this recommendation.
Recommendation 3

Increase interdisciplinarity in primary healthcare group practice

In order to enhance performance of primary healthcare services and their contribution to overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

3.1 Family medicine groups (FMG) and other authorized models include a larger presence of healthcare professionals who are not physicians, such as nurses, nurse auxiliaries, psychologists, dietitians/nutritionists and social workers currently providing services within health and social services centres (CSSS) to increase interdisciplinary teamwork within primary healthcare services;

- These professional workers should maintain their employment link with the CSSS but a portion of their activities should be assigned to medical office practice.

3.2 Contractual links be signed between primary healthcare medical offices and health and social services centres to outline specific service corridors to ensure patients with access to care delivered by professionals other than physicians when delivery within medical offices is not possible;

3.3 Coordination mechanisms be instituted with all local health and social services networks for local provision of care integrating all service providers in physicians' offices and institutions in the local network;

3.4 Health science professional workers, including physicians, be trained in interdisciplinary approaches, especially during clinical internships. This must be done in collaboration with clinical settings and teaching institutions.

What are the implications of increased interdisciplinarity?

From an organizational point of view, such a recommendation requires a major reorganization of the work of professional staff in the health and social services centres, regardless of the employment link maintained. An increase in the provision of interdisciplinary care in the context of family medicine groups requires, following the example of FMG nursing practices, the introduction of mechanisms allowing the mobilization of professionals providing care in institutions to work in medical offices located within the community. Negotiations with union representatives and contractual agreements will be required. In addition, agreements with the clinics aimed at setting out guidelines for the participation of professionals who are not physicians and planning their functional integration, including offices, assignment of appointments and participation in the activities involving planning of services and client follow-up must be established.

Numerous obstacles have also been identified. These include the operating costs associated with increased staff, the threats perceived by physicians concerning extended practices and the patient-physician relationship. In Québec these obstacles take the form of resistance in the field (lack of trust and opposition to the proposals, a difference in professional cultures and styles of practice,
lack of understanding of mutual competencies), lack of consistency in the financial, legal and regulatory frameworks according to objectives sought and lack of support for change management (Beaulieu, 2004).

In addition, this proposal also entails challenges related to the medicalization of practices of professionals other than physicians resulting from the transfer of a portion of their activities outside the CSSS. In fact, mobilizing professionals working in a CSSS to work in primary healthcare service outlets such as clinics could lead to a drift towards service provision that is based on a more medical than holistic logic. Since resources are limited, it could be difficult to maintain quality CSSS services or certain types of social or preventive services.

### Multidisciplinary resources

As is currently the case for nurses, a portion of the activities of healthcare professionals from CSSS with a CLSC mission could be assigned to family medicine group (FMG) practice. The number and type of healthcare professionals could also be adjusted according to the size and needs of the FMG clientele and the resources available at the health and social services centre (CSSS). It is estimated that currently for the CLSC mission at the CSSS there are one social worker full-time equivalent position per 5000 inhabitants, 1 dietitian/nutritionist full-time equivalent position per 35,000 inhabitants, 1 occupational therapist full-time equivalent position per 13,000 inhabitants (data officially published by the MSSS). For an average FMG with 15,000 patients registered, a team could reasonably include two to four full-time equivalent positions for healthcare professionals. This team could be composed of social workers, dietitians/nutritionists and other professionals (occupational therapists or physiotherapists for example). On another note, the MSSS unveiled in June 2008 a series of measures designed to structure the challenge of nursing care staffing availability on a sustainable basis. The proposal is to create 115 nurse practitioner positions for primary healthcare services (MSSS, 2008b). These positions could be integrated into FMG teams. The nurses would work in tandem not only with general practitioners but also with nurses already in place for whom they could provide coaching and training due to their specialized training.

Another aspect to consider is that the training of future healthcare professionals must be reviewed to encourage their capacity for collaboration during training at a college or university level as well as during clinical internships. An impressive number of Québec students on the verge of receiving diplomas are poorly or not at all informed about the work carried out by other healthcare professionals. After their diploma has been earned, healthcare professionals should complete their training in interdisciplinary teamwork through ongoing training sessions throughout their professional development. As was the case for training dealing with the role of FMG, the MSSS could assign grants to newly authorized FMG to provide training dealing with an interdisciplinary team approach (MSSS, 2003a).

From an economic point of view, an interdisciplinary team approach may not represent a source of additional expenditure in terms of human resources to the extent that a small percentage of current resources in the network are mobilized to provide services in primary healthcare clinical settings. However, costs related to leasing additional space to facilitate the arrival of new professional workers in medical offices could occur as a result of this recommendation and should be taken into consideration. In addition, the mobilization of interdisciplinary resources to primary healthcare clinics and the introduction of healthcare coordination resources on a local
level may involve opportunity costs, since the resources are not available to offer their services within institutions in the network. In many contexts where resources in the institutions are already lacking, such an increase in interdisciplinary teamwork for primary healthcare services could require major collaboration by actors in the network.

From an ethical point of view, given the current legislative framework governing the funding of healthcare services, encouraging an interdisciplinary team approach could take various forms based on the resources in the public or private sector that would be involved. Problems concerning equity could arise because the development of interdisciplinary teams is often carried out within organizational models that require a financial contribution from users. Improvement in primary healthcare services would then be limited to a privileged segment of the population. Linking funding of interdisciplinary services within the context of primary healthcare services also requires designing modalities to mobilize the existing resources taking into account the capacity of people to pay and their insurance coverage to minimize issues related to fair access regarding the care provided by professionals other than physicians.

2.2 Acting on clinical practices and provision of services

The need to provide support for individuals and their families when interacting with the healthcare services and in managing their health was a major topic during the consultation process. Scientific publications have highlighted how better preparation is needed for individuals and their healthcare teams if quality of care is to be maximized and the health of individuals improved. This requires modifying the means with which healthcare professionals interact with individuals and equipping them to face the challenges related to health promotion, the prevention of illness and living with illnesses that affect daily living. Individuals and their families are increasingly sharing the responsibility with healthcare professionals in the prevention, treatment and control of health problems.

The specific theme of prevention and "managing one's own health" occurred on many occasions in the discussion of the Consultation Forum of the Commissioner. Firstly, actions in the field of prevention are deemed of capital importance and there is a need for greater prevention efforts in people's lives and citizens must be sensitized from an early age about health concerns and receive information about the organization of healthcare services and social services. Lastly, the importance of informing the public has been reiterated on many occasions by members of the Consultation Forum of the Commissioner. They emphasised the need to provide citizens with basic information on the services offered and the organization of the system that would allow them to navigate it to obtain services.

These various actions are in fact related to the practices of healthcare professionals and the manner used to interact with these individuals. A modification of clinical practices and provision of services could provide a response to these issues related to illness prevention and participation by the public in the progression, maintenance and reestablishment of their health. This section addresses topics concerning the design of new modalities for the provision of care, the participation of patients in their own care and registration of the public.
2.2.1 Development of new modalities for the provision of care

The consultation process of the Commissioner outlined various social, demographic and technological transformations affecting the system and which compel us to review our traditional methods for delivering primary healthcare services. Such transformations include an aging population, the modification of health problems (mainly chronic rather than severe) and continual increase in the capacities for diagnostic and therapeutic intervention. The very concept of medical consultation, which was traditionally defined as an office visit between an individual and a healthcare provider, has been called into question.

The experts and decision-makers who were questioned, suggested various actions that could lead to innovation in the ways that care and services are delivered to individuals beyond the traditional face-to-face consultation. These actions could be introduced into primary healthcare service organizations and include modalities for group medical consultations, care delivered by peers, electronic and virtual consultations, telemedicine and advanced access programs in which scheduling programs foster better linkage between individuals and the services provided.

What benefits can be expected from new care delivery modalities?

The various modalities for care delivery proposed during the consultation process are based on various levels of scientific evidence. For many, the innovative character and the fact that development and implementation have hardly been completed greatly limits our capacity to understand fully the potential benefits or the possible negative effects. Nevertheless, this series of new ways to deliver services should make it possible to enhance quality and satisfaction with the services received.

Group consultations with physicians or healthcare professionals have been introduced in various healthcare systems or organizations, mainly in the context of care delivered to those suffering from chronic illnesses. According to the documented health research, some persons who have recurring needs for care and services aimed at strengthening their capacity to control their health problem and carry out their treatment plan often have the same questions or complementary questions. They may therefore benefit from the experiences of others and mutually share clinical interactions. Although different individuals will be at different stages in the development of their illness, with different secondary effects or specific difficulties in maintaining their treatment, they can learn from the responses offered by healthcare professionals and thus become better equipped to deal with situations that may arise during their lives. Voluntary participation in group consultations with a physician or nurse clinician may allow several patients, in an efficient manner, to benefit all at the same time from instruction provided by the proper healthcare professional. Such group consultations have been introduced in various settings as complementary measures to individual consultations during which a private, personalized therapeutic relationship has been built.

International healthcare publications show that patients acquire much expertise during the time they are suffering from illness and consequently may be a source of care or lessons learned for other patients who are less experienced or who have not yet had to face similar situations. The feasibility and effectiveness of such peer consultations have been demonstrated in various contexts and seems to be a method that is as effective as a personal consultation and also represents a method for utilizing resources in a more efficient manner.
In line with implementation of new information and communication technologies, the concept of electronic and virtual consultations has also emerged in the most innovative clinical settings and may take various forms in the context of primary healthcare services. An interactive mode of communications between healthcare professionals and their patients in the form of emails or personal health journals or virtual consultations at a distance are examples of practices that could permit continuous medical follow-up while responding to patient questions and avoiding travel. Sometimes these consultations may take the form of prepared responses dealing with a specific health problem or its treatment. Individuals may also replay a consultation in order to assimilate the information more completely if it was delivered too quickly or was not understood for that reason. The availability of electronic interactive materials (health portals, prerecorded answers and questions, etc.) provide support tools for service delivery. These modalities for consultations can be complementary to the traditional clinical appointment and could avoid consultations resulting from a poor understanding of clinical conduct and they may also increase the capacity of individuals to control their own health.

The last modality proposed concerns advanced access programs. The focus of this consultation modality consists of ensuring that individuals and professional healthcare workers are able to obtain access to the services they require at the most convenient time based on previously defined care trajectories. Advanced access programs provide individuals with guarantees of being seen as quickly as their state of health requires and according to their availability. Consequently, an individual seeking to schedule an appointment for the next day may obtain one, as will an individual requesting an office visit for the next week or month. While such a measure may appear difficult to reconcile with the long wait times encountered in many healthcare systems, it has nonetheless been introduced in many contexts. It requires properly structuring the service provision to include slots specifically dedicated to walk-in consultations, short lead-time scheduled consultations as well as long lead-time scheduled consultations and patient follow-up. Proper knowledge of patient case management is fundamental for introducing this modality.

Although recently introduced, advanced access programs have been the subject of appraisals in certain American and European contexts. The appraisals of advanced access programs have generally revealed that wait times were reduced and there was an increase in user satisfaction without requiring healthcare professionals to work additional hours. Among the observed effects that made more prompt service possible, it was noted that fewer patients scheduled visits far in advance (since they were certain to be seen quickly through the advanced access program) and that there were fewer patient no-shows for scheduled appointments. Making an appointment that takes into account work constraints or family obligations helps patients keep appointments more easily. This last finding is important when considering the large impact for physicians of patient no-show rates that can total 10 to 20% of the time for all visits scheduled.

What is the situation for new modalities for care delivery in Québec?

These new consultation modalities are rare in Québec. Although some clinical settings have adopted and introduced certain aspects of these modalities, it must be admitted that the public overall in Québec does not have access to them and that we should, therefore, collectively explore these avenues to increase access by individuals to the medical and interdisciplinary primary healthcare services they require. Lastly, the low rate of interdisciplinary team work and the low penetration of electronic medical files into primary healthcare offices probably represent barriers to implementation of these new consultation modalities that, in most cases, require a higher degree of primary healthcare organizational structure than is present in most physicians' offices in Québec.
For citizens, what are the issues related to these new modalities for care delivery?

Within the context of the deliberations of the Consultation Forum of the Commissioner, the topic of new consultation modalities was not specifically addressed. Nevertheless, certain issues brought up in discussions dealing with other themes, in particular the topic of information technologies, did emphasize that privacy and the right to choose the manner in which each individual decides to consult healthcare professionals are a focus of concern for the members of the Consultation Forum of the Commissioner. These concerns are all the more relevant when discussing the transmission of information using emails or group consultations.

In conclusion, introducing such modalities for consultations must, at all times, respect privacy concerns for personal information and personal lives. Moreover, these modalities must be introduced in such a manner that individuals are well-informed and free to make choices related to use of them.

Key elements for the Commissioner concerning new modalities for care delivery

These new consultation modalities offer important possibilities that require exploration. A variety of actions proposed within the context of the consultation and which also occur in the health science publications reviewed consist of specific modalities for consultations and interaction between care providers and individuals. While some receive more support than others, the new methods for service delivery should, in an overall manner, be evaluated and be included in a program designed to renew primary healthcare service practices.

The scientific evidence concerning these diverse innovations such as group consultations, peer consultations, electronic and virtual consultations and advance access programs is not conclusive. Some innovative techniques have results that are at times contradictory or mitigated or simply have not yet been assessed.

If these organizational measures offer great potential, it is highly necessary for us to explore them immediately in order to assess whether they are appropriate for our context and whether they have the potential to enhance primary healthcare service performance and facilitate better coverage and accessibility for the population of Québec. To encourage full participation by the public in primary healthcare services, the Health and Welfare Commissioner recommends to the Minister of Health and Social Services that the development of new modalities for care delivery be explored in order to evaluate them and their potential introduction in the network (see Recommendation 4).
Recommendation 4

Explore new modalities for care delivery

In order to enhance performance of primary healthcare services and their contribution to overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

4.1 The relevance, effectiveness and security in our context for new modalities for delivery of care be evaluated including, but not limited to, group consultations, peer consultations, electronic and virtual consultations as well as programs for advanced access to care;

- This should be carried out in collaboration with the Agence d’évaluation des technologies et des modes d’intervention en santé (AETMIS) or possibly with the Institut national d’excellence en santé et services sociaux (INESSS).

4.2 Experience that exists within clinical settings in Québec related to the introduction of these new methods for interaction with patients be catalogued and analyzed in order to encourage their implementation in other settings;

4.3 The scientific evidence and feasibility of introducing these new consultation modalities be evaluated in order to meet the growing needs of populations in the context of primary healthcare services;

- This should be carried out in collaboration with the Agence d’évaluation des technologies et des modes d’intervention en santé (AETMIS) or possibly with the Institut national d’excellence en santé et services sociaux (INESSS).

What are the implications of these new modalities for delivery of care?

From an organizational point of view, the recommendation to explore and evaluate these new modalities for care delivery will require developing partnerships with clinical and research organizations. Possible implementation would also required putting organizational structures into place that would allow for planning and introduction of group consultations, peer consultations, electronic and virtual consultations and programs for advanced access to care. As mentioned earlier, physicians' offices that do not possess the interdisciplinary resources, do not share clinical responsibilities as part of a team and do not possess efficient clinical information systems, risk being the most difficult settings for introducing these new modalities for delivery of care.

Certain organizational implications must also be considered in the event of implementation. For example, electronic and virtual consultations require fully-developed computer installations. Group consultations and peer consultations are more effective in settings in which a team of several healthcare professional workers can provide support for discussion activities. Advanced access programs require that a team of physicians and other healthcare professionals share scheduling hours in order to provide flexibility in scheduling short–term appointments at times that are convenient for patients.
From an **economic** point of view, a portion of the development funds already present in the health and social services network could be allocated to evaluate the innovative techniques in use in primary healthcare physicians' offices and to support pilot projects aimed at better documenting the effects and the possibilities of implementation. However, it remains difficult to estimate the economic impact of this recommendation as the specific modalities for implementation will have a major impact on the related expenses.

From an **ethical** point of view, evaluation of the new modalities for patient consultations and follow-up should be accompanied by an evaluation of their acceptability by individuals. Privacy is obviously an issue for certain modalities that call for consultations in the presence of third parties or carried out using information technologies. Lastly, other complex ethical issues may arise due to the different capacities of individuals to take charge of their own health, participate in group consultations or interact with healthcare professionals in ways other than in the traditional personal office visit. Respect for the autonomy and the freedom of choice of individuals must remain at the core of these new modalities for delivery of care.

### 2.2.2 Participation by individuals in healthcare

The very nature of health problems is changing and is compelling us to review the practices of our healthcare professionals in order to respond better to the needs of the population and even to review the role patients themselves play in maintaining their own health. The aging of the population and the decline in the birth rate have also changed the balance between the generations and lead us to investigate the role of informal caregivers and the social support provided to individuals. Smaller families and increase in the proportion of individuals living with a chronic health problem would mean a larger percentage of the population taking on the role of natural or family caregiver.\(^5\)

An overall greater capacity for obtaining, understanding and transmitting information concerning health (health literacy) leads to new expectations by individuals in relation to healthcare. Individuals are increasingly informed about available treatments and wish to take part in decisions concerning the healthcare they are to receive. This observation is especially important for primary healthcare, the main point of contact for individuals with our healthcare system.

From the experts and decision makers consulted, primary healthcare performance will be enhanced when patients and their loved ones play active roles in promoting and managing their health and have easy access to primary healthcare professional services. Health management must however always be supported by information which helps provide understanding of how to prevent health problems and related complications, by tools to assist decision-making, by a structured approach that foster self-care practices, by support for informal caregivers and by mechanisms to support mutual assistance.

Various modalities can be envisaged to encourage self-care practices and support for informal caregivers. The participants in the seminar of experts and the panel of decision makers stated several examples such as interactive websites containing information on health, group medical

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\(^5\) A natural or family caregiver is a family member or acquaintance who provides significant, continuous or intermittent support services on a non-professional basis to a person with an incapacity... (translation, MSSS, 2003, p.6)
consultations aimed at developing the capacities of patients, introduction of centres for prevention and instruction on healthy lifestyles, the prevention and management of chronic illnesses as well as the introduction of electronic medical files allowing patients to have access to relevant data concerning their state of health and the risk factors for illness.

To increase and facilitate the active participation of patients and the public, and the consideration of their point of view in general, the proposal is to encourage intersectoral actions to support informal caregivers within the health and social services network. This proposal is linked to the proposal that consists of developing and making available approaches encouraging self-care practices within clinical settings. These various tools and approaches could also help inform citizens through primary healthcare clinics and physicians' offices of the various means to take charge of their state of health and access healthcare services and social services regardless of their cultural background and knowledge of healthcare.

**What benefits can be expected from increased participation by individuals?**

The scientific publications examining care for individuals living with one or several chronic illnesses are instructive concerning the potential benefits of increased participation by individuals and their friends and family members in their healthcare, especially through a self-care approach. From a life cycle perspective, it must be accepted that taking charge of one's health or that of a family member (child or elderly family member) is a responsibility at every stage in life.

Several recent studies suggest that there are notable benefits for individuals with health problems and for their informal caregivers when their participation in their own care is encouraged, along with development of their capacities. When carried out in the framework of properly structured care by a proactive team providing care, interventions designed to increase the knowledge and capacities of individuals concerning their own health result in stabilizing their functional capacity and better perception of their health, without the risk of increased complications or undesired side effects. Moreover, participation by individuals in the clinical decisions also makes it possible to better orient treatment and ensure better observance.

Greater participation by individuals and their loved ones in their healthcare can generate an increase in productivity and effectiveness of the healthcare system. Various studies show, in fact, that patients become to some extent, experts concerning their own state of health, make less use of care and services, are hospitalized less often and live in a better state of health. Moreover, these patient-experts can play a role among their peers suffering from similar problems when properly supervised by an attending team using clinical assistance tools for decision-making and interfaces providing proper communication with patients. The increased burden on the healthcare system caused by chronic illnesses, whether on primary healthcare services or on specialized services, requires examination of the options available to us to make the best use of services that the health and social services system can offer.
What are self-care practices?

Self-care is a concept that refers to a situation in which individuals suffering from health problems provide some of the needed care either by themselves, or with the assistance of an informal caregiver. Self-care can involve various types of care with the taking of medication being the most commonly cited example. In recent years, it has been noted that those suffering from chronic illnesses acquire in-depth knowledge over time concerning their health problems and the related treatments which suggests that these persons themselves - sometimes called patient-experts - are often the best placed to manage their own health. Other examples that should be mentioned include controlling the level of sugar in the blood of diabetics, the taking of blood pressure measurements by those with hypertension, the taking of antibiotics at home, as well as control over the intake of salt and liquids by those with cardiac insufficiency. The same goes for informal caregivers who also acquire special expertise during the time they are providing support and assistance to a loved one suffering from illness or an incapacity. Note that informal caregivers generally provide support in the activities of daily life, care or obtaining health or social services.

What is the situation for participation by individuals in healthcare in Quebec?

The data available indicates that in Quebec as in Canada as a whole, there are different degrees of participation by patients in their own care. Among patients suffering from chronic illnesses, two out of three individuals declare they have received self-care plans in Canada but only 14% of physicians state they provide home care management plans adapted to patient needs on a regular basis (The Commonwealth Fund, 2006). According to a recent study carried out in Quebec, 61% of individuals state that the physician takes a lot of time to talk about prevention, 75% mention that their opinion is taken into account and 71% state that they were helped to evaluate the positive and negative aspects of decisions concerning their health at their regular primary healthcare services delivery site (Levesque et al., 2007). According to the same study, 77% of the individuals state that they received clear answers to their questions, 69% were of the opinion that the services received allowed them to properly control their health problems, and 65% felt that the services received greatly helped them motivate themselves and adopt proper lifestyles (idem).

In addition, the consultations carried out among actors in the network suggest that primary healthcare services do not have the organizational structures that would encourage participation by the public, self-care approaches or support for informal caregivers in a structured and systematic manner. Such approaches seem to have been instituted in networks of specialized care where many diverse initiatives, such as integrated clinics and teaching centres, are available for individuals suffering from specific chronic illnesses. In primary healthcare services, the physicians still receive little support for setting up instructional activities aimed at patients and must handle often excessive patient volumes with the result that they do not have the time needed to allow for patient participation in clinical decisions.

According to recent data from the Institute de la statistique du Quebec (2009), nearly 30% of the population aged 12 or more state that they suffer from a chronic illness and nearly 14% from two chronic illnesses. Many women and men in Quebec are already living with health problems requiring long-term care. Moreover, nearly 30% of Quebecers aged over 45 are reportedly
providing assistance to another person for a health problem or long-term physical limitation (Statistics Canada, 2008). These informal caregivers, mainly women, provide a significant amount of the care required by those receiving the assistance and as such complement the services provided by health and social services institutions and community organizations. It also frequently occurs that taking on the task of assisting an ill family member or friend, can be the source of health problems for the informal caregiver. In fact, a little more than one in ten of those providing informal care to a loved one have seen their own state of health deteriorate (idem). These health problems add to the other consequences associated with this role such as the expenses related to health care, the reduction in time available for social activities or vacations and absenteeism at work, thus generating much pressure on the individuals taking on the role of informal caregiver (Conseil des aînés, 2008).

**For citizens, what are the issues related to participation by individuals?**

Increased participation by individuals other than healthcare professionals in care and services requires that these individuals are able, based on their own knowledge and skills, to take action in a safe and effective manner on their health. However, not all individuals have the same capacities to improve their health nor do they all have the same degree of support from their loved ones. Various factors, such as education, socio-economic situation, prior health history, place of residence, social environment and life history, can have an impact on the burden that self-care practices impose or on the burden on informal caregivers in providing care. It is important to note that in the context of the deliberations, the Consultation Forum of the Commissioner expressed that it was favourable to the notion of self-care on the condition that its promotion did not lead to any disengagement by the government. To avoid such situations, certain conditions are required, especially an increase in the resources devoted to patients and informal caregivers along with training and follow-up of the individuals involved. Rather than a simple transfer of responsibility, these actions require reappraisal of the services to be delivered and an assurance of equitable development.

There is an issue concerning the increased responsibility of individuals and informal caregivers who participate in care, which can represent an additional burden for them. A shared responsibility develops between the individuals, the informal caregivers and the healthcare professionals that can encourage greater follow-up of interventions when daily adjustment adapted to the individual is required. To the extent that the individuals involved can benefit from appropriate training and from assistance, a greater engagement on their part may thus increase the impact of their role on service delivery. However, one of the risks inherent in greater participation by individuals consists of possible errors in action and treatment and the exhaustion of the individuals or the informal caregivers who are themselves exposed to the illness.

Lack of accountability of the network is therefore a risk. It must not be forgotten that the government has specific responsibilities with regard to the health and welfare of its citizens. It is required, in particular, to ensure appropriate funding for the system and ensure quality services that include accessibility, relevance, effectiveness, efficiency, continuity of service and observance of the rights of individuals. Greater citizen accountability for their own state of health could also result in a reduction of services and lack of support through the participation of informal caregivers.
Key elements retained by the Commissioner concerning participation by individuals

Placing the citizen at the centre of the network is an objective that many commissions of enquiry or work groups have suggested in recent years in Québec. In the context of our consultation process, this proposal occupied a central position and took on a new form - that of participation by individuals and their loved ones in the care provided. In the context of an aging population, an increase in chronic illnesses, multi-morbidity, technological developments that are surpassing the capacity to deliver services, patients are becoming increasingly better equipped to take control over their own health.

The context of the expanding influence of information and communications technologies in the field of health care has also opened up new avenues for the participation by individuals in making decision and in providing care that is tangibly relevant. The concept of self-care is now one of the cornerstones of integrated models for prevention and management of chronic illnesses. As seen in previous sections, self-care practices have been shown to be effective for improving the quality of services and for controlling illnesses without increasing the costs borne by the health care systems.

Lastly, it is highly important to consider the support necessary for the participation of loved ones in the care of individuals receiving primary healthcare services but who have a limited capacity to take charge of various aspects of their own healthcare. These informal caregivers have a crucial role to play and make it possible to offer quality care in collaboration with the attending team.

The Commissioner recommends to the Minister of Health and Social Services that a program be established to develop self-care and support for the contributions made by informal caregivers within the context of primary healthcare clinics in Québec (see Recommendation 5). However, this must be carried out with respect for the choice of persons and the strengthening of their capacities to fulfill this role in an adequate manner.

**Recommendation 5**

**Foster self-care practices and support the contributions made by informal caregivers**

In order to enhance performance of primary healthcare services and their contribution to overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

5.1 **Activities to promote and support self-care be conducted within the primary healthcare clinical context** in Québec;

- These activities include tools to encourage self-care practices integrated into clinical information systems, collaboration with teaching institutions, participation by an interdisciplinary team in developing the capacities of individuals to manage the various aspects of their state of health and their care as well as information available through electronic health information portals.
5.2 Tools be developed and implemented that are designed to improve the capacity of informal caregivers to participate in the health care of the person receiving assistance and that the participation of informal caregivers be supported within the context of primary healthcare services;

- This will require taking into account the consequences of participation by informal caregivers on their personal or professional lives.

5.3 The different approaches aimed at encouraging self-care within the context of primary healthcare services be the subject of an appraisal of their effectiveness and safety in order to guide implementation within clinical settings.

- This should be carried out in collaboration with the Agence d’évaluation des technologies et des modes d’intervention en santé (AÉTMIS) or with the Institut national d’excellence en santé et services sociaux (INESSS).

What are the implications of self-care?

Approaches to self-care require a series of conditions on an organizational point of view to provide for their realization. An interdisciplinary team approach, electronic information systems, group practice and the usage in clinical contexts of new methods to deliver healthcare such as group consultations, peer support and patient-experts, have all been recognized as facilitating the implementation of self-care approaches. For healthcare professionals, these are approaches that require reorganization of clinical practice and reevaluation of the role of healthcare professionals and individuals and their loved ones.

From an ethical point of view, encouraging self-care raises several issues such as concerns over fairness since, as we have seen, all individuals do not have the same capacities with regard to improving their state of health nor the same support from their loved ones. The intervention should also be modulated according to the values of the individuals and their capacity to take charge of various aspects of their health. A second issue relates to increasing the accountability of individuals and informal caregivers who participate in health care. Shared accountability may be developed among the individuals, informal caregivers and the professional health workers that would permit the professional health workers to focus their efforts on the dimensions of health interventions that are not amenable to self-care or assistance provided by informal caregivers. This could however, increase the burden on individuals and shift onto such individuals a portion of the responsibility borne by the health and social services system. Lastly, it must be noted that not all individuals benefit from the presence of loved ones who are able to support them in a self-care approach.

In conclusion, it will be important to enhance the competencies of network healthcare workers to provide support for patients while respecting the capacities and values proper to each individual. Issues related to the risk of lack of accountability in the network must remain a concern in evaluating the modalities that are the most suited to encouraging the participation by individuals in their healthcare. Fundamentally, the participation of individuals and their loved ones in healthcare must be seen as a way to increase the impact of care on the state of health of the individuals rather than simply a way to rationalize health costs.
2.2.3 Registration of the population

Our description of the current situation in this appraisal report on the performance of the health and social services system has made it possible to recognize that one of the deficiencies in primary healthcare consists of the weak level of affiliation between individuals with their regular care provider or family physician in comparison with the level of affiliation in other provinces or industrialized nations. Affiliation with a regular care provider becomes especially important in the context of an aging population, which entails an increase in the burden of treatments related to chronic illnesses. Healthcare needs will focus less and less on short-term intervention and will require more and more long-term case management.

For the experts and decision makers consulted, enhancing primary healthcare service performance will require that the entire population is registered with an interdisciplinary primary healthcare team that knows its patients and assumes their case management. On the other hand, registration should facilitate access to primary healthcare services, to diagnostic and therapeutic technical services and specialized secondary services providing support to primary healthcare physicians. In the context of registration, healthcare professionals would be accountable for the case management of their patients and be accountable to the local population as a whole.

What is registration of the population?

Registration of the population refers to the existence of a formal agreement between a professional providing services and the persons receiving treatment. The healthcare professional maintains a list of patients who have identified him or her as the service provider and, in return, there is a commitment to provide services to the population that is registered. Registration of the population can be carried out in different ways. While some countries have opted for registration based on geography (residents of an area are registered for the service provider in that same area), many countries, including our own, have opted for voluntary "client-based" registration. According to this formula, individuals are free to register with the professional healthcare provider of their choice in the place they choose.

What are the expected benefits for registration of the population?

It is expected that formal registration of patients with a designated clinic will establish a strong link between the patients and the service provider. It has been shown that continuity encourages quality of care and has a positive impact in several ways with examples of positive impact including enhanced care for specific illnesses, increased clinical prevention, child immunization, greater adherence to treatments, patient satisfaction, lower rates of hospitalization and visits to hospital emergency services (Shortt, 2004). It was suggested that registration be aligned with continuity incentives to encourage consultation at the place of client registration.

Registration also makes it possible to ensure better continuity of service, follow-up of medical interventions and implementation of an approach to ongoing improvement for quality of care. International evidence suggests that primary healthcare follow-up for the whole population makes better control possible for costs and avoids the occurrence of undesirable secondary events such as the multiplication of tests or treatments. Numerous studies have illustrated the crucial role of primary healthcare physicians in coordinating the prescribing of medications and in the integrated management of pharmaceutical treatments.
How does registration affect the population in Québec?

Under the current situation in Québec, individuals registered with a primary healthcare service provider are registered either with a physician practising in a family medicine group or are registered with a physician as a vulnerable individual. Recent data suggests that 19% of the population in Québec is registered with an FMG. Despite this figure, 76% of Quebecers aged 15 or more state that they have a family physician (Statistics Canada, 2007). Formal registration with a physician practising in an FMG is not the only way to obtain routine affiliation with a service provider. This does suggest that one in four Québécois does not have a family physician, a situation which is worse in comparison with other Canadian provinces.

In 2008, of the overall clientele registered with FMG in Québec, 28% were registered as members of a vulnerable clientele (data officially published by the MSSS, 2008). While the exact number of vulnerable individuals in Québec is not known, it is estimated that 30% of the proportion of the population of Québec meet the criteria for vulnerable status. This would represent a little more than 2.1 million women and men in Québec (data officially published by the MSSS, 2008). Individuals aged 70 or more are all considered a vulnerable population even in the absence of illness, representing 10% of the population of Québec.

For citizens, what are the issues concerning registration of the population?

While the members of the Consultation Forum of the Commissioner expressed that they were in favour of registration of individuals with primary healthcare medical resources, they did state that registration must be on a voluntary basis and not be obligatory or systematic. This measure must also be introduced with a degree of flexibility to avoid affecting the right of citizens to choose their healthcare professional and institution. However, the members did feel that registration must be made attractive and that citizens must be informed of the experiences that function well. Beyond the aspects related to the desirability of registration, many members of the Consultation Forum of the Commissioner wondered about the feasibility of introducing full registration of the population in the current context. They doubt the system is capable of quickly absorbing such change.

It is important to note that although citizens in Québec currently enjoy full freedom to choose a family physician, in fact this freedom is greatly restricted by the relative shortage of physicians offering primary healthcare services. In fact, recent surveys suggest that Québec is the province in Canada where the percentage of individuals who do not have a family physician is the highest. The reasons put forward to explain this situation are linked to recent losses of physicians (due to retirement or death) and primarily to the lack of physicians accepting new patients in the territory in which the individuals live. In actual fact, most agree that the current situation affords very little possibilities with regard to the choice of a physician. In addition, few individuals would be inclined to change physicians if dissatisfied with the services received from fear of not being able to find medical follow-up, as is the case for many people in Québec. Lastly, data from appraisals of pilot projects on primary healthcare service reform in Ontario suggest that a minority of patients refuse registration (Hutchison, 2004).

While registration offers the guarantee of medical follow-up, it does restrict individuals to consulting one healthcare provider. In exchange for the provision of services, the registered individual makes a commitment to visit the same care provider rather than visiting any provider
when the time comes. In consideration for registration, there is a better guarantee for access and the assurance of being recognized as one of the clinic's patients. Moreover, while it is implicit that the services rendered by different professionals are the result of demand by individuals for care, this presupposition is not always confirmed. Health is not a consumer good and healthcare needs are determined by both patients and the professionals being consulted. The choice is limited by the very nature of the health problems and by the fact that it is difficult for an individual needing services to determine which services are necessary. The same applies to the choice of a physician, and individuals generally have little information to act on.

Key elements for the Commissioner concerning registration of the population

The accessibility and continuity of care are two fundamental characteristics that are especially important in the context of primary healthcare services in Québec as elsewhere. In order to meet the needs of individuals for care, services must be accessible. Greater continuity ensures an avoidance of duplication of services and medical errors and thus increases accessibility through efficient use of the resources that have been invested.

The consultation process and the review of scientific publications carried out by the Commissioner suggest that one of the key elements for accessibility and continuity, beyond the availability of resources and the mechanisms of coordination, is affiliation with a physician or a group of healthcare professionals. Registration with a service provider has demonstrated multiple advantages concerning the creation of a relationship of trust between the attending teams and individuals, the efficient utilization and avoidance of duplication of healthcare services, and the capacity to determine care needs and specific services for client groups. In this context, the Commissioner recommends to the Minister of Health and Social Services that registration be encouraged for the whole population wishing to be formally affiliated with a family medicine group (see Recommendation 6).

Recommendation 6

Ensure that individuals wishing to register with groups of primary healthcare physicians can do so.

In order to enhance performance of primary healthcare services and their contribution to overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

6.1 All those in the population who so desire be registered with primary healthcare groups of physicians such as family medicine groups and other medical clinics;

- Registration would consist of a mutual commitment between the individuals and their physicians. The individuals would be free to change clinics according to specific modalities to maintain their right to choose, while guaranteeing a level of stability in the clientele of the clinics. In return, the primary healthcare groups of physicians would make a commitment to deliver services on a collective basis to meet the regular medical needs of those registered.
6.2 Priority for registration be placed on persons who meet current criteria for vulnerability in relation to a specific medical activity with subsequent priority place on registration of the entire population;

6.3 Individuals be registered within their territory of residence to facilitate access to medical services in their community and linkage of primary healthcare offices with services within the local network of health and social services;

6.4 The ratio of patients registered per primary healthcare physician be reviewed along with the ratio of professional healthcare workers who are not physicians per family medicine group in order to make the goal of registration of the population possible.

- The review of the ratios should take into account the care needs of current users as well as those of individuals who currently are not receiving care but who in the future may benefit from affiliation with a group of primary healthcare physicians and other authorized models for preventive and curative purposes.

What are the implications of registration of the population?

Ideally, all men and women in Québec should be registered with an FMG or a group of primary healthcare physicians. Since registration would be on a voluntary basis, a target of registering 95% of the population would be desirable and this takes into account those who do not wish to be registered. To reach such a target, it would be necessary to proceed with registering 5.8 million new individuals in addition to the 1.5 million already registered. From an organizational point of view, based on current ratios of patients per physician, such a registration target would require authorizing nearly 400 new FMG or other authorized models in Québec, a number that is higher than the current number of 300 FMG in operation. It is therefore necessary to review the ratio of patients per physician to ensure access by all to a primary healthcare clinic. For reasons of fairness, vulnerable individuals should be registered on a priority basis. There are still at least 800,000 vulnerable patients according to current medical criteria to be registered if all the vulnerable individuals in Québec are to be taken care of.

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6 Taking charge of new vulnerable patients could require a contribution of 2000 additional family physicians based on the assumption that each physician can handle 400 vulnerable individuals, or the equivalent of a workload of approximately 12 hours per week as defined according to special medical activities (AMP).
A human resources challenge

With regard to human resources, the current staffing level of family physicians in Québec would hardly suffice, based on current registration ratios in group practice to register the entire population with FMG, even in the event that family physicians only practised in primary healthcare services without carrying out any other essential medical activity such as emergency services or short-term hospitalization (CIHI, 2007, official data published by the MSSS, 2008). In addition, it is expected that a number of family physicians will retire in the coming years, which is attributable to aging in the medical corps. There were already 1000 family physicians who were 60 or older in 2007 (official data published by the Régie de l'assurance maladie du Québec). In addition, the number of new family physicians in Québec has tended towards stabilization, and even towards a decline in recent years. While 215 and 234 available places were filled by new family physicians in 2006 and 2007 (rates achieved in relation to the authorized targets of 113% and 109% respectively), only 200 places were filled in 2008 (official data published by the MSSS, 2008).

Various issues that have implications in terms of ethics and law may be raised with regard to registration of the population. One issue concerns the value of freedom of choice. Registration of the population could limit the right of individuals to choose the service providers that respond the best to their expectations and need, as is recognized in the provisions of the law. It should be noted that this right allows individuals to consult professionals in whom they trust or to seek the opinion of another professional when not satisfied with the services received for various reasons (they may have doubts concerning the diagnosis produced or feel that their rights were not respected, etc.). However, while individuals have the right to choose their physician, this right is currently subject to the constraint, as indicated earlier, of the availability of medical resources.

A second issue is the result of the lack of primary healthcare physicians that can vary by region in Québec and the varying degree of implementation of new methods of primary healthcare organization among the regions. While the mechanisms for registration proposed for Québec rely on the client base and not on territories, the varying availability of physicians in the territories can limit the possibilities of registration for individuals in the regions where medical staff is limited (in particular in remote regions) or in regions where organizational models for primary healthcare services offering better management have been implemented to a lesser degree (urban areas). Moreover, in a context in which network institutions have the responsibility to orient patients without a physician in their territory to a resource such as the health and social services centres (CSSS), a type of territoriality for registration would be favourable to practice in local service networks.

7 To register 95% of Québécois with an FMG, the participation of an additional 4000 family physicians is required. A portion of the physicians could be recruited from among family physicians already practising in primary healthcare services. In 2007, more than 6000 family physicians were practising in CLSCs or in private offices. Among them 68% were not yet partners in an FMG (data officially published by the MSSS, 2008).
2.3 Acting on the planning and management of clinical activities

The current context characterized by limited human and financial resources and the ever-expanding need for care and services requires better planning and improved organization of services and requires ongoing appraisal of their impact on the health of the population. While there may be complaints that the health and social services system is sometimes bureaucratic and run by managers, consultations suggest instead that there is still poor planning for services. In most cases, clinicians do not have the use of the tools needed to target their clientele, target the services rendered or those on which priority should be placed. Managing the system should go beyond the administrative management of institutions and include mechanisms for governing clinical activities in order to adapt the provision of services to the needs of individuals and to recognized best practices.

One of the major findings from the consultation process constituted the realisation that our primary healthcare service system had major deficiencies with regard to planning and managing clinical activities. As we saw in the description of the current situation, it is still difficult for clinicians to know who their patients are and what their health problems are, to plan services designed to respond to their patients and to assess whether the services provided have had an impact on the health of the populations served. Primary healthcare services remain essentially reactive in nature responding to the immediate short-term needs of individuals. Although the care provided is high in quality based on personal office visits with patients, the primary healthcare professionals only enjoy a few clinical tools to plan care in a proactive manner for the ever-expanding populations for which they are accountable.

The members of the Forum also consider it very important that citizens feel that the system is well managed and services are properly coordinated. This would inspire more confidence among the public. However, the decision makers consulted noted that the current economic context and technological innovations are raising issues that concern system management. In this subsection the review of primary and secondary care accountability, clinical governance and the appraisal and ongoing improvement process will be addressed.

2.3.1 Revising primary and secondary clinical responsibilities

In the healthcare systems of highly developed industrial nations, medical care is delivered by physicians who are trained as general practitioners or specialists. In Québec, physicians complete their medical doctoral degree and then proceed to a residency that enables them to specialize in various fields of medicine. Family medicine is one of those specialties, as for example is cardiology, surgery and pediatrics. However, in our daily parlance, the specialists in family medicine are considered general practitioners, and are sharply contrasted with other specialists. Their training is different and the organizations that certify them are different. General practitioners take care of the current problems in a population while specialists focus on the problem of a specific biological system (such as neurologists, endocrinologists) or a specific clientele (such as pediatricians, oncologists).

During the consultation process involving the experts and decision makers, the sharing of clinical responsibilities between general practitioners and specialists was selected as an issue affecting primary healthcare performance and, ultimately, the overall health and social services system. For the actors consulted, the vision of effective primary healthcare performance presupposes the need
for better definition of the roles between the services and the need to ensure that general practitioners and specialists are able to exercise their practices in a complementary and coordinated manner. Moreover, this better integration and improved coordination between primary and secondary care requires that primary healthcare practitioners be trained and possess the tools that will allow them to exercise their roles. Two-way reference and information mechanisms for the purpose of coordination and continuity should also be put into place so that secondary service practitioners are able to provide continuous support to the primary healthcare service team.

Various actions related to revising the collaboration between general practitioners and specialists have been proposed. These actions mainly concern the establishment of partnerships and revising respective responsibilities. It would be necessary to build new partnerships between family physicians and specialists, especially through training and development of "attending specialist" agreements under which such specialists provide support to family physicians without being obliged to see the patient in consultation. Revising responsibilities with an aim towards complementarities of expertise (and not competition for the establishment of a clientele) requires the set-up of coordination structures between primary and secondary care. This is in line with the principle of hierarchal organization of services that is the basis for the creation of the local network of health and social services (RLSSSS) and integrated university health networks (RUIS).

**What benefits can be expected from revising primary and secondary care clinical responsibilities?**

The proposal to revise the responsibilities linking general practitioners and specialists may take a variety of forms. The consultation process of the Commissioner suggests that revising the responsibilities of general practitioners and specialists with regard to their role towards patients individually and their role in covering the full range of care needs for the populations would allow for better use of the resources and would break the vicious cycle that makes family physicians increasingly less accessible for primary healthcare because they are filling in for lack of services in institutions and as a corollary because specialists are increasingly obliged to provide basic care to patients who are unable to obtain general medical care from family physicians. The trend towards specialization and institutional practice by family physicians on the one hand and generalization of practice by specialists on the other has been raised on many occasions during the consultation process.

Beyond revising the roles, the actions proposed also emphasize the need to support primary healthcare clinic activities by making specialists available using new modalities of intervention that go beyond the personal office visit. The development of an attending specialist role for primary healthcare medical clinics and the set-up of ongoing training activities designed to increase the autonomy of primary healthcare teams could also lead to reducing secondary care consultations and ensure better integration of care. This would occur through the initial identification of patients who truly need such consultations and through support of primary healthcare services.

As we emphasized earlier, a strong primary healthcare service is associated with better health of the population and lower costs for healthcare systems in comparison with countries where priority is placed on specialized medicine. If general medicine excels in taking into consideration the full complexity of the individual and the various treatments, specialized medicine excels in a specific
diagnosis and related treatment. The point has been underscored by many that the tests and treatments provided during specialized care show greater effectiveness when primary healthcare services contributes its holistic approach. At the same time, primary healthcare services that receive advice and support are better able to fulfill their function of holistic management of health.

**What is the situation with regard to clinical responsibilities for primary and secondary care in Québec?**

In Québec, a visit to a specialist does not require first consulting a general practitioner, and specialized office practice is relatively common. The only constraint on such direct consultations for secondary or tertiary care at the current time is the refusal by certain specialists to see patients without a referral from another physician for the simple reason that remuneration is higher for referrals. Other countries have reserved the practice of specialists to hospital settings where they assume responsibility for hospitalization and attend to referrals from family physician offices.

In practice, the distinction between the clinical roles of specialized and general medical practitioners is not always clear. While certain specific clinical activities, such as consultations and clinical activities in the care units of university centres, are in general carried out by specialists, these services are also performed by general practitioners in many regions in Québec. Conversely, many specialists from a variety of medical specializations can intervene in primary healthcare with patients without having obtained a referral for the patient from a general practitioner. Certain medical specialties devote a large percentage of their activities to primary healthcare services, meaning that they are the initial care provider in assessing a problem.

Moreover, certain specialities also have the possibility of following patients over the long term without the participation of a general practitioner. In Québec, nearly 5% of individuals receive medical follow-up solely through specialized care. As a result, many specialists practice within primary healthcare services while numerous general practitioners practice within secondary and tertiary care settings. A specialization in family medicine in fields that are increasingly restricted in practice is a trend that has been noted. A portion of the problem of access to family physicians could obviously be explained by this situation.

The most recent commissions of enquiry have highlighted the problem of coordination among the levels of care. These coordination problems concern problems of continuity experienced by individuals who must navigate their way through the health and social services system. Currently, the roles of the various professional healthcare workers and the most appropriate places for consultation may be difficult to identify for individuals. Moreover, these problems of coordination may also result in poor utilization of human resources. Ultimately, certain services are used inappropriately while some individuals have to deal with major problems related to accessibility.

In comparison with other provinces in Canada, Québec has a relatively high number of general practitioners and specialists as has been explained in the document dealing with the performance monitoring indicators. In fact, Québec places second in terms of the number of general practitioners per 1000 inhabitants and holds first place for specialists. It is in Québec that the percentage of individuals having to wait less than a month to see a specialist is the most positive. While our knowledge in this regard remains partial and poorly documented, certain actors in the
system during the consultation process carried out by the Commissioner, have stated the hypothesis that the wait time to obtain certain general medical services, such as screening for cancer of the uterus, regular monitoring of pregnancy, or regular follow-up for children, is in fact shorter with specialists than it is in primary healthcare services. This situation has been denounced both by specialists and by general practitioners.

At the present time in Québec priority medical activities\(^8\) include, in many regions, emergency coverage, hospital care units and services provided in residential and long-term care centres. However, the impact of this situation on the availability of family physicians for primary healthcare services and conversely, the availability of specialists in settings designed for the delivery of specialized care, have been only poorly examined. While these priority medical activities have been implemented to correct situations of service breakdown in the regions concerned, they are not without repercussions on the availability of physicians for general services in primary healthcare.

Lastly, there is the fact that in Québec, as was outlined in our description of the current situation, there is a certain lack of interest among physicians for family medicine at the present time. A parallel trend involving specialization of the activities of general practitioners (for example sport medicine, esthetics, monitoring of oncology) is seen as a current challenge.

**For citizens, what are the issues concerning revision of the clinical responsibilities of primary and secondary care?**

The actions that result from better sharing of the activities of generalists and specialists can also have repercussions on the patients as well as on the professional health workers. For the professional healthcare workers, this affects their way of practising medicine and their personal investment in the place of practice as well as the income that can be affected. For individuals, it is the relationships they established with the professionals that may be affected.

A certain degree of hierarchal organization, however, would allow for increased coordination of care and better understanding by patients of their care pathway thus improving the quality of their care experience. On a system-wide scale, better utilization of the available resources could result in greater effective availability of care for the population as a whole. The challenge here is to modify the manner in which care is shared between primary, secondary and tertiary services without compromising the viability of the system and to make the modification acceptable to the actors in the system.

Lastly, revising the responsibilities means reviewing primary healthcare service organization as well as that of specialized care taking into consideration the burden of the tasks and guiding individuals to the appropriate services provided by various professional healthcare workers.

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\(^8\) Initially instituted to handle the shortage of family physicians in emergency services, special medical activities (AMP) now cover a range of services for which deficiencies have been identified. All family physicians are affected by AMP. The quantity of AMP required is currently at 12 hours per week for family physicians with 15 years of practice or less, 6 hours per week for those with 15 to 20 years of practice and it is modulated according to the capacities and types of practice for those with more than 20 years of practice.
According to the members of the Consultation Forum of the Commissioner, revising the sharing of responsibilities between general practitioners and specialists should take into account issues related to remuneration and involve contributions from the various professionals in order to respect their competencies and maintain a balance in the burden of tasks involved. In their opinion, the mode of remuneration and salaries should be reviewed with that in mind.

In addition, some members see no restriction of choice, especially for service, treatment, service providers, or establishments, if the roles are properly defined based on the competencies of each professional category of healthcare worker. The sharing of roles and responsibilities and a referral system could direct an individual to consult a service provider other than the one the individual desired, such as a nurse practitioner instead of a physician, but this should not necessarily be perceived as restricting freedom of choice. Others stressed that they are prepared to restrict choice on the condition that a relationship of trust is created with the system and they are assured of obtaining access to services that their state of health requires. The importance of protecting freedom of choice was reiterated by certain members as a principle that must be safeguarded. In actual fact, it is maintaining access to healthcare and services that must be preserved.

Key elements for the Commissioner concerning the revision of primary and secondary care clinical responsibilities

If, on the one hand, a good number of individuals question special medical activities or the remuneration of specialists, two factors that contribute to confusion concerning the primary and secondary care roles, on the other hand the actors in the network who were consulted suggested that an overall review of the relationship between general practitioners and specialists must be carried out. In light of these considerations, it seems clear for the Commissioner that the network representatives, specialists and generalists must come together around the same table for a team review of the sharing of clinical responsibilities and the organizational and financial modalities allowing them to deliver complementary services without duplication of services. In this context, the Commissioner recommends to the Minister of Health and Social Services that the clinical responsibilities between primary and secondary care physicians be reviewed (see Recommendation 7).

Recommendation 7

Review the clinical responsibilities of primary and secondary care physicians

In order to enhance performance of primary healthcare services and their contribution to overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

7.1 The framework for primary healthcare medical practice and specialized medical practice in Québec be revised in collaboration with the medical federations and the Collège des médecins du Québec to ensure clarification of the roles and greater complementarities between generalists and specialists in Québec;

7.2 Mechanisms to support primary healthcare medical activities by attending specialists be instituted;
- Such mechanisms could include telephone consultations or an integration of specialized clinical activities in primary healthcare medical offices.

7.3 **Incentives for primary healthcare medical practice for family physicians and incentives for secondary and tertiary care practice for specialists be instituted;**

- Either organizational or financial in nature, these incentives must be designed to reduce the incidence of family physicians specializing in other practices and reduce the incidence of specialists providing primary healthcare services.

7.4 **The framework and definitions of special medical activities be revised,** in collaboration with the federations of general practitioners and specialists in order to encourage the availability of family physicians for primary healthcare activities and greater participation by specialists in covering secondary and tertiary care.

**What are the implications of revising primary and secondary care responsibilities?**

Revising primary and secondary care responsibilities will certainly involve, from organizational and economic points of view, the mobilization of various actors in the network. and revising of the modes of remuneration of the professionals most adapted to appropriate sharing of responsibilities in primary and secondary care. In fact, the current modalities for remuneration, essentially fee-for-service for both general practitioners and specialists have repercussions on the services rendered to patients. These services are difficult to reimburse based on a fee-for-service schedule (telephone consultations, evaluation of complex cases, etc.). Moreover, the fee-for-service remuneration schedule does not encourage case interdisciplinary management of complex cases (persons with multiple chronic illnesses, mental health problems, etc.). Among specialists, current remuneration could favour establishment of an ambulatory clientele rather than activities in secondary and tertiary institutions or support for primary healthcare professional health workers.

Revising these responsibilities would also require a high degree of joint efforts by various primary and secondary care actors as well as changes in case management practices and recommendations by general practitioners and specialists. Lastly, for citizens, revising these primary and secondary care responsibilities could require, to the extent that the primary healthcare services offer adequate accessibility, an initial incentive to visit a family physician first.

**2.3.2 Clinical governance**

The deliberations of the Consultation Forum of the Commissioner allowed identification of elements affecting the manner in which care is managed. The members of the Consultation Forum of the Commissioner suggested that measures should also be taken to enable better organization of work for healthcare professionals and to maximize utilization. For them, the introduction of more appropriate work tools that would permit a reduction in duplication of services and burdensome administrative tasks (forms to be filled out) is a concern. In addition, the members of the Forum are concerned about the fact that physicians are working under pressure and lack the time to adequately follow-up with their patients. Better planning of clinical activities would make it possible to respond to concerns expressed by the members of the Consultation Forum.
### What is clinical governance?

The notion of clinical governance refers to proactive planning of the services provided and frequent monitoring according to the needs of individuals and the populations being served. Clinical governance is differentiated from administrative governance that deals with the aspects of managing the resources and administrative organization. As a result, while administrative management includes billing, scheduling appointments, leasing premises and hiring professional healthcare workers, clinical governance is concerned instead with planning clinical services such as care plans for individuals suffering from chronic illnesses, reminders about preventive activities and screenings, the development of care protocols or service corridors between levels of care.

In the context of health and social services networks, this services planning carried out to meet the care needs of individuals is often called a "clinical project". A clinical project is described in the MSSS publications as an approach intended to respond to the health and well-being needs of the population of a territory by means of various modes of service delivery adapted to and articulated in line with local conditions and which cover the entire range of interventions concerning the promotion of health and well-being and prevention of illness, diagnosis, interventions or treatments, follow-up, adaptation and support for social integration, re-adaptation and end of life support service.

A major trend was highlighted concerning our approaches towards service planning. It concerns management based on volume of services and planning of healthcare according to the expertise of the health professionals in place, making the network the subject of major developments involving planning based on the needs of the communities to be served. This situation should also translate into greater participation in network management activities by clinicians and professionals. Consequently, various proposals intended to enhance clinical governance of primary healthcare and better planning of resources and services include the following: the introduction of guidelines and care protocols for standardization and sharing of best practices, competencies and treatments by multiple professionals engaged in patient care as well as the outlining of predefined service trajectories which also contribute to increased coordination among the hierarchal levels of service.

In the same way, the Commission of Study on Health and Social Services (2000) stressed the importance of putting into place proactive management of services to face the challenges posed by social and demographic transformations, changes in the profile of those who are ill in the population and changes in technological capacities to intervene in health care. This proactive - or preventive - management must assist the goals of prevention, healing and care through analysis of problems and their causes, through recognition of the interventions available, through deployment of effective interventions and through systematic follow-up of health outcomes. The Commission emphasized the essential role of information systems and the production of convincing data in this respect.

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9 This involves promoting methods to organize care or render services that have been demonstrated as the most appropriate and effective based on the studies and analysis available.
What benefits can be expected from enhanced clinical governance?

International experience suggests that good coordination of care is associated with good modalities for management of clinical activities. This is especially true in pluralist systems where responsibility for care is shared by a number of more or less autonomous actors and where accountability is diffused among them. Our system possesses this characteristic with its various actors and organizations that have great autonomy concerning their clinical decisions and aspects related to the conditions of their clinical practice. Such systems require mechanisms for coordination and linkage due to lack of being able to structure the system in a hierarchal and authoritarian manner.

Recent scientific publications illustrate the potential for clinical governance to enhance the appropriateness of services and more efficient use of services in a perspective of taking charge of the clientele or the population. These findings are particularly eloquent in the context of care for persons living with one or several chronic illnesses. Several elements of integrated models of case management of chronic illnesses consist of improvements in the capacity of care teams to put services into place that meet the predictable care needs of their clients in an adequate manner.

Moreover, these processes of clinical governance, coupled with development of software for assisting clinical decision-making have proven highly effective in improving the quality of care and observance of recognized practice guidelines. The large quantity of these practice guidelines is a good illustration of the complexity of their application in the normal context of providing care. In a very tangible manner, clinical governance requires a series of conditions. First, it requires that clinicians be able to identify their patients along with their main characteristics and needs in relation to receiving care. Then it requires the establishment of protocols defining the nature of the services to be delivered according to the needs of the individuals and setting the sequence of the services required and the place where the services may be obtained. For the person needing services, this high degree of planning and management can facilitate navigation through the required services and increase access.

Many studies have highlighted the fact that introducing electronic medical files and assistance tools for clinical decision-making, such as practice guidelines and care protocols, encourages the provision of preventive services and diagnostic and curative services that comply with current standards of practice. The aspect of prevention is especially interesting. If a large proportion of the population requires a variety of screening interventions or counseling, the clinical settings are often too overloaded to deliver such services in a systematic manner. The integration of tools to support clinical decisions, coupled with registration of the groups of clientele, fosters preventive activities within the clinical context and the capacity of professionals to identify the individuals who should be targeted even before those persons enter the physician's office.

Certain particularly highly performing healthcare systems such as the Kaiser Permanente or the Veterans Health Administration in the United States have introduced various mechanisms of clinical governance to support the efforts of physicians and interdisciplinary teams and have produced enviable results. These mechanisms for clinical governance include software applications using electronic medical files, the development of optimal care protocols and trajectories by interdisciplinary teams and services planning according to the composition of the clientele of the various care teams.
What is the situation of clinical governance in Québec?

The experts consulted suggest that despite a large number of practice guidelines on the quality of care required for various health problems, there are very few clinical protocols on a local scale to ensure proper understanding of the patient pathways through the different levels of care and from the various types of professional healthcare providers in Québec. From the point of view of the patient, there are many points of contact with the system for obtaining an appointment since the concept of a single window for services has not yet been introduced in most regions in Québec and in fact only marginally covers the primary healthcare services provided by physicians' offices.

Various organizational characteristics also suggest deficiencies in clinical governance of primary healthcare in Québec. The lack of registration of the population in the context of individual and professional healthcare worker mobility makes planning of clinical activities difficult. As we have seen, registration allows for services planned according to the needs of a defined population rather than services delivered in an unplanned fashion due to lack of knowledge of the clientele. On this subject, less than 20% of the medical clinics in Québec can produce a list of their patients ranked by diagnosis. Moreover, the lack of development of group practice, beyond the sharing of office expenses and the virtual absence of an interdisciplinary team approach also make planning difficult. The low level of information technology use in offices represents a challenge for the development of clinical governance. The current situation that we have described clearly illustrates that only a very small percentage of the clinics are in a position to generate lists of patients according to diagnosis. Their capacity to generate a list of patients using specific medications or to evaluate the proportion of their patients receiving a range of care recommended in the guidelines is also probably very low.

Lastly, one of the main barriers to implementing primary healthcare reform would be the absence of a management structure in primary healthcare medical organization (Shortt, 2004). This absence of clinical management structure (committees for the development of care protocols, existence of a medical director, participation by professionals in care planning activities, etc.) would hinder the introduction of innovative new practices. While regional departments of general medicine and regional departments of medical affairs proceed with a certain level of planning of care on a local and regional scale, their activities do not appear to have an impact on medical clinics.

For citizens, what are the issues related to clinical governance?

The deliberations of the Consultation Forum did not raise specific issues affecting citizens concerning clinical governance.

Key elements for the Commissioner concerning clinical governance

In view of these observations, it appears essential, in the opinion of the Commissioner, to develop tools that would allow primary healthcare clinicians to manage their activities and care planning better. Many actions identified in the preceding sections are fundamental in that respect. In fact, group practice permits collegial practice in which activities designed to develop management tools becomes possible. Moreover, registration of the population permits better identification of clients and their current and future needs. Introduction of electronic medical files allows for integration of tools to support clinical decision-making. Lastly, the introduction of primary
healthcare interdisciplinary teams or service agreements makes it possible to ensure access by patients. While various primary healthcare service settings are already innovating, it must be noted that the overall primary healthcare network in Québec could benefit from better support in this respect.

The Commissioner considers that establishing clearer protocols governing the pathways for individuals throughout the local care network is crucial to ensure efficient access to all the resources available. These care protocols must be outlined in collaboration with the primary healthcare resources deployed in physicians' offices and be submitted to a mechanism for coordination at a local level. In this context, the Commissioner recommends to the Minister of Health and Social Services that various actions designed to establish mechanisms for clinical governance within primary healthcare settings be developed based on current organizational foundations on regional and local levels (see Recommendation 8).

### Recommendation 8

**Develop mechanisms for primary healthcare clinical governance**

In order to enhance performance of primary healthcare services and their contribution to overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

8.1 *Information systems based on utilization of electronic medical records and integration of tools to assist clinical decision-making for clinical governance* be developed and introduced in primary healthcare offices;

8.2 *Indicators for patient needs and indicators tracking clinical outcomes supporting clinical governance* of primary healthcare services be developed and introduced;

8.3 *Local care protocols for common illnesses be instituted* in the context of primary healthcare services linked to health and social services centre clinical projects;

- This could require the participation of the DRMGs, regional directorates of medical affairs and the various administrative units of the health and social services centres.

8.4 *Orientation gateways for individuals be instituted on a local scale based on the degree of needs of individuals and case managers* all across the CSSS;

8.5 *Agreements be introduced governing access to clinical data for the purpose of planning and evaluating of services and in order to ensure that privacy concerns are addressed* in the utilization of electronic medical files.

**What are the implications of enhanced clinical governance?**

Clinical governance and any project to increase primary healthcare clinical governance in Québec requires, on an organizational point of view, a series of reorganizations already discussed in the preceding sections. In the context of medical care, this type of proactive management of services linked to the needs of individuals being served calls for collaborative efforts from a group of
physicians and healthcare professionals from other disciplines, registration of the clientele enabling identification of individuals that must be reached and their current and future needs and lastly, tools providing support for planning. Electronic medical records and the capacity to analyze the profile of the clientele is certainly one of the tools that would allow clinicians to carry out clinical governance successfully. The implications stemming from the recommendation to increase clinical governance in primary healthcare organizations in Québec are mainly tied to the consequences of the different organizational modalities proposed in the preceding sections.

From an ethical point of view, standardizing clinical practices can reduce the capacity of clinicians to adjust treatment and their approach to specific needs of their patients, sometimes not related to the state of health of the individuals, but more to their preferences and values. Development of intervention protocols and formal care corridors also tends to reduce choices regarding the professional healthcare workers to be visited or the institutions delivering care. For the purpose of efficiency and quality improvement, freedom of choice may be restricted through this type of process and individuals may have the impressions that care has been "bureaucratized".

In addition, the priority placed on services connected to clinical management and planning for the provision of care may also raise issues related to the exclusion of certain services that are aimed at specific persons. In a perspective of decentralized clinical management, this could translate into a different service offer based on the service outlets or regions. This could possibly lead to issues of fairness because some individuals with specific problems could find their needs considered as less important in certain settings and as a result could possibly experience reduced access to care.

2.3.3. Appraisal and ongoing improvement of performance

When questioned about the aspects that are the most important for them concerning primary healthcare medical services, the members of the Consultation Forum of the Commissioner mentioned the need to develop greater accountability in medical clinics, along the lines of the mechanisms present in the institutions in the networks. They also emphasized the appropriateness of designing authorization mechanisms, quality controls and the introduction of mechanisms to deal with complaints to ensure individuals with quality care and recourse in cases of professional error or negligence.

The experts and decision makers consulted by the Commissioner also strongly insisted on the need to set up mechanisms for performance appraisal and ongoing improvement of primary healthcare medical services. In this respect, they reiterated the central role given to electronic medical files that would allow for greater availability of data related to services offered and their health outcomes and thus would encourage an environment that would foster ongoing quality improvement. Moreover, performance appraisals require setting up systems that allow for aggregating of clinical data from patient files to evaluate various aspects such as coverage of care, technical quality, the appropriateness of services to the needs of individuals and the existence of undesired events. This would permit clinicians, managers and decision makers in care facilities to obtain an overview of their practice, have a good understanding of their clientele and their needs and be able to target aspects that merit improvement.
This type of effort requires an integrated approach and in terms of technology means developing practical and meaningful data and quality training. In terms of organizational structure, it would be necessary to encourage decentralized decision-making and the participation of clinicians and decision makers, set up effective communication methods and encourage the upgrading of the capacities of those involved. Concerning economic investments, the experts consulted emphasized the need to increase and introduce new information and communication technologies in clinical settings and to train, starting with doctoral studies, the managers and clinicians to carry out performance appraisals and put in place incentives to achieve better performance from managers.

Lastly, the population must also be seen as having a role to fulfill in appraising performance and improving clinical management. In many ways, it is the individuals involved who are the best placed to assess the services received and the responses provided to care needs. Many countries regularly ask patients to respond to questionnaires distributed in physicians' offices in order to measure specific outcomes in relation to their care experience. This constitutes one example of a performance appraisal.

**What benefits can be expected from performance appraisals?**

Performance appraisals and the introduction of an ongoing improvement approach to quality of care are recognized as essential elements for optimizing the impact of services on the health of populations. These approaches to improving performance are not limited to only healthcare system governance authorities but are to be used in clinical settings and care organizations. Major efforts are underway around the world to develop and introduce effective methods for appraisal of performance that could be integrated into an ongoing quality improvement approach. Coupled with funding to achieve specific targets or recognized standards, performance appraisals have had some impact on the delivery performance of many services, as well as on preventive activities. The successful attainment of certain performance targets achieved to the detriment of other clinical services that are not linked to specific performance targets has been reported and highlights the need for a prudent approach when employing measures essentially funded to foster quality improvement.

While few studies have scientifically documented the impact of performance appraisals, the experts and decision makers consulted agreed on their potential when linked to an ongoing improvement approach within the clinical units. International experience suggests that performance appraisals used in a professional perspective rather than a reporting context foster acceptance in clinical settings. Various interventions, such as clinical audits, authorization or certification procedures and professional peer review activities, are all avenues that have demonstrated positive effects on achieving performance standards and increasing compliance with clinical norms.

Similarly, Emerging Solutions, the report published by the Commission of Study on Health and Social Services (2000) stressed the important role of information technologies in appraising performance. For its part, the Task Force on the Funding of the Health Care System highlighted the need to provide the means for appraising the performance of our system. It suggested setting up specific indicators, carrying out comparative appraisals between providers and competencies, and sharing information obtained to determine the most efficient practices.
What is the situation for performance appraisal in Québec?

The inventory of scientific evidence available, the consultation process and the findings drawn from the current situation that we have established for the network suggest that in Québec there are few structured activities for performance appraisal in place in primary healthcare clinical settings. Although the professional orders foster the updating of clinical competencies through programs to maintain competencies and carry out investigations of the files of physicians who are subject to complaints, there are few other obligations within clinical settings to appraise the results that are achieved. The near absence of information systems, the low level of registered clients, the lack of formal authorization or certification procedures, and the lack of activity audits for primary healthcare clinics cause us to believe that few performance appraisals are being carried out. In contrast to physicians' offices in other countries such as the United Kingdom and certain Scandinavian countries, medical clinics in Québec do not proceed systematically with appraisal of the coverage of care provided, whether practices are recognized as effective or even the satisfaction of their clientele.

For citizens, what are the issues concerning performance appraisal?

The Consultation Forum of the Commissioner did not raise major issues related to a systematic approach to appraising the performance of primary healthcare services. A consensus within the Forum formed around the idea that non nominative data could be used to appraise performance, but on the condition that clinicians participate in the analysis and that citizens participate in the decisions concerning improvements to services and that priority be placed on access to primary healthcare services, while safeguarding the principle of freedom of choice.

The proposal that consists of introducing a performance appraisal process also raises certain issues related to information systems and data gathering which is necessary for the appraisal process. These systems constitute certain challenges concerning confidentiality and privacy, subjects that we have already addressed. These topics were examined in the preceding sections.

As we have emphasized, performance appraisals have been associated with reorienting certain clinical activities to the detriment of other activities, which can cause contrary effects. In fact, for individuals this may result in exclusion or greater difficulty in obtaining certain types of care. Performance appraisal, divulgence of outcomes or remuneration based on performance appraisals may result in avoidance behaviours by certain groups of clientele when problems related to productivity, achievement of goals or level of resources depend on certain individual behaviours. Patients who have difficulty following their treatment, adopt behaviour that is deleterious to health or require longer visits (communication problems with new arrivals, low levels of schooling, delinquency or mental illness problems) could be adversely differentiated in comparison with groups or clienteles deemed "easier" to manage and which would boost performance indicators in clinical settings during performance appraisals.

Key elements for the Commissioner concerning performance appraisals

As a result of the consultation process and the summary of available scientific evidence, the Health and Welfare Commissioner recommends to the Minister of Health and Social Services that better methods to develop mechanisms to appraise performance in Québec be explored. International experience offers lessons learned which should provide inspiration. Several modalities for performance appraisals, such as clinical audits carried out by clinicians when supported by clinical information systems and registration of the clientele permitting evaluation of care needs coverage manifested by the clientele and the population, must be explored.
Recommendation 9

Introduce mechanisms for clinical performance appraisal and ongoing medical improvement

In order to enhance performance of primary healthcare services and their contribution to overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

9.1 Appropriate clinical performance indicators concerning primary healthcare medical group usage be integrated into the implementation process of new information and communications technologies, such as electronic medical records;

- The future Institut national d’excellence en santé et services sociaux (INESSS) could fulfill a central role in establishing such clinical performance indicators in collaboration with professional orders and representatives from clinical settings.

9.2 Priorities for improvement and targets for clinical performance be defined on a Québec-wide scale, in collaboration with the professional federations and orders;

9.3 A system of official certification or authorization of primary healthcare medical clinics be developed and implemented, including clinical performance audits by peer committees;

9.4 Technical support teams for analysis of performance be set up on a regional basis to provide assistance for primary healthcare physicians' offices in their care appraisal and improvement process.

- This could require participation by local primary healthcare organization officials such as the regional departments of general medicine and the health and social services centres.

What are the implications of clinical performance appraisal and ongoing medical improvement?

From an organizational point of view, the implementation of this type of appraisal process and ongoing improvement of clinical performance requires shaping tools that could include questionnaires to survey the opinion of patients about the services received in primary healthcare clinics and indicators from medical files that permit appraisal of clinical practice norms. In addition, the performance appraisal process may require mandating local or regional organizations to provide assistance for these performance appraisals and ongoing improvement activities.

As highlighted in the preceding sections, the existence of electronic medical files which make it possible to obtain data on the services rendered in conjunction with the registration of patients which makes it possible to identify a population to be associated with the clinical indicators are fundamental elements for implementing this recommendation. Lastly, this recommendation also requires integrating performance appraisal techniques into medical training in order to improve the capacities of clinicians to measure important aspects of their practice and to carry out a critical review of it.
From an **economic** point of view, performance appraisal and ongoing improvement presuppose the allocation of the necessary funds to implement the mechanisms needed to carry out the process. In fact, the volume of clinical activities performed in primary healthcare imposes a major constraint on clinicians with regard to performance appraisals. Peer audit activities and analysis of indicators require aligning remuneration to allow for their integration into clinical activities. Lastly, the establishment of provincial targets for performance will require negotiating a budget allocation dedicated to the remuneration of physicians based on the targets.

From an **ethical** point of view, implementing the appraisal and ongoing improvement process for clinical performance requires taking into account all the needs of individuals and being certain to avoid creating conditions that could generate the exclusion of patients who are the most difficult to treat or whose health problems offer no incentive to treat in terms of performance indicators. In fact, the potential adverse effect of implementing economic incentives should be the subject of an appraisal in order to minimize its effects on individuals or specific groups within the population. Striving for better performance cannot be carried out to the detriment of fairness and freedom of the individual.

### 2.4 Acting on healthcare funding

The issue of funding for healthcare returned often during the consultation process of the Commissioner concerning primary healthcare. Beyond the discussion concerning the public or private nature of funding, the focus of the debate was on the manner adopted to finance care, rather than the source of funding, which was linked to health and social services system performance.

The proposals issuing from the consultation process address various aspects linked to the methods of allocating resources and coverage of service. The issue of remuneration is the proposal that received the most support during the various phases of the consultation process. Moreover, in light of the proposals put forward in the context of the seminar of experts and the discussions held during the panel of decision makers on primary healthcare services, it must be noted that many of the proposals receiving support require considerable modification to the manner in which health care and social services are planned, organized and managed. In fact, the extent of the legislative amendments dealing with current modes of allocation of resources resulting from the proposed changes led to questioning of the feasibility of such proposals over the short or even medium term. Nevertheless, these proposals merit special consideration. Readers interested in the detailed proposals submitted to the Commissioner by the group of experts and the decision makers consulted may consult the document entitled "Report on the Consultation Process Concerning Primary healthcare."

**Realign the modes of remuneration for physicians**

One of the main aspects linked to the funding of primary healthcare services that was addressed in the consultation process carried out by the Commissioner concerned the modes of reimbursement of medical services. In fact, one of the main findings of the consultation process and the summary of scientific evidence was the fact that the mode of remuneration for physicians and healthcare professionals exerts a determining influence on clinical actions carried out and on the potential introduction and impact of certain clinical practices. It appears that funding must be properly adapted to the objectives and specific modalities chosen.
The experts and decision makers who were consulted suggested introducing a mixed mode for medical system remuneration. Based on this proposal, physicians would be paid according to various modalities according to the responsibilities assumed and this would be augmented with non-economic incentives in line with the same goals. The experts and decision makers also suggested setting up a payment system associated with primary healthcare performance that would take the form of a performance bonus for groups of primary healthcare physicians.

It should be noted that, for its part, the Commission of Study on Health and Social Services (2000) proposed setting up a mixed system for family physicians. Under the new mixed system, family physicians who work in an FMG would be paid, according to the number of people registered and their health and social characteristics, a lump sum for participation in certain programs according to contracts or agreements and a fee-for-service amount either for specific prevention activities or to support productivity in high-volume activities (Idem). The Task Force on the Funding of the Health Care System (2008) suggested setting up a lump sum remuneration and a mixed system of remuneration with financing linked to the number of patients registered with the physician.

**What benefits can be expected from mixed modalities for physician remuneration?**

Current modalities for remuneration, essentially fee-for-service for both general practitioners and specialists, have repercussions on the services rendered to patients. Some services are difficult to reimburse based on a fee-for-service schedule (telephone consultations, evaluation of complex cases, etc.). Moreover, fee-for-service remuneration does not encourage case management of complicated cases (individuals with multiple chronic illnesses, mental health problems, etc.). Lastly, fee-for-service remuneration does not fit well with the emerging context of new methods to deliver care such as group consultations, support for self-care or telephone or distance consultations. However, fee-for-service remuneration is recognized for encouraging a high volume of service delivery.

The proposals to modify remuneration suggest adding other modalities to the fee-for-service remuneration such as capitation, salary or hourly rate and performance bonus remuneration. While each of these remuneration modalities has advantages and disadvantages, the current trend within industrialized nations is to use them simultaneously to benefit from the advantages and minimize the disadvantages. That is why many countries and care organizations have opted for a mixed system for remuneration.

The scientific evidence essentially suggests that these various modalities for medical system remuneration are aligned in a more or less suitable manner with different types of services. Remuneration by capitation which consists of establishing a lump sum payment for the case management of an individual based on the degree of need for care manifested or according to clinical parameters seems appropriate for remuneration of a range of predictable services required by an individual suffering from a complex or chronic illness. In fact, some studies suggest that remuneration by capitation encourages comprehensive service delivery to these individuals in comparison with fee-for-service remuneration which fosters fragmentation of services into units that can be easily billed. This would translate into an overall service delivery focused on controlling chronic illnesses and based on prevention with the salary of physicians not varying according to the volume of care provided but rather according to the number of patients and the
degree of care required according to their state of health. In counterpart, remuneration by capitation would be associated with a lower production level of services with remuneration essentially linked to the number of patients registered and not to the quantity of services the patients receive.

Salary-based remuneration or hourly-based remuneration prove to be the best modalities for the variety of clinical activities linked to services planning, coordination of care, discussions of cases and production of medical opinions. These liaison and clinical coordination activities carried out in a context in which various professionals interact require organizing meetings for discussion, the reserving of timeslots dedicated to telephone follow-up and the drafting of medical opinions. In contrast to fee-for-service remuneration, which does not modulate the duration and intensity of coordination or planning activities, remuneration based on a salary or an hourly rate does permit such modulation. However, remuneration based on salary or on an hourly rate is considered the method which offers the smallest incentives for productivity since remuneration is not linked to the number of patients seen.

A fee-for-service remuneration would be appropriate for remuneration of short-term clinical activities for which a high volume of service is desirable. This mode of remuneration is acknowledged as the one that fosters the greatest productivity, since the remuneration of the physician is strictly related to the volume of services rendered. Various types of services, such as emergency or walk-in consultation and the provision of preventive care, are not particularly well suited to this type of remuneration. The fee-for-service remuneration, however, is the method that offers the fewest incentives towards quality of clinical interactions since remuneration is tied to volume of services rendered.

Lastly, several countries have recently instituted clinical performance bonuses within primary healthcare service settings. In this regard, the United Kingdom is pioneering by establishing clinical targets for a vast range of health problems or particular services across its territory. A proportion of the income of British physicians will come from annual bonuses tied to reaching performance standards. In this context, this mode of remuneration has been associated with an increase in the delivery of various services (such as mammograms and pap tests) or certain effects on the state of health (control over blood sugar levels or blood pressure). However, this mode is associated with undesirable effects linked to the priority placed on certain services for which a performance target has been set to the detriment of the provision of services for which no bonus has been set.

What is the situation concerning remuneration of physicians in Québec?

In Québec, the main mode of remuneration, regardless of the nature of the service delivered is a fee-for-service remuneration. The current situation as described in this document has amply demonstrated how other modalities for remuneration are less prevalent in Québec. In the context of primary healthcare services, this mode is the most prevalent, with 70% of physicians’ pay based on a fee for service. Although most family physicians in Québec are paid using more than one mode of remuneration, this depends more on the location of service delivery (such as private office, CLSC, emergency service department or hospital) rather than the nature of the service rendered.
It should, nevertheless, be noted that recent years have seen the emergence of changes to the modes of remuneration for physicians in Québec. In fact, lump sum amounts for case management of vulnerable patients and certain modalities for reimbursement of administrative activities in family medicine groups have been added to the fee-for-service remuneration prevalent in physicians' offices and salary-based remuneration adopted mainly in the CLSCs. Moreover, specialists working in university settings can now take advantage of a mixed system of remuneration that includes a lump sum payment to cover a range of services in addition to fee-for-service remuneration. However, no performance pay has been introduced in the medical context in Québec.

For citizens, what are the issues related to remuneration?

We have not submitted to the Consultation Forum of the Commissioner any questions related to the area of funding. However, it should be noted that the Forum spontaneously addressed the issue of remuneration of professional healthcare workers. The current mode of remuneration for physicians and their autonomy have also been seen by members of the Consultation Forum of the Commissioner as being hindrances to certain changes that could be made to the healthcare system. In fact, fee-for-service remuneration as currently in force does not allow physicians to be remunerated for administrative activities, management, collaborative efforts or follow-up of patients. According to the members, these actions should be envisaged to change the situation.

Key elements for the Commissioner concerning the remuneration of physicians

Remuneration, especially the mode of remuneration of physicians, was seen throughout the consultation process and the summary of scientific literature as a fundamental issue for the transformations that must be made to primary healthcare services. While this recommendation is the last in the series of our recommendations, especially for the challenges such a recommendation poses, it is, nonetheless, central in importance. In fact, revising the remuneration of physicians and realigning it according to the diversified care needs of the populations provides leverage for the full range of recommendations being put forward.

There was consensus at each phase in the consultation process that a fee-for-service remuneration model was outmoded. This suggests that it is time to offer clinicians new modes of remuneration which better account for the complexity of current, diversified clinical practice and which are part of an interdisciplinary team approach and increased responsibility assumed by the public. Introducing new modes of remuneration would take into account new challenges and remove from clinicians the time-consuming task of compiling individual services that does not truly reflect the extent of the services rendered. Scientific evidence is clear however that there is no perfect model and that a combination of modes of remuneration is necessary. As a result, the Commissioner recommends to the Minister of Health and Social Services that the remuneration mode for physicians be realigned in collaboration with the medical federations to ensure implementation of the various proposed recommendations of this report (see Recommendation 10).
Recommendation 10

Realign the modes of remuneration for physicians

In order to enhance performance of primary healthcare services and their contribution to overall performance of the health and social services system, the Health and Welfare Commissioner recommends that:

10.1 New modalities of reimbursing medical services, based on mixed modalities for payment, be introduced;

- This will require convening medical federations to negotiate implementation of a mixed style of remuneration that should
  - include portions of salary for the remuneration of clinical management and coordination activities, a portion of capitation based on the characteristics of the patients registered, a portion for fee-for-service for certain initial contact or prevention activities
  - be compatible with interdisciplinary group practice and encourage substitution and interprofessional complementarities within clinical practice
  - be adjusted to encourage new consultation modalities, other than office visits by individuals
  - include a portion of remuneration within family physicians groups based on achieving clinical targets agreed upon according to the care needs of the population being served.

10.2 Economic incentives be put in place encouraging the registration of individuals, especially vulnerable individuals with clinics adopting group practice;

10.3 Remuneration modalities for specialists be introduced encouraging support for primary healthcare clinical activities and fostering practice in hospital settings.

What are the implications of a realignment of medical remuneration modalities?

It is not necessarily an easy task to introduce new mode of remuneration into society. While several actors may agree at the outset on the advantages of different modes of remuneration for physicians, the context of negotiations can have an influence on the true capacity to modify the current methods of remunerating physicians. Nevertheless, other countries have instituted modes of remuneration that respond better to the care needs manifested by the populations being served.

From an organizational point of view, introducing mixed modes of remuneration will require implementation of several recommendations proposed in this report. These include implementation of remuneration partially based on capitation presupposes introduction of registration by individuals at primary healthcare services clinics and would be strongly facilitated by implementation of electronic medical files allowing for adequate stratification of the level of needs of the registered individuals and adjustment of the capitation fee according to the actual complexity of the case. Similarly, introduction of bonuses tied to performance requires the
development of clinical performance indicators using information technologies. While these mixed modes of remuneration do require a more highly developed organizational base, they also facilitate the implementation of other recommendations such as expanded interdisciplinary team approaches and those linked to new modalities for delivering services.

From an ethical point of view, the consultation process of the Commissioner did not raise specific issues related to the remuneration of physicians.

Lastly, from an economic point of view, the introduction of mixed modes of remuneration for physicians requires putting mechanisms into place that would make it possible to remain within budget allocations for medical system remuneration while allowing for modulation of remuneration according to various clinical activities. The establishment of a balance between the different modes of remuneration requires careful scrutiny of the issues integrating clinical, organizational and budgetary aspects. Ultimately, such changes in funding require much joint effort from the full range of actors in the system.
3. AN OVERVIEW OF THE RECOMMENDATIONS

This report offers an examination of the various proposals designed to enhance primary healthcare performance and ultimately, through this process, the performance of the overall healthcare and social services system. As mentioned in the first section, the recommendations have been analyzed with careful attention to their interconnections. As a result, the potential benefits of each recommendation appear less impressive than the benefits that could emerge from the synergy created by implementing a coherent series of measures. Moreover, certain recommendations, as we have seen, are necessary for the implementation of others. Thus, the priority has been placed on the recommendations whose combined action guarantees beneficial impact on the performance of the system as a whole and whose implementation could facilitate implementation of a wider series of measures.

The ten recommendations put forward by the Commissioner are thus all linked to each other and interdependent (see the figure below). In light of the synopsis of the information, it appears appropriate to start with an expansion of group practice in the context of primary healthcare services to allow for implementation of subsequent recommendations. In fact it would be difficult, if not impossible, to bring in the other recommendations into clinical settings characterized by solo practice or a simple sharing of office space by a few physicians. It has been clearly demonstrated that group practice is fertile ground for introducing a series of more comprehensive organizational innovations and exemplary practices. An expansion of group practice has been launched in Québec mainly within the context of setting up family medicine groups. This promising initiative should be pursued.

During the consultation process and in the summary of scientific evidence, it was noted that information technologies reappear constantly as a fundamental concern. More than an end in itself, the introduction of information technologies to assist clinical activities is perceived as a very basic tool to enhance care and implement effective organizational models. The demands of interdisciplinary practice, services planning and performance appraisal require a technological foundation on which to build. Moreover, information technologies are a key tool for registration of the population and for recognition of their needs for care and services. In many ways, the use of information technologies in primary healthcare clinical activities could improve the understanding of local actors in the system regarding care needs, the services rendered and the specific locations at which individuals are affiliated. As a result, the updating of the local health and social services networks could be facilitated.

An increase in interdisciplinary team approaches, which is possible essentially in group practice and greatly facilitated by the sharing of information technology installations, also seems to be the basis on which new consultation modalities could adapt the service offer to the needs of populations and permit better participation by the public and better support for informal caregivers. In the near future, these new consultation modalities, in the context of interdisciplinary settings and greater, more effective participation by individuals in their care would also facilitate full registration of the population with primary healthcare clinics.

Full registration as has been eloquently demonstrated is necessary for better services planning and integration of preventive activities into the care given at various phases in life. However, there is real concern within the network over the capacity to ensure access for the whole population to primary healthcare clinics. In this report, we propose registration for the entire population that so
These organizational modifications in the methods of rendering services are the basis on which better services planning could be built. These modifications could facilitate revising the sharing of responsibility among professionals in primary and secondary care whose roles are sometimes inverted in the current situation, and, in return, they would permit the primary healthcare service teams to focus on their role as the first contact with the individual and on holistic case management of health. The tools used for clinical governance and performance appraisal also contribute to adjusting the service offer according to the priority needs of individuals and of the populations by employing methods shown to be effective and the ongoing improvement in quality.

Ultimately, the topic of remuneration for primary healthcare services physicians returned as another central theme. More than an end in itself, revising the modes of remuneration, in the context of the public funding of medical services, can be one element facilitating implementation of other measures such as interdisciplinary group practice, registration of the population and performance appraisal.
The recommendations are therefore closely linked to each other. We invite the Minister of Health and Social Services, in collaboration with all the actors in the network, to closely consider these recommendations and view them in their logical sequence. In our opinion, they represent major milestones in an approach to enhancing the primary healthcare performance over the coming years. Over the short term significant repercussions for our system could be felt as well as in satisfaction with primary healthcare services and the state of health of individuals in addition to the impact on the overall performance of the health and social services system.

Lastly, this series of recommendations has been drawn up by adopting a perspective of support and capacity building for the actors in the system who must provide quality services on an everyday basis. We have attempted to determine the organizational causes for performance deficiencies in our system. That was the approach used to formulate the recommendations, which in our opinion may help local clinicians and managers to plan, deliver and evaluate service while continuing to deliver excellent levels of service for years to come.
CONCLUSION

Analyzing the performance of our health and social services system using the method of consulting clinicians, experts, decision makers and the public, analysis of performance monitoring indicators and the synopsis of scientific evidence enabled us to identify, beyond the normal step of identification of the problems, the various changes we could make to enhance the performance of our system. Regarding primary healthcare services, our synopsis of the information from scientific, organizational and democratic sources enabled us to better understand what we must do to enhance the performance of our primary healthcare services and how primary healthcare contributes to the health and social services system as a whole.

As we have seen in the preceding sections of this document, in the document dealing with the performance monitoring indicators and in the documents dealing with the current situation and the consultation process, primary healthcare services can have a determining effect on the performance of our health and social services system.

We have also seen that there are challenges facing us as we strive to ensure better utilization of the resources in which we have invested. Although we are experiencing a shortage of human resources, this shortage is also the result of inappropriate use of professional healthcare workers and poor organizational support for maximizing their contributions. In this context in which there are encouraging signs concerning admissions in medicine and nursing sciences, in additional to encouraging signs within the network for other healthcare professionals, we have directed our focus especially on the methods for planning, organizing and appraising the services that could improve the situation. What is at stake is not simply to add on resources or ask them to perform the same tasks as before, but instead to reorient the efforts of physicians and other healthcare professionals and provide them with assistance in this task.

Lastly, the consultation process and the analysis of the data also emphasized the preponderant role of the individuals for whom the health and social services system exists. Patients are more or less perceived as those who received care whereas now the system must adapt to individuals who are much more proactive in terms of their health and in terms of using services.

Major concerns are present within our network regarding the place that family physicians and primary healthcare services in general should occupy. Recent studies and analyses have also raised concerns as to the future of primary healthcare services. We must enhance the role of primary healthcare services and make this practice more attractive to professional healthcare workers while improving the response to the initial care needs of the population. Individuals often turn to specialized services to fill their care needs, due to an inability to access the required services in the context of primary healthcare services. This is a major challenge facing our system.

The Health and Welfare Commissioner is proposing ten recommendations that are each related to the others and which are intended to enhance primary healthcare performance and its interaction with the overall health and social services system in Québec. These recommendations deal with four fundamental aspects of healthcare systems and social services system: the organization of care and resources; clinical practices and delivery of services; planning and management of clinical activities; and funding. Establishing a modern organization with suitable resources, as several industrialized nations have already done, fostering greater participation by the public in
healthcare, better planning, organization and appraisal of care and providing appropriate funding for primary healthcare are what we are asking of our health and social services system. In the process, improvements will accrue to the system as a whole.

While each one of the recommendations, considered in isolation, may appear difficult to put into application, the mutual overall impact of the recommendations should ensure gradual and complete implementation. In fact, by emphasizing each one of these recommendations, it will ultimately be possible to implement them all, as a whole. These recommendations call for actions that, at different levels, are essential to implementation of all the others. Nevertheless, as our approach strongly implies, the challenge is not to implement all the measures at once, but instead to begin immediately implementing a portion of each one of them.

The recommendations formulated all contribute to supporting primary healthcare practice and also help to make it attractive to future generations of healthcare professionals, thus ensuring its continuity. To the extent that our resolve is strong, and with the collaboration of all the actors in the system, it is our belief that it will be possible to reach the levels of performance that other countries have already achieved in terms of primary healthcare services.
LIST OF RECOMMENDATIONS

The Health and Welfare Commissioner has formulated the following ten recommendations dealing with four fundamental aspects of the health and social services system in Québec.

ACTING ON THE ORGANIZATION OF CARE AND RESOURCES

Recommendation 1 - Encourage medical group practice

1.1 A target of 300 family medicine groups (FMG) be achieved over the next few years to ensure that 75% of the public is covered;

1.2 FMG fundamental organizational characteristics (group medical practice, registration of the clientele, contractual agreements with CLSC, presence of healthcare professionals other than just physicians) be maintained along with all current obligations tied to these organizational models for care during official certification or authorization procedures;

• This will require preserving the flexibility during implementation in order to meet the specific demands of various geographic settings (urban, rural, remote or isolated) and organizational (clinic size, availability of human resources locally, specific characteristics of the local network of health and social services).

1.3 Other authorized organizational models with characteristics similar to FMG be added to extend primary healthcare services to the population overall;

1.4 Medical students and family medicine residents be exposed to FMG practice early in their training before and after graduation.

• This will require the collaboration of network clinical settings and institutions with teaching institutions.

Recommendation 2 - Support the implementation of electronic medical records and Québec’s shareable Electronic Health Record

2.1 Electronic medical files and related technologies (electronic transmission of queries and of data, electronic prescriptions) be implemented throughout all family medicine groups and throughout all other officially recognized models;

2.2 Support activities for training and introduction of information technologies in clinical settings be set up at local and regional levels;

2.3 A partnership between medical federations and network authorities be developed to foster the introduction of electronic medical records and related technologies into all primary healthcare clinics and offices which so request it.

• This could be supported through financial or organizational incentives within a context of agreements stating the conditions of such incentives.
2.4 Québec’s shareable Electronic Health Record and electronic medical files introduced into FMG and other offices be technologically harmonized in order to foster circulation of appropriate information related to the care of persons throughout the health and social services network;

2.5 Guidelines be instituted in collaboration with clinics and professional corporations and in line with Québec legislation governing such matters to ensure confidentiality and protection of medical information contained in the shareable electronic health record and electronic medical files.

Recommendation 3 - Increase interdisciplinarity in primary healthcare group practice

3.1 Family medicine groups (FMG) and other authorized models include a larger presence of healthcare professionals who are not physicians, such as nurses, nurse auxiliaries, psychologists, dietitians/nutritionists and social workers currently providing services within health and social services centres (CSSS) to increase interdisciplinary teamwork within primary healthcare services;

- These professional workers should maintain their employment link with the CSSS but a portion of their activities should be assigned to medical office practice.

3.2 Contractual links be signed between primary healthcare medical offices and health and social services centres to outline specific service corridors to ensure patients with access to care delivered by professionals other than physicians when delivery within medical offices is not possible;

3.3 Coordination mechanisms be instituted with all local health and social services networks for local provision of care integrating all service providers in physicians’ offices and institutions in the local network;

3.4 Health science professional workers, including physicians be trained in interdisciplinary approaches, especially during clinical internships.

- This must be done in collaboration with clinical settings and teaching institutions.

ACTING ON CLINICAL PRACTICES AND PROVISION OF SERVICES

Recommendation 4 - Explore new modalities for care delivery

4.1 The relevance, effectiveness and security in our context for new modalities for delivery of care be evaluated including, but not limited to, group consultations, peer consultations, electronic and virtual consultations as well as programs for advanced access to care;

- This should be carried out in collaboration with the Agence d’évaluation des technologies et des modes d’intervention en santé (AÉTMIS) or with the Institut national d’excellence en santé et services sociaux (INESSS).
4.2 Experience that exists within clinical settings in Québec related to the introduction of these new methods for interaction with patients be catalogued and analyzed in order to encourage their implementation in other settings;

4.3 The scientific evidence and feasibility of introducing these new consultation modalities be evaluated in order to meet the growing needs of populations in the context of primary healthcare services.

- This should be carried out in collaboration with the Agence d’évaluation des technologies et des modes d’intervention en santé (AÉTMIS) or with the Institut national d’excellence en santé et services sociaux (INESSS).

**Recommendation 5 - Foster self-care practices and support the contributions made by informal caregivers**

5.1 Activities to promote and support self-care be conducted within the primary healthcare clinical context in Québec;

- These activities include tools to encourage self-care practices integrated into clinical information systems, collaboration with teaching institutions, participation by an interdisciplinary team in developing the capacities of individuals to manage the various aspects of their state of health and their care as well as information available through electronic health information portals.

5.2 Tools be developed and implemented that are designed to improve the capacity of informal caregivers to participate in the health care of the person receiving assistance and that the participation of informal caregivers be supported within the context of primary healthcare services.

- This will require taking into account the consequences of participation by informal caregivers on their personal and professional lives.

5.3 The different approaches aimed at encouraging self-care within the context of primary healthcare services be the subject of an appraisal of their effectiveness and safety in order to guide implementation within clinical settings.

- This should be carried out in collaboration with the Agence d’évaluation des technologies et des modes d’intervention en santé (AÉTMIS) or with the Institut national d’excellence en santé et services sociaux (INESSS).

**Recommendation 6 – Ensure that individuals wishing to register with groups of primary healthcare physicians to do so.**

6.1 All those in the population who so desire be registered with primary healthcare groups of physicians such as family medicine groups and other medical clinics.

- Registration would consist of a mutual commitment between the individuals and their physicians. The individuals would be free to change clinics according to specific modalities to maintain their right to choose, while guaranteeing a level of stability in the clientele of the clinics. In return, the primary healthcare groups of physicians would make a commitment to deliver services on a collective basis to meet the regular medical needs of those registered.
6.2 **Priority for registration be placed on persons who meet current criteria for vulnerability in relation to a specific medical activity** with subsequent priority place on registration of the entire population;

6.3 **Individuals be registered within their territory of residence** to facilitate access to medical services in their community and linkage of primary healthcare offices with services within the local network of health and social services;

6.4 **The ratio of patients registered per primary healthcare physician be reviewed along with the ratio of professional healthcare workers who are not physicians per family medicine group** in order to make the goal of registration of the population possible.

- The review of the ratios should take into account the care needs of current users as well as those of individuals who currently are not receiving care but who in the future may benefit from affiliation with a group of primary healthcare physicians and other authorized models for preventive and curative purposes.

**ACTING ON THE PLANNING AND MANAGEMENT OF CLINICAL ACTIVITIES**

**Recommendation 7 - Review the clinical responsibilities of primary and secondary care physicians**

7.1 **The framework for primary healthcare medical practice and specialized medical practice in Québec be revised** in collaboration with the medical federations and the Collège des médecins du Québec to ensure clarification of the roles and greater complementarities between generalists and specialists in Québec;

7.2 **Mechanisms to support primary healthcare medical activities by attending specialists be instituted.**

- Such mechanisms could include telephone consultations or an integration of specialized clinical activities in primary healthcare medical offices.

7.3 **Incentives for primary healthcare medical practice for family physicians and incentives for secondary and tertiary care practice for specialists be instituted.**

- Either organizational or financial in nature, these incentives must be designed to reduce the incidence of family physicians specializing in other practices and reduce the incidence of specialists providing primary healthcare services.

7.4 **The framework and definitions of special medical activities be revised**, in collaboration with the federations of general practitioners and specialists in order to encourage the availability of family physicians for primary healthcare activities and greater participation by specialists in covering secondary and tertiary care.

**Recommendation 8 - Develop mechanisms for primary healthcare clinical governance**

8.1 **Information systems based on utilization of electronic medical records and integration of tools to assist clinical decision making for clinical governance be developed and introduced** in primary healthcare offices;
8.2 **Indicators for patient needs and indicators tracking clinical outcomes supporting clinical governance of primary healthcare** services be developed and introduced.

8.3 **Local care protocols for current illnesses be instituted** in the context of primary healthcare services linked to health and social services centre clinical projects;

- This could require the participation of the DRMG, regional directorates of medical affairs and the various administrative units of the health and social services centres.

8.4 **Orientation gateways for individuals be instituted on a local scale based on the degree of needs of individuals and case managers** all across the CSSS;

8.5 **Agreements be introduced governing access to clinical data for the purposes of planning and evaluation of services and in order to ensure that privacy concerns are addressed** in the utilization of electronic medical files.

**Recommendation 9 - Introduce mechanisms for clinical performance appraisal and ongoing clinical improvement**

9.1 **Appropriate clinical performance indicators concerning primary healthcare services medical group usage be integrated into the implementation process of new information and communications technologies**, such as electronic medical records.

- The future Institut national d’excellence en santé et services sociaux (INESSS) could fulfill a central role in establishing such clinical performance indicators in collaboration with professional orders and representatives from clinical settings.

9.2 **Priorities for improvement and targets for clinical performance be defined on a Québec-wide scale**, in collaboration with the professional federations and orders;

9.3 **A system of official certification or authorization of primary healthcare medical clinics be developed and implemented, including clinical performance audits by peer committees;**

9.4 **Technical support teams for analysis of performance be set up on a regional basis to provide assistance for primary healthcare physicians’ offices in their care appraisal and improvement process.**

- This could require participation by local primary healthcare organization officials such as the regional departments of general medicine and the health and social services centres.
ACTING ON HEALTHCARE FUNDING

Recommendation 10 - Realign the modes of remuneration for physicians

10.1 New modalities of reimbursing medical services based on mixed modalities for payment, be introduced.

- This will require convening medical federations to negotiate implementation of a mixed style of remuneration that should
  
  o include portions of salary for the remuneration of clinical management and coordination activities, a portion of capitation based on the characteristics of the patients registered, a portion for fee-for-service for certain initial contact or prevention activities
  
  o be compatible with interdisciplinary group practice and encourage substitution and interprofessional complementarities within clinical practice
  
  o be adjusted to encourage new consultation modalities, other than office visits by individuals
  
  o include a portion of remuneration within family physicians groups based on achieving clinical targets agreed upon according to the care needs of the population being served.

10.2 Economic incentives be put in place encouraging the registration of individuals, especially vulnerable individuals with clinics adopting group practice;

10.3 Remuneration modalities for specialists be introduced encouraging support for primary healthcare clinical activities and fostering practice in hospital settings.
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ACKNOWLEDGEMENTS

The Health and Welfare Commissioner wishes to thank all the individuals and organizations that participated in the work required to produce this appraisal report on the performance of the health and social services system and specifically the primary healthcare system. As for the production of this specific document, the Commissioner thanks the members of the Orientation Committee of the Commissioner and the members of the Consultative Committee on Primary Healthcare.

The Commissioner would also like to express his gratitude towards a number of clinical settings for accepting to take part in various phases of the consultation. They include the Groupe de médecine de famille de Montmagny, the Unité de médecine familiale – Groupe de médecine de famille located at the Cité de la santé de Laval, the Family Medicine Group Sutton - Cowansville, the Clinique médicale Vimy, and the Clinique médicale Médiclub au Sanctuaire.

The appreciation of the Commissioner is also addressed to the local and regional organizations that took part in the various phases of the consultation. These include the regional DRMG table (Département régional de médecine générale) for LaPommeraie and the DRMG table for the Mauricie and Centre-du-Québec region, the Centre de santé et de services sociaux de Montmagny-L’Islet, the Centre de santé et de services sociaux de Bordeaux-Cartierville–Saint-Laurent, the Centre de santé et de services sociaux de Beauce, the Centre jeunesse de Montréal, the Agence de la santé et des services sociaux de l’Abitibi-Témiscamingue, the Agence de la santé et des services sociaux du Bas-Saint-Laurent, the Agence de la santé et des services sociaux de la Montérégie, and the Agence de la santé et des services sociaux du Saguenay–Lac-Saint-Jean.

In addition, the Commissioner expresses his gratitude to the Ministère de la Santé et des Services sociaux, the Fédération des médecins omnipraticiens du Québec and the Fédération des médecins spécialistes du Québec, the Collège des médecins du Québec, the Ordre des infirmières et infirmiers du Québec, the Association médicale du Québec, the Association québécoise d’établissements de santé et de services sociaux, and the Association des cadres supérieurs de la santé et des services sociaux for their collaboration during the various phases of data collection and consultation.

The Health and Welfare Commissioner thanks the experts representing the various research centres and university institutions for their gracious participation in the consultation process. They include the Centre de recherche du CHUM, the Université de Montréal, the Université de Sherbrooke, the Université Laval, McGill University, the Université du Québec à Montréal, the Université du Québec à Rimouski, the École nationale d’administration publique – Québec, the Douglas Hospital Research Centre, The C.T. Lamont Primary Health Care Research Centre, Ottawa, and the Institut national de santé publique du Québec.

The Commissioner also thanks all the members of the Consultation Forum of the Commissioner for their participation in the work examining primary health care.
APPENDIX 1. LIST OF THOSE WHO PARTICIPATED AT THE SEMINAR OF EXPERTS CONCERNING PRIMARY HEALTHCARE SERVICES THAT WAS HELD IN MONTRÉAL ON NOVEMBER 26 AND 27, 2007

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PRODUCTION

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March 2009