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Improving Access to Family Medicine in Québec through Quotas and Numerical Targets

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Abstract

Despite various health reforms over the last 20 years, access to primary care remained stagnant in Québec, and in 2014 the province had the highest proportion of residents in Canada without a family physician. In November 2014, the Québec Minister of Health and Social Services introduced Bill 20, *An Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation.* Bill 20 aimed to increase access to family medicine through a system of quotas of registered patients and penalties for family physicians. Health system user support groups and the governmental advisory group on women's rights supported Bill 20's approach to ensure the rights of system users to access family physicians. However, the union of general practitioners was strongly against the bill due to the clash between the minister's reliance on numbers and the realities of family practice. The union of general practitioners entered negotiations with the minister and while Bill 20 was legalized in 2015, it was agreed that family physicians would be excused from the bill as long as they reached two targets at the end of December 2017: *1*) 85% of Québecers must have a family doctor and *2*) family doctors must ensure the patients registered to them see them, and not other doctors, 80% of the time. The targets were not met at the end of December 2017 but the quota system in Bill 20 has yet to be implemented.

Malgré diverses réformes de la santé au cours des 20 dernières années, l'accès aux soins primaires est demeuré stagnant au Québec et en 2014, la province affichait la plus forte proportion au Canada de résidents sans médecin de famille. En novembre 2014, le ministre de la Santé et des Services sociaux du Québec a présenté le projet de loi 20, Loi favorisant l'accès aux services de médecine familiale et de médecine spécialisée et modifiant diverses dispositions législatives en matière de procréation assistée. *Le projet de loi 20 visait à accroître l'accès à la médecine familiale grâce à un système de quotas de patients inscrits et de pénalités pour les médecins de famille ne se conformant pas à ces quotas. Les groupes d'usagers du système de santé et le groupe consultatif gouvernemental sur les droits des femmes ont appuyé l'approche du projet de loi 20. En contraste, la Fédération des médecins omnipraticiens du Québec s'est vivement opposée au projet de loi, arguant que les quotas qui seraient imposés ne tenaient pas compte des contraintes structurelles imposées sur la pratique de la médecine familiale, elles-mêmes issues de mandats gouvernementaux. Le syndicat des médecins généralistes a entamé des négociations avec le ministre et, bien que le projet de loi 20 ait été légalisé en 2015, il a été convenu que les médecins de famille seraient dispensés de l'application du projet de loi à condition d'atteindre deux objectifs à la fin du mois de décembre 2017: 1) tous les Québécois devaient avoir un médecin de famille et 2) les médecins de famille devaient s'assurer que 80% des visites à un médecin d'un patient soient avec le médecin avec lequel ils sont inscrits.Bien que les objectifs n'aient pas été atteints à*

la fin de décembre 2017, le système de quotas prévu dans le projet de loi 20 n'a pas encore été mis en œuvre.

Key Messages

- Family physicians strongly opposed Bill 20, notably due to its focus on performance metrics that did not sufficiently factor in the structural constraints on family practice in Québec.
- As of 25 August 2019, Bill 20's system of quotas and penalties for family physicians has yet to come into effect.
- It has been suggested that Bill 20's proposal to establish patient quotas for family physicians may have served as a negotiation tool for Québec's Minister of Health and Social Services.

Messages-clés

- *Les médecins de famille se sont fortement opposés au projet de loi 20, notamment en raison de l'emphase mise sur les indicateurs de performance qui ne tenaient pas suffisamment compte des contraintes structurelles de la pratique de médecine de famille au Québec.*
- *En date du 25 septembre 2019, le système de quotas et de pénalités pour les médecins de famille proposé dans la loi 20 n'est toujours pas encore entré en vigueur.*
- *D'aucuns ont suggéré que la proposition du projet de loi 20 visant à établir des quotas de patients pour les médecins de famille n'était en fait qu'un outil de négociation pour le ministre de la Santé et des Services sociaux du Québec.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

On 28 November 2014, the Québec Minister of Health and Social Services, Dr. Gaétan Barrette, introduced Bill 20, *An Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation.* This health reform analysis will focus on Bill 20's proposal to increase access to family medicine, arguably the component of the omnibus bill that encountered the staunchest opposition.

Bill 20 aimed to promote access to family medicine by mandating family physicians to meet a quota of registered patients inversely related to the physician's seniority. Failure to meet this quota would result in up to a 30% reduction in their pay. Before the bill was passed a year later, the union representing general practitioners of Québec (*Fédération des médecins omnipraticiens du Québec*, FMOQ) successfully reached an agreement with the Ministry of Health and Social Services (MSSS) that postponed the implementation of the patient quotas for two years (MSSS-FMOQ 2015). In exchange, family doctors were required to meet two targets by the end of December 2017: *1*) 85% of Québecers must have a family doctor and *2*) family doctors must ensure the patients registered to them see them, and not other doctors, 80% of the time. If these goals were reached, Bill 20 pertaining to family physicians would not be implemented.

2 HISTORY AND CONTEXT

In Canada, timely access to primary health care has been at the forefront of priorities for almost two decades. "Access to primary health care" can be operationalized in many dimensions, and attachment with a family physician can be used as such a measure.

Primary health care reforms that have taken place in Québec (e.g., family medicine groups, rostering bonuses) have not lived up to their expectations, resulting in only slight improvements in access to primary care (Pineault *et al.* 2016). In 2014, 25.2% of Québecers were without a primary physician, the *highest* proportion provincially (Statistics Canada 2015). Yet the problem did not appear to be due to a shortage of family physicians: Québec counted 117 family physicians per 100,000 people while Ontario counted 100 and only 7.5% of Ontarians lacked a family doctor, the *lowest* proportion nationally (Canadian Medical Association 2017). Furthermore, compared with Ontario, Québec had a lower average of patients per physician (1,081 versus 1,539) and Québec doctors also worked fewer hours per week (34.9 versus 43) (Forget 2014; Gladu 2007). To the government, these metrics portrayed Québec family physicians as underperforming.

However, these figures were superficial and did not reflect structural constraints on practice that were imposed through governmental regulation: unlike other Canadian provinces, family doctors in Québec spend more time working in specific medical activities (*activités*

médicales particulières, AMP) that have been legally mandated since 1991 (FMOQ 2015). During their first 24 years of practice, family physicians are required to work between 6 to 12 hours a week (30 to 40% of their time) in health care institutions such as the emergency department of a hospital or long-term care facilities (FMOQ 2017). This professional mandate constrains family physicians' time to care for patients in private practice.

In this context, Bill 20 was presented as an accountability framework on physician practice based on clear performance indicators to ensure greater productivity and accessibility to primary care. The bill was deemed particularly inequitable for junior family physicians by adding to their existing mandate of 12 weekly hours of AMPs, the additional quota of following at least 1,008 patients per year (i.e., about the average of patients per physician in Québec at the time, knowing that more junior physicians tended to see fewer patients than average due to restrictions on their practice imposed by the AMPs). In contrast, family doctors having practised for 35 years or more would not have been held to a minimum of either hours of AMPs *or* of registered patients.

3 GOALS OF THE REFORM

3.1 Stated

As described in the explanatory notes of Bill 20, the overall goal of the reform is to "optimize the utilization of the medical and financial resources of the health system with a view to improving access to family medicine" (National Assembly of Québec 2015).

3.2 Implicit

Data from the Québec health administration agency indicated that the number of medical services offered by family physicians had been steadily decreasing since 2007 despite increases in physician salaries (Rochon 2013). Financial incentives having produced few results to increase access, it appears that a strategic decision was made to turn to punitive measures. The minister later stated that Bill 20 was only a threat meant to spur physicians to implement innovative solutions to accessibility issues and that the system of quotas and penalties as outlined in the bill would never need to take effect (Fidelman 2015). As such, the part of the bill aimed at regulating family physician's behaviour could be seen as a negotiation tool.

4 FACTORS THAT INFLUENCED HOW AND WHY

4.1 The issue came onto the government's agenda

Despite numerous reforms since 2000, access to primary care still lagged in Québec when elections were declared early in 2014. In fact, the proportion of Québecers without a

family doctor had remained stagnant since 2003 (Statistics Canada 2013). Media reports and public concerns about access to care led to the implementation of the centralized waiting list (*Guichets d'accès pour la clientèle orpheline*) for unattached patients in 2008 (Breton *et al.* 2019). Over time, issues with discrimination against the selection of certain types of patients surfaced and there was pressure to ameliorate the attachment process (Breton, Gagne, Gankpe 2014). Improving access to primary care featured highly in the electoral campaign of the Québec Liberal Party, with electoral promises as specific as the creation of 24/7 super clinics and expansion of family medicine groups, which were aimed at encouraging patients away from emergency rooms and into primary care. The Québec Liberal Party was elected in April 2014 under the leadership of Dr. Phillipe Couillard (Québec Minister of Health from 2003-2008).

4.2 The final decision was made or not made

4.2.1 Interests

Upon tabling Bill 20, eight rounds of special consultations and public hearings were held where various stakeholders presented their briefs to the minister. These actors included health system user groups, medical professional associations, medical students, regulatory health colleges, deans of medical schools, patients' rights lawyers, and the governmental advisory group on women's rights. While all stakeholders expressed a common *interest* to improve accessibility to family medicine in the province, those who favoured Bill 20's solution were few. Among them, the provincial consortium of user committees (*Regroupement provincial des comités des usagers*, RPCU) supported the bill's approach to legally ensure the rights of health system users to access a family physician and shift the responsibility of accessibility onto each family physician (RPCU 2015).

The union of general practitioners (FMOQ) opposed the bill outright and requested to engage in negotiations with the ministry. Physicians were concerned about negative impacts of the bill on the quality of patient care and physician practice, decreased opportunities for teaching, poor understanding of physician workloads, lack of respect for family medicine, and reduced professional autonomy (FMOQ 2015). Moreover, physicians were concerned that the bill discriminated against those trying to balance work and family, especially junior female practitioners with young children. Declaring that they prioritized female patients over female family physicians, the governmental advisory group on women's rights (*Conseil du statut de la femme*, CSF) supported Bill 20 (CSF 2015). This position was controversial and criticized for disregarding the fact that female physicians disproportionately provide services to female patients, such as obstetrics, breast health clinics, breastfeeding, family planning, mental health, and sexual assault kits (Dufresne 2015).

4.2.2 Ideas

The controversy around Bill 20 arose notably out of a clash between the minister's reliance on numbers and the realities of family practice. Québec had more physicians per capita than any other province, but its physicians worked less hours and had fewer patients enrolled than Ontario, for instance. Thus, the minister argued, the solution to solve inaccessibility issues was purely mathematical, hinging on imposing quotas on average number of hours worked per week and average number of patients enrolled compared with those of neighbouring provinces (Barrette 2015).

Family physicians argued that this view was overly simplistic and neglected the realities of primary care practice in Québec. In addition, they viewed the ministry's accounting framework as dehumanizing of patients, by turning them into numbers (FMOQ 2014; McCarty 2014) and as undue governmental interference in the conditions of private medical practice. They pointed instead to other solutions such as the abolition of the AMPs (which required them to work in institutions and created disincentives to open a family practice), the promotion of advanced access technique (which notably block off time slots for emergency patients, allowing same-day appointments), the creation of super clinics, and the computerization of medical records (FMOQ 2013).

4.2.3 Institutions

A Liberal majority government facilitated the final passing of the bill. The enactment of Bill 20 was touted as fundamental a reform as Bill 10, *An Act to modify the organization and governance of the health and social services network*, tabled only two months before, and which effected a profound reorganization of the system, centralizing and increasing powers to the ministry (Quesnel-Vallée and Carter 2018). The new centralized health establishments implemented through Bill 10 would allow more concerted efforts toward improving physician access and increase the ministry's stewardship role over how doctors manage their hours (Young 2015).

5 HOW THE REFORM WAS ACHIEVED

5.1 Policy instruments

Bill 20 was adopted in principle on 20 May 2015 with 63 votes for and 52 votes against outlining new obligations for family physicians. Ongoing negotiations then led to an agreement between the MSSS and FMOQ to excuse family doctors from the bill on 2 June 2015. The bill came into assent on 10 November 2015.

5.2 Implementation of ideas

While the implementation of the quotas defined in Bill 20 was delayed to 31 December 2017 as per the MSSS-FMOQ agreement on 2 June 2015, several other strategies were adopted to facilitate access to primary care (MSSS-FMOQ 2015; MSSS 2017a). These include:

- Launch of an online family doctor finder tool (*Guichet d'accès à un médecin de famille*, previously called *Guichets d'accès pour la clientèle orpheline*) in April 2016,
- Decreasing maximum wait times on the centralized wait lists for patients without family physicians,
- Promotion of advanced access techniques,
- Promotion of the creation of new family medicine groups (*groupe de médecine de famille*),
- Modification of the agreement regarding AMPs to include patient registration and follow-up of registered patients as a possible AMP, and
- New agreement includes a plan to phase out AMPs.

6 EVALUATION

Following section 72 of Bill 20, data are published every three months to ensure progress toward the agreed upon target (National Assembly of Québec 2015). Patient fidelity was at 82% as of September 2017 (MSSS 2017a). As of December 2017, some regions in Québec surpassed the target of 85% attached to a family doctor, and the overall provincial registration rate reached 79%, up from 66.4% in April 2014 (MSSS 2017b). The minister asserted that the provincial target of 85% should be reached in the following quarter, and he stated that, as long as physicians actively pursued the targets agreed upon with the FMOQ, the quotas stipulated in Bill 20 would not be implemented (La Presse Canadienne 2017).

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1 summarizes the strengths, weaknesses, opportunities, and threats of increasing access to family physicians under the proposal indicated in Bill 20.

Table 1: SWOT analysis

Strengths	Weaknesses
• Increased access to a regular family physician. • Decreased low priority visits to emergency rooms. • Increased continuity of care.	• Mathematical approach of patient quotas affects quality of care (physicians). • Top-down strategy (physicians). • Lack of consultation with family doctors prior to tabling of the bill (physicians). • Inequity of the proposed quota system based on seniority (younger physicians). • Registration with family physician does not necessarily result in effective access (users).
Opportunities	**Threats**
• Threat of bill could lead to the mobilization of solutions to facilitate access to family physicians. • Refocus work of family physicians toward private practice and away from institutions (physicians, Minister).	• Mathematically weighing patients based on health needs in calculating a physician's caseload is dehumanizing (users). • Exacerbation of gender inequality in remuneration, as female physicians were more likely to face 30% cuts for not meeting quotas (female family physicians). • Devaluation of family practice, discouraging medical student enrolment in this specialty and driving some in-province doctors to leave the province (medical students, physicians, deans of medical schools). • Further centralization of powers to the minister: regulation of previously autonomous private family practice (physicians). • Ethical implications of relying on quotas and penalties as coercive and punitive methods (physicians).

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