



## Health Reform Monitor

## Promoting access to family medicine in Québec, Canada: Analysis of bill 20, enacted in November 2015\*

Maude Laberge<sup>a,c,\*</sup>, Myriam Gaudreault<sup>b</sup><sup>a</sup> Faculty of Business Administration, Université Laval, 2325, rue de la Terrasse, Québec, Québec, G1V 0A6, Canada<sup>b</sup> Faculty of Business Administration, Université Laval, Canada<sup>c</sup> Centre de recherche en soins et services de première ligne de l'Université Laval (CERSSPL-UL), Québec, Canada

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## ABSTRACT

Primary care can potentially make an important contribution to improving health system performance. However, Canada does not fare as well as other developed countries in terms of timely access to primary health care services. In November 2015, Bill 20 was introduced in the province of Québec. The goal of Bill 20 was to optimize the utilisation of medical and financial resources to improve access to primary care. Bill 20 states the obligations of general practitioners to register a minimum number of patients, ensure the continuity of care of that population, and practice a minimum number of hours in hospitals. Many actors agreed that access to primary care had to be improved in Québec, but disagreed with Bill 20. In particular, family physicians strongly opposed the financial penalties that were introduced for physicians failing to meet the specified targets. In January 2018, 3 years after Bill 20, indicators for patient registration and continuity of care have considerably improved. However, the attractiveness of general practice seems to have decreased among medical graduates, which creates uncertainty regarding the sustainability of the achievements brought on by Bill 20.

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## 1. Introduction

Primary care is an important contributor to the health of a population [1–8]. It is where the majority of care is delivered and access to health care is the basis of primary care [9,10]. Better and more timely access to primary care services is associated with better outcomes and with lower utilization of emergency departments for low acuity health problems [11–13]. Another key characteristic of primary care is the continuity of care offered to its users. Lower continuity has been associated with a higher emergency department utilisation [14–16]. Compared to other wealthy countries, Canada performs poorly in terms of timely access to services with the lowest proportion of people reporting being able to access primary care services on the same or next day, and the highest proportion having to wait six days or more [17]. Close to 16% of Canadians aged 12 or older reported not having a primary care provider, and this proportion was the highest in the province of Quebec, where it reached 25.6% [18]. In 2015, the provincial government decided to

implement a reform of the Quebec health care system with goals of improving access and efficiency.

## 2. The Quebec health care system: context and reform

Canada has a universal health care system that is administered publicly by each province, in respect of the five principles of public administration, comprehensiveness, universality, portability, and accessibility as defined in the Canada Health Act [19]. Prior to the reform, Quebec's universal health care system had three levels of governance: the Ministerial level with the Ministry of Health and Social Services (MSSS), the regional level with 18 regional health agencies, and the local level with 182 health care organizations of which 95 were health and social services centers (CSSS) and the remaining ones being independent hospitals, youth centers, rehabilitation facilities, and local community health centres [20]. While the MSSS defined province-wide policies and provided funding to agencies, the responsibility of planning and organizing services with their respective CSSS and other health care organizations belonged to the agencies. CSSS provided services throughout the continuum of care.

The majority of physicians in Quebec receive most of their remuneration from fee-for-service payments from the public health insurance (*Régie d'assurance maladie du Québec –RAMQ*) [21]. Fees as well as other conditions of medical practice are negotiated

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\* Corresponding author.

E-mail addresses: [maude.laberge@fsa.ulaval.ca](mailto:maude.laberge@fsa.ulaval.ca) (M. Laberge), [Myriam.gaudreault.2@fsa.ulaval.ca](mailto:Myriam.gaudreault.2@fsa.ulaval.ca) (M. Gaudreault).

**Table 1**  
Performance indicators and targets.

| Indicator   | Actual <sup>a</sup><br>30/06/2015 | Agreed target <sup>a</sup><br>31/12/2017 | Actual <sup>b</sup><br>31/03/2018 | Actual <sup>b</sup><br>31/12/2018 |
|---|-----------------------------------|--|-----------------------------------|-----------------------------------|
| <b>Provincial indicators</b>  |                                   |  |                                   |                                   |
| The percentage of insured people who are registered with a GP                 | 68%                               | 85%                                      | 79.5%                             | 81%                               |
| The percentage of registered patients meeting the continuity of care criteria | 68%                               | 80%                                      | 84.0%                             | 84.4%                             |

<sup>a</sup> As per Agreement between the FMOQ and the MSSS.

<sup>b</sup> Data from the RAMQ, provided by the MSSS [30].

provincially between the government and the medical federations: the Federation of General Practitioners of Quebec (FMOQ) and the Federation of Specialist Physicians of Quebec. Agreements between the government and the federations lay out the working conditions of physicians. In the early 2000s, a new primary care model was introduced: family medicine groups (GMF). This model provided a small capitation payment for registering patients as well as additional resources to support multidisciplinary team-based care and continuity of care [22,23]. The incentive for registering patients was soon after extended to physicians not part of a GMF, as a way of promoting a continuous patient-provider relationship. A specific feature of family practice in Quebec is the obligation to work a number of hours in a hospital setting, unlike family physicians in most provinces. After a hospital was forced to close its emergency department because there were no physicians available, and to avoid re-occurrences, the Quebec government introduced into its legislation on health and social services, mandatory specific medical activities (AMP) for general practitioners in 1991 [24]. Although the details of these AMPs have evolved, the concept was that essential activities were identified and categorized into blocks. Regional authorities would identify their needs for physicians for each type of activity within the blocks, and GPs would be obligated to work on these activities with the number of hours depending on their years of practice [25]. In retrospect, the policy, by forcing GPs to work in hospitals, had the unintended consequence of reducing access to primary care services [26].

The health care system in Quebec has gone through important structural reforms every 10–15 years, following a regular cycle, since its inception as a public health care system in 1970. After a previous reform that focused on regionalization of health care, the government decided to re-centralize the health care system and implement accountability measures affecting health care providers with Bill 10. To reduce what was considered as administrative waste in the system, the reform forced mergers within the previously independent 182 health care structures creating 34 integrated health care systems and hospitals. Bill 10 also eliminated all regional health agencies [27]. Bill 20 was then introduced into the legislation to target access to primary care services, specialists' services, and in-vitro fertilization services. Although bill 10 and bill 20 are not explicitly related, they are the basis of the Health Minister's reform plan to improve the health care system's efficiency and improve access for the population. Both are centred on increasing accountability of health care providers. Bill 10 enabled a centralization of power, where CEOs of health care organizations reported to the Health Minister. The power given to the Health Minister by Bill 10 may have offered him the legitimacy required to enact Bill 20 in a context where high physician autonomy governed.

### 3. Key elements of Bill 20

The goal of bill 20 - An Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation - was to optimize the utilisation of medical and financial resources to improve access to medical services [27]. It was the Health Minister's

strategy to better control the roles and activities of general practitioners (GPs) and specialists, to provide timely access to their services. Bill 20 was also aimed at modifying the assisted procreation programs for similar reasons [28].

Bill 20 states the obligations of general practitioners to 1) register a minimum number of patients and ensure the continuity of care of that population, and 2) practice a minimum number of hours in a hospital setting. Hospital activities are determined by the director of professional services, based on guidelines provided to the health care organizations by the Health Minister. Physicians are to inform the regional departments of medicine of their preferences for hospital activities as well as the hours that they would like to provide [27]. These hospital activities are in line with the AMPs that have been in place for over twenty years. The proposed bill also identified indicators to be tracked with set targets [27]. Initially, each physician had to reach a target of 1,500 weighted registered patients [29]. Reaching this target was expected to result in at least 80% of the population being registered with a family doctor. Each physician would also need to reach a level of 80% on a continuity of care indicator, which was defined by the proportion of services that registered patients received from the physician that they were enrolled with. The objective of this target was to reduce emergency department (ED) visits for low acuity health issues on the Canadian Triage Acuity Scale (CTAS) defined as CTAS 4 and 5. These targets were then the subject of intense negotiations with medical federations so that the initial timelines stated in Bill 20 (March 31<sup>st</sup>, 2017) were removed and a new agreement was reached (December 31<sup>st</sup>, 2017). They were also transformed into collective targets, at the practice level, rather than individual physician targets. Table 1 provides a summary of indicators for which there were performance targets to be reached, as well as the actual performance attained.

Other indicators to be tracked included the following:

- The average wait time for an appointment with a GP;
- The average wait time for an appointment with a specialist for people registered on a mechanism for priority access;
- Total number of registered people;
- Percentage of registered patients having continuity of care;
- Total number of ED visits rated at a level of 4 or 5 on the CTAS;
- Ratio of CTAS 4 & 5 visits on the total number of ED visits.

The original Bill 20 had set high targets for physicians to achieve within restricted timelines. Although there were no major changes in the payment structure for physicians, Bill 20 had provisions for enforcing behavioral change from physicians, such as inducing them to register more patients, in the form of financial penalties. These penalties could represent up to 30% of a physician's remuneration but details on the calculation of these penalties were not available.

### 4. Implementation of Bill 20: a one-sided legislative approach

The Quebec Liberal Party was elected in the provincial election of spring 2014 with a majority government. The party had held power

since 2003 with a short 18-month interruption during which the Parti Québécois had a minority government (2012–2014). In their electoral platform, the Liberal Party promised to review the funding for health care services and to reduce bureaucracy, in order to improve access to health services [31]. The intended actions of Bill 20 were not explicitly presented during the electoral campaign nor was it clear that once in power, the Liberals would proceed to a complete re-structuring of the Quebec health care system. The 2014 electoral platform aligned with the direction previously taken regarding funding mechanisms by the Liberals when they were previously in power. They intended to expand a form of activity based funding to health care organizations but they had not mentioned changing physician payment mechanisms. However, the idea of introducing capitation for family physicians had been circulating informally. It is possible that the Liberals decided that changing the physician payment scheme would either not achieve the policy's objective of improving access or that it would have a higher price tag than the chosen approach. Bill 20 may have been an initial step towards introducing capitation in family physicians' payment mechanism.

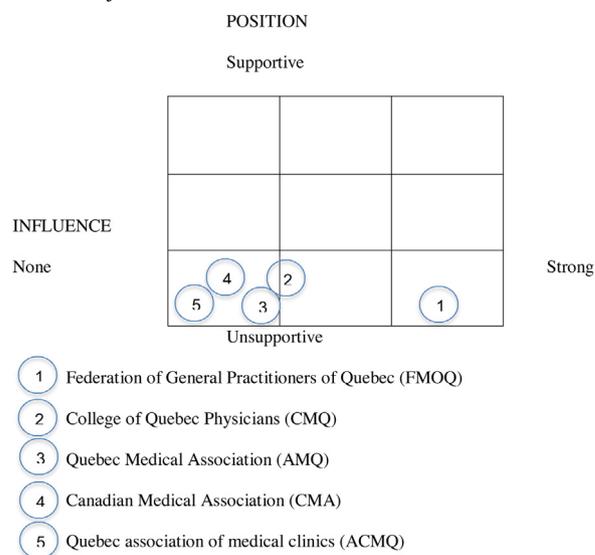
Bill 20 was initially proposed in November of 2014, and it was adopted one year later, in November of 2015. In that year, interest groups had the opportunity to provide their opinion on the proposed bill, which was done by many physician groups and other associations. The people that were most affected by the policy were GPs. Their interests are protected by the FMOQ which is a professional union representing all GPs of Québec. It has over 9,500 members grouped into 19 associations. Its main role is to negotiate the practicing conditions of GPs with the provincial government. The FMOQ defends GPs' professional autonomy and tries to achieve the best conditions for them [32]. The FMOQ was supportive of the goal of Bill 20, which was to increase access to services, but was opposed to the strategy outlined in Bill 20. The FMOQ considered that establishing targets and financial penalties was counter-productive and likely to decrease access to health care. The FMOQ was strongly opposed to Bill 20 and said that it would greatly limit physicians' autonomy [33].

Their opposition was echoed by the College of Quebec Physicians (CMQ) who recommended that the implantation be collaborative, rather than oppressive [26]. The CMQ also criticized Bill 20 for lacking details about its operationalization. For example, there were no numbers on the minimum quota of patients per physician to be reached, nor did it quantify the extent of the penalties imposed on the physicians who would not meet the targets.

The Quebec medical association (AMQ) and the Canadian medical association (CMA) joined forces in presenting their concerns with Bill 20 [34]. Both of these associations are voluntary-based and include physicians of all specialties as well as residents and medical students. They opposed the approach and the imposition of quotas which they considered would affect the quality of medical care and could increase overdiagnosis [34]. They pointed to alternatives that they had previously proposed to increase access to primary care services, such as improving interprofessional collaboration, creating and implementing interdisciplinary teams with effective electronic medical records, and developing a payment plan that would support population accountability. In their opinion, their proposed solutions had not been considered in the development of Bill 20 [34].

Similarly, the Quebec association of medical clinics (ACMQ) also expressed opposition to Bill 20. The ACMQ represents clinic owners and promotes their best interests. The ACMQ was concerned that the resources were not currently available in primary care to support increasing family physicians' panel size. The association also suggested that older physicians may decide to retire earlier than they had planned to if they could not gradually reduce their work load without being penalized for not achieving targets [29].

**Table 2**  
Position of key stakeholders.



Overall, there was a general opposition from physicians in regards to Bill 20. The main actors had not been consulted in the development of the bill and perceived it as being coercive. In addition, it could increase the gender inequities, as women physicians appear to spend more time per visit and tend to work fewer hours compared to men physicians [35]. The latter could be related to when they have children and make changes to better balance their professional and personal lives [36]. An additional concern was regarding the enrolment of vulnerable patients [36]. There were no details on a weighting system that would ensure equity in patients' access to a physician. A summary of the position and influence of different stakeholder groups is provided in Table 2.

Although the approach was criticized, key stakeholders, including professional colleges and associations agreed that improving access specifically to primary care services ought to be a priority for the government. Some applauded the integration of a continuity of care measure, which would balance the incentive of enrolling patients with that of ensuring that enrolled patients would have access to their physician. There was also a recognition of the value of supporting the implementation of advanced access in the clinics.

## 5. Positive results or unintended consequences?

There has not yet been a formal and comprehensive evaluation of the effects of Bill 20 in terms of access to primary care physicians for the Quebec population. However, data on the indicators are available. As of December 31<sup>st</sup>, 2018, 81.0% of the Quebec population was registered with a primary care physician, just short of the 85% target that was originally meant to be reached by December 31<sup>st</sup>, 2017 but still an improvement to the 68% prior to the reform [37]. Continuity of care had increased from 68% to 84.4%. Though performance measurement is key to both accountability and quality improvement [38–40], the focus on specific metrics could affect provider motivation [41] and divert attention from other challenges that may be relevant for quality of care that are not being measured [42].

The bill also had unintended consequences. The media releases on physician remuneration showing a widening gap between specialists and family physicians over the past decade as well as the harsher conditions imposed on family physicians contributed to making the practice less attractive. In 2018, of the 78 residency spots left vacant in Canada after the annual matching of medical

students, 65 were spots in family medicine in the province of Quebec. This was an increase from the 56 spots left unfilled in 2017 and 43 spots left unfilled in 2015 [37,43]. In fact, the Canadian Resident Matching Service (CaRMS) reported a 2.5% drop in the number of students who choose family medicine as a first choice for residency between 2016 and 2018 [44]. In comparison, the second highest unfilled residency in Quebec for 2018 was that of medical microbiology with 4 empty spots [44]. The FMOQ blamed Bill 20 as being at least partly responsible for the increased “unattractiveness” of family medicine in Quebec [28].

Family physicians in Quebec threatened to retire earlier because of the bill [45]. However, there is not currently any evidence to support that the bill could have had an effect on early retirement. In the 2017 Physician Workforce Survey from the Canadian Medical Association, 6.7% of Quebec physician respondents reported that they planned to retire within 2 years, just slightly above the 6.2% national average [46]. The proportions declaring planning on relocating to another province (2.0%), to the United States (0.7%), or to another country (0.8%) are all lower than the national averages of 3.1%, 1.0%, and 0.9%, respectively [46]. One of the limitations is that data reported at provincial levels do not separate GPs from specialists. These numbers are also lower from those reported in the National Physician Survey of 2013, where 8.7% of respondents from Quebec declared that they planned to retire within 2 years, 4.5% planned to relocate to another province, and 2.5% to the United States [47]. When comparing to national data, it appears that the proportion of physicians planning to make either change to their practice has decreased, with the trend in Quebec mirroring the national trend.

If measures inducing a loss of autonomy have a repelling effect, the province could experience a shortage of family physicians, which could aggravate the access issue, unless solutions are put in place to counterbalance this phenomenon. In this effect, the provincial government suggested increasing the number of nurse practitioners.

One of the issues largely discussed in the media and in health policy circles in Quebec was the payment mechanism of physicians. It has been suggested that a capitation-based payment scheme would best support access to physicians [48]. Physician associations have long expressed their preference for FFS payment. However, requiring physicians to have minimum numbers of registered patients, initially set at the individual physician level, could have been an alternative to implementing a capitation-based payment to physicians. Should physicians not make changes to their number of hours worked, increasing the number of registered patients would require the physician to decrease the average number of visits or services per patient. Future research could examine such effects of Bill 20 and provide a better understanding of how physician practices may evolve, either by serving patients differently, by identifying areas for efficiency improvement, or by having other health professionals, such as nurses, provide services previously delivered by physicians. The government may obtain the desired effect of a capitation-based payment system, without actually implementing one.

Establishing a performance framework and attaching incentives to targets as a means of bringing change is not a new strategy in primary care [49]. Other provinces in Canada [50] and other countries that also have a public health insurance program have started implementing performance governance strategies with intrinsic or extrinsic tools to strengthen primary care [51]. For instance, Denmark’s strategy included few sanctions to physicians and focused rather on accreditation and quality improvement, whereas New Zealand used a combination of instruments including targets and performance incentive payments [52]. France [53], Belarus, and Lithuania [51] have similar strategies. The UK is notorious for its Quality and Outcomes Framework, which had mitigated results [42,54]. However, each approach distinguishes itself by how

it was adapted to a given context. In Canada, medical unions have a very strong influence, and physicians are well organized to ensure the historically high level of professional autonomy. With financial penalties associated to lower productivity, the Quebec Health Minister sent a strong signal regarding the desired change and also of the power that the government held in making such change happen. Even though the penalties were not applied, performance on the indicators improved substantially. It is not clear whether such improvements would have happened without the initial threat of financial penalties.

## 6. Conclusion

The Health Minister proposed a bill with strategies to improve access to primary care. All the stakeholders agreed that addressing access to primary care was important, yet they disagreed on the approach that was taken which was perceived as being overly coercive. Negotiations between government and medical unions have long shown the power struggles between them. There are several lessons to learn from the Quebec experience on its attempt to improve access to primary care. First, a coercive approach with penalties can lead to a strong opposition. Although carrots and sticks can correspond to two sides of the same coin, stakeholders appear to feel more directly attacked by the introduction of financial penalties. Second, despite resistance, such an approach can be associated with substantial improvements on the performance metrics, without actually having to implement penalties. Third, there are potentially unintended and harmful consequences to implementing policies that will make a group of individuals such as family physicians feel like they are treated relatively unfairly in comparison, for instance, to specialists. An example of an unintended effect is the difficulty of attracting physicians into family medicine and retaining those practicing it. Finally, a comprehensive evaluation of the impact of such health policies is necessary to improving the performance of health care systems.

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