SUMMARY

PRIMARY CARE SERVICES ORGANISATION

A portrait of primary care medical services in Montréal and Montérégie

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Primary care services have undergone significant changes in Québec. It is in this context that a research project on accessibility and continuity of care in Québec was conducted. This study of primary care services was carried out in two health regions in the province: Montréal and Montérégie (Pineault, Levesque et al. 2004). The main objective of the study is to identify organisational models for primary care services that are best adapted and most likely to meet the population's needs and expectations concerning primary care medical services.

The study was conducted by researchers from the Population Health and Health Services team at the Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal and from Institut national de santé publique du Québec, as well as researchers from the Hôpital Charles LeMoyne research centre. Numerous partners and other researchers collaborated in this study.

INTRODUCTION

This summary report on primary care services organisation (Hamel, Pineault et al., 2007) is part of a series of publications focusing on the research project results. It presents evidence and unpublished data on primary care medical services organisation. Results are given according to administrative region and Health and Social Services Centre (CSSS) territory.

The data come from a large 2005 study of primary care medical offices and clinics in the regions chosen. This report is intended for clinical and administrative decision makers in Montréal and Montérégie as well as for research groups, clinicians and anyone else interested in primary case services organisation.

Under the current circumstances, at a time when Québec's health system is undergoing significant changes, these data provide very useful information. Moreover, data for this study was collected when the first Family Medicine Groups (FMG) were being implemented and the new CSSS set up. The data precedes implementation of the first *Cliniques-réseau*. The study period is therefore regarded as time 0 in relation to the implementation of CSSS.

PRIMARY CARE MEDICAL CLINICS IN MONTRÉAL AND MONTÉRÉGIE

In all, 665 medical clinics were surveyed: 440 in Montréal and 225 in Montérégie. The number of clinics varies greatly among CSSS territories, ranging from as few as 5 points of service in Haut-Saint-Laurent to 85 in La Montagne (Figures 1 and 2).

In both Montréal and Montérégie, the vast majority of primary care clinics provide services on an essentially private basis, that is, they have no administrative link with public institutions such as CLSCs or hospitals and receive no public funding to operate as FMG. At the time of the study, in 2005, 84% of clinics surveyed were in this category. A total of 53 points of service in CLSC and 11 family medicine units offered general medical services, and some of the physicians in 41 medical clinics were part of FMG. The territories of Vaudreuil-Soulanges, Suroît, La Pommeraie and Haute-Yamaska, characterised by their small number of medical clinics, stand out because of their high proportions of clinics associated with FMG or in CLSCs (50 % and over).

Figure 1: Number of primary care medical clinics – Montréal

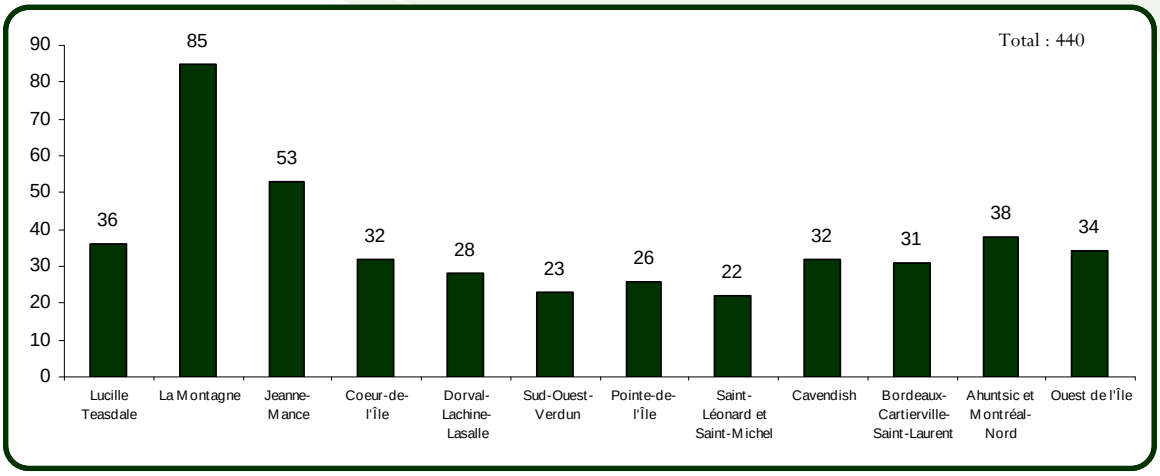
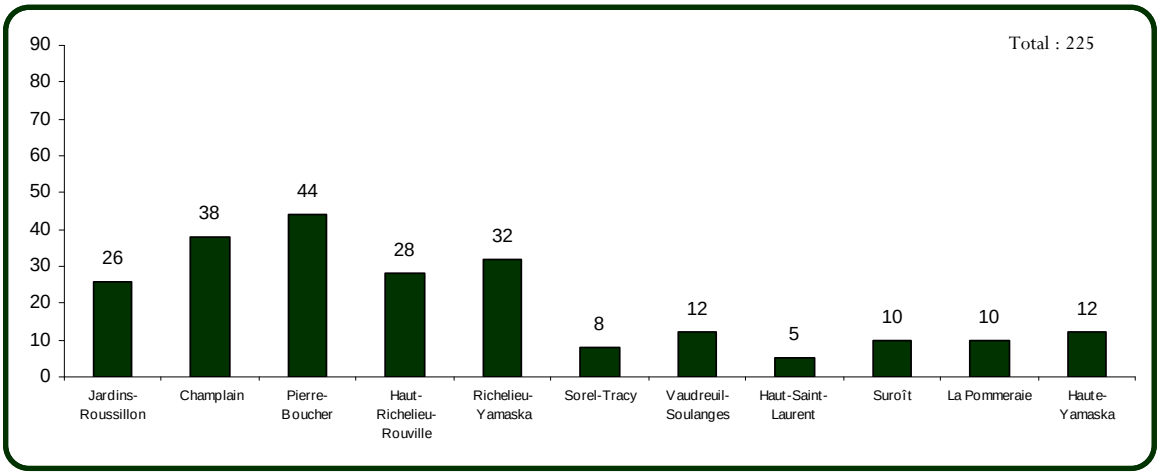


Figure 2: Number of primary care medical clinics – Montérégie



SYNTHESIS OF THE FINDINGS

In Montréal and Montérégie, over 85% of users of health services identified primary care medical clinics, including CLSC, as their regular source of care. Our study shows that overall, these organisations are based on the "family medicine" approach, with priority given to services and follow-up for regular clients rather than to accessibility. Moreover, under current circumstances where most primary care clinics are not concerned with population-based responsibility, it is not surprising that precedence is given to regular patients rather than to access for the population in the territory. There is, however, a gap between predominating perspective focusing on continuity of client services and organisational practices. Indeed, the mechanisms in place are often inadequate to provide comprehensive services at all times. Examples that come to mind are on-call services, which are restricted, and range of services offered, which is not always very broad. Results concerning structures and resources underscore the primary care network's potential to improve in the areas of medical group practice, interdisciplinary teams including nurses, and use of cutting-edge information.

A cross-sectional reading of study results reveals significant contrasts between the two administrative regions and among CSSS territories. Differences are noticeable not only in approaches clinics have adopted to organise their services, but also in their resources, organisational structures, and practices that are made available to the primary care service network. The main findings are presented in this document.

Main findings

- By and large, medical teams remain relatively small. Over a third of organisations work "in solo" and fewer than 16% have more than 7 full-time equivalent (FTE) physicians.

- A relatively low proportion of clinics (37%) employ nurses. The roles of nurses can be considered innovative in less than 40% of these organisations.

- Almost two thirds of organisations have more than one physician on staff. Indicators that capture intensity and group work organisation show that many physicians in these organisations already share certain clinical activities (74%). However, fewer organisations have mechanisms that provide frameworks for group work (having a physician in charge, 65%; inter-professional coordination, 41%; resource sharing, 46%). Based on these results, we can assume that there is some potential for developing medical practice groups within these organisations.

- Information technologies have not reached primary care organisations. Indeed, more than 80% of them have few or no leading-edge tools to support clinic activities, whether for communicating information about patients or managing the clinic.

- In general, we see deficiencies in accessibility to primary care services. As little as 16% of medical clinics offer services evenings and weekends. Less than 2% of primary care organisations provide on-call services for the population (that is, for all individuals, whether or not they have files at the clinic) outside their opening hours. Finally, less than 10% of organisations are involved in a regional on-call system.

- We observe that only a quarter of organisations offer an on-call system for regular clinic patients; a third always provides systematic follow-up for chronic diseases; and a quarter has a very broad range of medical services.

- The evidence suggests that primary case services are integrated into the health system through the connections professionals develop among each other to coordinate the care their clients require rather than through formal organisational structures.

Contrasted regions and variations among CSSS territories

- Generally, compared with Montérégie, in Montréal we see more small clinics and "solo" organisations; fewer primary care nurses; more clinics that give priority to access to services rather than continuity; more clinics with on-call services outside opening hours; and fewer clinics offering a broad range of services.

- Generally, in Montérégie the pattern is reversed for these indicators. These findings partly reflect the situation in a few territories where results for a number of indicators are clearly different from the rest. This is particularly true for the territories of La Pommeraie, Haute-Yamaska, Suroît and Haut-Saint-Laurent, and, to a lesser degree, Vaudreuil-Soulanges. These territories have a predominantly population-based outlook regarding a clinic's responsibilities, more nurses in innovative roles, more physicians groups integrated into formal structures, and indications of greater systemic integration for several clinics.

- In Montréal, a significant part of the population identified their regular source of primary care as ones that are outside their own CSSS territory. In this context, the organisation of primary care services requires a good understanding of client movement among the territories. Territorial autonomy becomes very complicated when it comes to primary care services organisation.

- In Montérégie, population affiliation with primary care services located outside territory of residence is high. This situation creates conditions that are favourable to populational approaches that adjust resource organisation according to the population's needs and to greater territorial autonomy. However, the relatively low number of FTE physicians in several of these territories is certainly a barrier to this type of approach.

CONCLUSION

Our study results highlight certain deficiencies that affect almost all organisations. The small number of primary care nurses and poor information technologies throughout the primary care network are examples of these shortcomings.

Finally, to appreciate the full development potential of primary care services, it is essential to study organisational structures that result from combining the organisations' different attributes, based on the data we have. An initial analysis of the profiles and types of primary care organisations has indeed revealed that new emerging models such as FMG possess many organisational qualities identified as desirable in the primary care literature (Pineault, Levesque et al., 2007). It also reveals that other organisational approaches compare favourably with newly emerging types.

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Primary care services organisation – A portrait of primary care medical services in Montréal and Montérégie

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