SUMMARY

ACCESSIBILITY AND CONTINUITY OF HEALTH SERVICES: A STUDY ON PRIMARY HEALTHCARE IN QUEBEC
Research report

Pineault R, Levesque J-F, Roberge D, Hamel M, Lamarche P, Haggerty J.

All around the world, primary care services are undergoing significant reform. In Canada, a number of provincial and federal committees have raised problems related to primary care medical services organisation. Over the past 10 years or so, Canadian and Québec health systems have experienced considerable changes that have especially affected primary care services. In Québec, these organisational changes have resulted more particularly in the implementation of Family Medicine Groups (FMG) and network clinics (NC) as well as in the creation of health and social services centres (HSSC).

It is in this context that a research project was conducted on accessibility and continuity in primary health care in Québec (*L'accessibilité et la continuité des services de santé : une étude sur la première ligne au Québec*). The study was conducted in two health regions on the province—Montréal and Montérégie. It looked at organisational models for primary care services and their influence on accessibility and use of health services by the population, as well as the experiences of users of these services. 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.

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

The research included three components:

1) A study conducted among the population that was designed to measure utilisation of health services as well as users' perception of the accessibility, continuity, scope, reactivity and results of services received (Levesque, Pineault et al., 2007).
2) A study of primary care clinics that aimed to describe and characterize primary care services organisation, and to identify the primary care medical services organisation that predominate in the regions studied (Hamel, Pineault et al, 2007);
3) A contextual analysis that aims to describe Health and Social Services Centre (HSSC) territories (Roberge, Pineault et al., 2007).

The study results are of particular interest to health care professionals including regional and local decision makers, clinicians, representatives of community groups, as well as anyone interested in having a deeper understanding of the primary care experiences of the population who interface with health services organisation. The study also presents a unique opportunity to inform decision makers, administrators and clinicians about the performance of organisations delivering primary care services.

Québec

Descriptive, methodological reports, thematic reports and articles have already been, or will soon be, published. Interested readers are invited to read these publications to become aware of the knowledge generated by this project.

HIGHLIGHTS

- Overall, individuals' assessment of their health care experiences with their regular source of primary care is favourable. These observations are similar to the results of international studies on health care user satisfaction. However, the population is clearly less appreciative of geographical and organisational accessibility.
- Appreciation of care experience varies greatly among territories of the health and social service centres (HSSC) in the two regions under study. The population's perception of the primary care experience is generally better in Montérégie than in Montréal.
- The contrasts characterizing the population's care experience is brought to light when CSSS territories are grouped by context. Urban territories described as *affluent commerçant* and characterised by the density of their populations and the wide diversity and quantity of health care resources obtain the lowest scores for both aggregate index of care experience and for most specific indices. It is also the context where the number of people who have regular family physicians is lowest. Rural territories, grouped in the category *équilibre coordonné*, are very different; they obtain the best scores for almost all care experience indices. Among this population, the rate of having a regular family physician is very high, with an average of 80%.
- Urban territories described as *affluent commerçant* have by far the greatest number of primary care resources. Even when taking into account the fact that resources in urban areas serve a sizeable number of people who live in other territories, this finding suggests that it is primary care service organisation rather than quantity of resources that shapes a positive care experience.
- Primary care organisations have been classified into five distinct models: four *professional* and one *community* model.
- The *professional single provider* model—characterised by a focus on the client, poor integration into the network, low number of resources, restricted range of services and mostly walk-in consultations—stands out favourably in terms of certain performance aspects, particularly the population's care experience and response to vulnerable individuals. However, this model shows little potential for coverage of the population and poor conformance with the primary care organisational ideal type. Although it is difficult for this model to represent an option for reform, its performance in terms of response to the needs and expectations of individuals highlights the need to preserve a positive patient-physician relationship in the other, more complex organisational models.
- The *professional contact* model—characterised by a responsibility that focuses on individual clients, moderate integration into components of the health system, modest number of resources, restricted range of services and mostly walk-in consultations—is the least well-performing model; it is noticeably unfavourable when compared with other models of primary care organisation. What is more, contrary to the set objectives, service accessibility in this model is inferior to that in other models.
- The *professional coordination* model—characterised by a responsibility that focuses on individual clients, moderate integration into components of the health system, average number of resources, a moderate rage of services and services provided mostly on an appointment basis—stands out favourably in terms of productivity, care experiences and population coverage. However, this model's organisational characteristics conform less with an ideal-type organisational structure.

- The *professional integrated coordination* model—characterised by population-based responsibility, strong integration into the health network's activities, a significant number of resources, a broad range of services delivered, and a mixture of services available through walk-in clinics or with appointments—stands out favourably from the other models in all aspects of performance. This model includes, for the large part, "Family Medicine Groups" (FMG) implemented in the two regions at the time of the study. Results aggregate to demonstrate that organisations associated with FMG post the best performance.
- The *community* model–characterised by a population-based approach, public governance, many resources, a broad scope of services offered, and a mixture of walk-in or with appointment clinics—stands out in terms of how it conforms to ideal-type primary care organisations and individuals' care experiences. However, low productivity and limited population coverage reduce its overall performance evaluation. These organisations are integrated into public institutions that extend beyond the context of general medical services delivery. An analysis of their potential for reform should take into account their complementary mission.
- The configuration profile of primary care service delivery differs greatly from one context to another. In rural areas, it is characterised by the predominance of professional integrated coordination organisations and the absence of the lack of a *professional contact* model. The *community* model is poorly represented here. In urban contexts, the single-provider model is still preferred, although each model is represented.

CONCLUSION

Based on study results, we can suggest that the potential for improvement in primary care certainly exists. In the current context of rising health care costs, the issue of performance is of capital interest to decision makers. Therefore, the preferred organisational models for primary care services should be not only effective but also equitable for the population. Moreover, given that our results tend to show that contexts interact differently with some of the organisational models, reforms should be based on organisational realities proper to each territory and user characteristics.

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Principal investigators
Raynald Pineault[1,2,3]
Jean-Frédéric Levesque[1,2,3]
Danièle Roberge[4,5]

Co-investigators
Marjolaine Hamel[1,2], Paul Lamarche[6], Jeannie Haggerty[4,5], Pierre Tousignant[1,2], Léo R. Poirier[2], James Hanley[7], Mike Bénigéri[8], Pierre Bergeron[2], Ginette Beaulne[1,2] et Marie-France Raynault[6]

Advisor committee
Yvon Brunelle[9], Sylvie Cantin[10], Louis Côté[8], Serge Dulude[8], Johanne Fournier[10], François Goulet[11], Richard Lessard[1], Laurent Marcoux[10], Jean Rodrigue[10], Denis A. Roy[10] et Lysette Trahan[9]

1 Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal
2 Institut national de santé publique du Québec
3 Centre de recherche du Centre hospitalier de l'Université de Montréal
4 Centre de recherche de l'Hôpital Charles LeMoyne
5 Université de Sherbrooke
6 Département d'administration de la santé, Université de Montréal et GRIS
7 Département d'épidémiologie et de biostatistique de l'Université McGill
8 Agence de la santé et des services sociaux de Montréal
9 Ministère de la Santé et des Services sociaux du Québec
10 Agence de la santé et des services sociaux de la Montérégie
11 Collège des médecins du Québec

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Written by:
Raynald Pineault[1,2,3], Jean-Frédéric Levesque[1,2,3], Danièle Roberge[4,5], Marjolaine Hamel[1,2], Paul Lamarche[6], Jeannie Haggerty[4,5]

1 Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal
2 Institut national de santé publique du Québec
3 Centre de recherche du Centre hospitalier de l'Université de Montréal
4 Centre de recherche de l'Hôpital Charles LeMoyne
5 Université de Sherbrooke
6 Département d'administration de la santé, Université de Montréal et GRIS

Québec
• Agence de la santé et des services sociaux de Montréal
• Institut national de santé publique

Centre de recherche Hôpital Charles LeMoyne
Centre affilié universitaire régional de la Montérégie

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