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Implementing Centralized Waiting Lists for Patients without a Family Physician in Québec

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Abstract

In 2008, the Québec government mandated the ninety-four *Centres de Santé et des Services Sociaux* (CSSS or Centres for Health and Social Services) to implement a *Guichet d'Accès aux Clientèles Orphelines* (GACO)—a centralized waiting list to help patients without a family physician find one. Specifically, the goal of GACOs is to increase the number of patients with a family physician as well as to give priority access to vulnerable patients. The media treatment of 'orphan' patients as well as the *Fédération des Médecins Omnipraticiens du Québec* (FMOQ or Federation of General Practitioners of Québec) both played a crucial role in the design and implementation of the reform. How the reform should be implemented was not detailed, leaving each CSSS considerable latitude in the strategies they adopted to introduce it on the ground. This room to manoeuvre led to large variability in what services GACOs offer and inequity in access to services for the population. Since their implementation, financial incentives set up to encourage the participation of family physicians have been modified twice, in particular with the goal of increasing the enrolment of more vulnerable patients through GACOs. A recent study shows that, despite a large difference in incentives to physicians for these vulnerable patients, more than 70% of patients enrolled with a family physician through a GACO are 'non-vulnerable' and are registered into the GACO from family physician self-referrals. Nonetheless, GACOs address an important problem by reducing the number of persons without a family physician.

En 2008, le gouvernement du Québec a mandaté les quatre-vingt-quatorze centres de santé et des services sociaux (CSSS) d'introduire un guichet d'accès aux « clientèles orphelines » (GACO; le terme de clientèle orpheline désigne les patients n'ayant pas accès à un médecin de famille) au sein de leur organisation. L'objectif des GACO est d'augmenter le nombre de patients avec un médecin de famille et de prioriser les patients vulnérables. La médiatisation de l'enjeu des patients orphelins et la Fédération des médecins omnipraticiens du Québec ont joué un rôle prépondérant dans la conceptualisation et l'introduction de cette réforme. Peu de balises ont encadré le développement de cette réforme laissant donc une grande flexibilité dans les stratégies de mises en œuvre à chacun des CSSS. Cette marge de manœuvre à l'échelle locale a entraîné une variation dans l'offre de services des GACO, conduisant à une inéquité de services pour la population. Depuis leur implantation, les incitatifs financiers mis en place pour favoriser la participation des médecins de famille ont été modifiés à deux reprises, particulièrement pour faciliter la prise en charge des clientèles plus vulnérables via les GACO. Une étude récente a montré que, malgré un différentiel important dans les incitatifs financiers donnés aux médecins pour des patients vulnérables, plus de 70% des patients inscrits à un médecin de famille via les GACO étaient des patients non vulnérables et provenaient majoritairement d'une autoréférence par un médecin de famille.

Le GACO répond, cependant, à une problématique importante en visant à réduire le nombre de personnes sans médecin de famille.

Key Messages

- The *Guichet d'Accès aux Clientèles Orphelines* (GACO) are an important organizational mechanism to help persons in Québec without a family doctor find one.
- Challenges remain in supporting the most vulnerable patients through the *Guichet d'Accès aux Clientèles Orphelines* (GACO) and additional strategies must be implemented to facilitate their care by family physicians in the community.

- *Les guichets d'accès aux clientèles orphelines sont un mécanisme organisationnel pertinent pour aider les patients sans médecin de famille à se trouver un médecin de famille.*
- *Des défis demeurent pour la prise en charge des patients les plus vulnérables via les guichets d'accès aux clientèles orphelines et des stratégies complémentaires doivent être implantées pour faciliter leur prise en charge par les médecins de famille dans la communauté.*

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1 THE GACO POLICY

Centralized waiting lists have been implemented in four Canadian provinces to help 'orphan', or unaffiliated, patients find a family physician: *Guichets aux clientèles orphelines* (GACO) in Québec, *Health Care Connect* in Ontario, *A GP for Me* in British Columbia, and *Patient Connect NB* in New Brunswick. These organizational mechanisms are intended to better coordinate the demand for, and supply of, family physicians.

In Québec, 94 GACOs were set up in 2008. Each of these waiting lists is overseen by a Health and Social Services Centre (CSSS), which is responsible for the population of a given territory. The aim of this policy is to facilitate the local population's access to family physicians based on a clinical priority scale and on the availability of medical personnel in that territory.

The GACOs are managed by a secretary and a nurse, in collaboration with a local physician coordinator. Requests for registration in a GACO may come directly from patients or from referring health professionals (nurses, social workers, physicians). Once registered on a centralized waiting list, patients are assessed by the nurse who determines their priority code according to the urgency and complexity of their health care needs. Patients are then enrolled with a family physician based on medical staff availability and the fields of practice of the physicians registered with the GACO, taking into consideration as much as possible the determined priorities.

A physician who accepts an orphan patient through the GACO receives a financial bonus upon the patient's first visit. This financial incentive was implemented to encourage physicians' participation in the GACOs. The amount of the incentive depends on whether the patient has been designated as vulnerable. Patients are considered vulnerable if they present one of the 14 vulnerability codes defined by Québec's health insurance board (RAMQ). These are based on the presence of medical diagnoses such as diabetes, chronic obstructive pulmonary disease, mental health disorder. This vulnerability code is different from the priority code determined by the nurse, but it influences that code, which establishes the patient's medical condition.

2 BACKGROUND AND HISTORY OF THE GACO POLICY

Most national and provincial commissions on health care services in Canada over the past decade have recommended that primary care services be strengthened in order to guarantee each citizen access to a family physician (Romanow 2002; Clair 2000; Government of Alberta 2001; Government of Ontario 2000; Government of Saskatchewan 2001; Kirby and LeBreton 2002). These recommendations are especially important given that family physicians are in charge of the majority of health care services and are responsible for providing primary care services to patients that are accessible, continuous, comprehensive, and

well coordinated with other levels of care. Despite these recommendations finding a family physician continues to be problematic.

The issue of enrolment with a family physician is worrying in Canada, where nearly 21% of the country's population reported not having a family physician in the last Commonwealth Fund survey (Commissaire à la santé et du bien-être du Québec 2010). This situation is even more acute in Québec, where nearly 29% of the population reported not having a family physician (*Ibid.*), including 16% of the population with the most serious health needs (Commissaire à la santé et du bien-être du Québec 2011). Even though Québec's ratio of family physicians to residents is among the highest in Canada, the time devoted to medical practice in primary care by family physicians is lower than in the other Canadian provinces. Compared to those in other countries or provinces, family physicians in Québec play a larger role in the hospital system. This is illustrated by the fact that 38% of family physicians' activities are carried out in secondary care (Paré 2012).

It should also be noted that formal enrolment of patients with family physicians is relatively new in Québec. Such enrolment involves a contract linking a patient with a family physician, in which each party's commitments are spelled out (Collège des médecins de famille du Canada 2012). In the early 2000s, with the introduction of a new primary care service organization model—family medicine group—enrolment incentives were put in place that were modulated based on clientele characteristics. The 2010-2015 strategic plan of the Ministry of Health and Social Services has again taken up this issue, setting as a target the formal enrolment of 70% of the population with a family physician by 2015. GACOs were put forward as one means of encouraging physicians' enrolment of orphan patients.

3 OBJECTIVES OF THE GACO POLICY

GACOs were implemented with two objectives related to family physicians' accessibility: *1*) increase the number of patients with a family physician, and *2*) in this process, give priority to vulnerable patients (Breton, Ricard and Walter 2012).

An unofficial objective of the Québec government and the Québec Federation of Family Physicians (FMOQ) was to document the number of orphan patients who wanted a family physician. The strategy of creating waiting lists of unaffiliated patients made it possible to better assess the problem of family physician accessibility. Governments have in fact often used this type of strategy in the area of elective surgeries to negotiate additional resources.

4 WHY AND HOW THE GACO POLICY WAS PROPOSED

In the political sphere, the magnitude of the proportion of the population without a family physician in Québec was one of the contextual factors that put this issue squarely on the political agenda. This was, in fact, a core issue in the debates preceding the last

provincial elections. Each political party proposed its own strategy for ensuring every Québec citizen would have a family physician. The GACOs represented a government response to a complex issue that had received intense media coverage and touched a large portion of the population.

This policy was also in keeping with a major reform of Québec's health care system undertaken in 2004, when CSSSs were created at the local level. In addition to creating new entities by merging acute care hospitals, local community health centres, and long-term care facilities, the CSSSs were also given the mandate to guide and coordinate the development of local integrated service networks in their territory. In particular, their responsibilities include improving the accessibility, continuity, and quality of services provided to their population. As such, the mandate to help orphan patients find a family physician fit squarely within the CSSSs' mission. There is a rather eloquent body of literature testifying to the benefits of having a family physician, particularly in terms of quality of care (e.g., prevention activities) and outcomes (patient satisfaction, compliance with treatment, better use of services) (Jatrana and Crampton 2009; Hay, Pacey and Bains 2010; Lambrew et al. 1996).

The FMOQ also played a major role in the development of the GACO policy, working closely with the Ministry of Health and Social Services (MSSS) on its conceptualization. Of particular concern was the issue of orphan patients. The FMOQ was actively involved in developing both the policy and implementation strategies. This partnership helped to ensure the medical community's collaboration with the GACO policy.

5 HOW THE REFORM WAS IMPLEMENTED

5.1 Political instruments: mandated reform

Setting up the GACOs was an MSSS initiative carried out in collaboration with the FMOQ, in which all CSSSs were officially mandated to implement, in their organization, waiting lists for orphan patients. In the *Act Respecting Health and Social Services* (L.R.Q., c-S4-2), CSSSs were given responsibility for a defined population (Breton, Denis and Lamothe 2010). To carry out this responsibility, CSSSs were required to undertake a variety of activities, including establishing a single, unified waiting list for orphan patients. However, family physicians' participation in the waiting list for their territory remained voluntary.

5.2 Flexible implementation plan

The agreement concluded between the MSSS and the FMOQ provided few guidelines for implementation. It gave the local level a great deal of flexibility in determining how GACOs would function and what resources would be allocated. The CSSSs received no additional funding from the MSSS to set up GACOs. Thus, the resources allocated to GACOs depended largely on each CSSS's strategic priorities. Some regional health and social services

agencies transferred budget envelopes within their region to facilitate implementation of this intervention, but this practice varied from one region to another.

Nevertheless, a local physician coordinator was appointed to each GACO to support its functioning. This coordinator was a family physician from the local panel of the regional department of general medicine, who was remunerated by the RAMQ for this task. The financial incentives assigned according to patient vulnerability were negotiated between the MSSS and the FMOQ and paid out by the RAMQ. This policy has been modified twice since the inception of the GACO project, in November 2011 and June 2013.

5.3 Perfunctory communications to the population

Communication sessions were held between the MSSS and CSSSs to discuss broad strategic directions for the GACOs. Likewise, the FMOQ informed its members about the various changes to the financial incentives put in place to encourage family physicians' participation in the GACOs. It also provided physicians with electronic forms to facilitate their self-referrals of patients. Self-referral occurs when a family physician takes on a patient that she/he has registered in the GACO her/himself. In the end, very little was done to inform the public about the existence of GACOs. When GACOs were created, the managers worried they would not be able to satisfy the public demand that would arise when this new service was publicized. Because of this, few promotion campaigns were undertaken, except in certain GACOs. There was also variation in patient registration criteria. For example, some GACOs agreed to register all patients who requested it, whereas others limited access to patients with at least one diagnosed chronic illness, and yet others registered only patients referred by a health professional.

6 EVALUATION

To date, in Canada there has been no implementation evaluation of centralized waiting lists or their impacts on patients' service utilization or care experience. However, one research team has studied the monitoring of GACO performance in Québec. That study was based on an analysis of quantitative data from a clinical-administrative database (SIGACO), which covers all patients who were enrolled with a family physician through GACOs with the exception of one region (n=7 GACOs). Thus, that study presented the data for 87 GACOs in Québec. The results showed that nearly 890,000 residents of Québec had been enrolled with family physicians through GACOs since their inception, and nearly 230,000 patients—including 60,000 considered vulnerable—were currently registered with a GACO and waiting to be matched with a family physician. The policy's prime objective of increasing the number of people enrolled with a family physician was largely achieved. Since the GACOs implementation, nearly 10.9% of Québec's population has become enrolled with a family physician.

Longitudinal analysis of the data showed significant changes over time in the profiles of patients enrolled with family physicians. These changes correspond with changes in the financial incentives. When GACOs were implemented in 2008, family physicians received $100 for each patient designated as vulnerable who was enrolled through the GACOs. This amount was paid in two instalments: one at the time of the patient's first visit, and the other after the patient's second medical visit in the following year. These financial incentives were modified in November 2011, such that family physicians now received $100 for each non-vulnerable patient and $200 for each vulnerable patient. These incentives were paid as bonuses upon the patients' first medical visit with the family physician. The results showed a very significant increase in the number of non-vulnerable patients enrolled with family physicians, whereas the number of vulnerable patients remained stable over time. Before the introduction of the new bonus for enrolment of non-vulnerable patients, nearly 70% of enrolled patients were vulnerable; after the new bonus, that proportion declined to 30%. Moreover, whereas before these changes in incentives 15% of patient enrolments were physician self-referrals, that proportion rose to 70% afterward. Thus, despite the considerable differential in financial incentives intended to motivate physicians to enrol vulnerable patients ($200 vs. $100), these changes led to marked growth in enrolment of non-vulnerable patients, but no increase in the volume of patients designated as vulnerable.

This observed self-referral phenomenon appeared to have short-circuited the GACOs' objective of centralizing patients' requests on one shared list and establishing access priorities based on the nurse's assessment of the urgency and complexity of each case. Self-referrals also led to a dramatic increase in costs. This is illustrated by the fact that, between November 2011 and June 2013, more than 298,457 patients were enrolled with family physicians through physician self-referrals to GACOs, generating added costs of about $2.7 million annually.

In June 2013, the MSSS tightened the rules for GACO functioning and prohibited physician self-referrals. However, a new financial bonus was provided for physicians who wished to enrol orphan patients without going through GACOs. This new mechanism allowed physicians to self-refer patients without using GACO resources. Also, because certain types of patients who had been designated high-priority were found to be waiting longer than other patients, other financial incentives were added to encourage the enrolment of 'more vulnerable' patients, including those with co-occurring mental health and substance abuse problems. The financial incentive for enrolment of these more vulnerable patients with a family physician through the GACO system was set at $250. Despite these new incentives, there continued to be newspaper reports of discrimination against certain types of patients as physicians selected their clientele (George 2013).

The analysis of GACO data since the most recent changes introduced in June 2013 showed considerable heterogeneity in the GACOs' performance. First, the number of patients waiting in GACOs varied greatly, ranging from 14 to 1,096 patients per 10,000 population. The numbers of patients referred to family physicians also varied widely, ranging from 8 to 34 patients per 10,000 population. Differences in GACO functioning produced

heterogeneity in the service offerings of different GACOs across the province, with significant variations observed even among GACOs of the same region.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1 – SWOT Analysis

Strengths	Weaknesses
• Response to an important population need • Centralization of requests from orphan patients • Patients referred to family physicians prioritized based on urgency and health status • Joint initiative of MSSS and FMOQ • Coordination of GACO and health personnel at the local level is a new management approach • Local responsibility and considerable flexibility in implementation, fostering creativity in actions	• Few guidelines formulated at the provincial level, leading to great variation in service offerings and ultimately to inequities • Introduction of *ad hoc* financial incentives that did not meet the objective of providing care for vulnerable patients • Physician participation left voluntary, resulting in variations in physician involvement • Ineffective priority-setting for certain patients (e.g., mental health) • Creation of an expectation that orphan patients on a waiting list would be matched with a family physician
Opportunities	**Threats**
• Creation of new primary care models, such as family medicine groups, to facilitate patient care • Mechanism to promote formal enrolment of patients with family physicians • Documentation of the issue of patients waiting for a family physician	• New physicians not motivated to take on patients • A great deal of family physician time spent in secondary care (nearly 40% of their time)

8 CONCLUSION

The implementation of the GACO policy was mandated by the government. This policy was intended to address an issue that was receiving considerable media attention (i.e., enrolment with family physicians). The financial incentives put in place to encourage physicians to take on orphan patients were modified twice. Despite significant increases in the incentives for enrolment of more vulnerable and complex patients, this remains a significant challenge. It is difficult to find family physicians for certain types of patients. Several innovations have been introduced to promote the care of these patients, including medical practice based on collaboration with a multidisciplinary team. Other policies should be implemented that would complement GACOs to facilitate the care of these more vulnerable patients who have significant health needs.

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