

Access to Primary Care in Ontario: 2009

Health Analytics Branch, Health System Information Management and Investment Division

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Introduction

This is the second in a series of reports produced by the Health Analytics Branch that provide an overview of access to primary care among Ontarians. *Primary care* refers to the first point of contact between a patient and the health care system. Family doctors, also known as family physicians (FPs), general practitioners (GPs), and medical doctors, typically provide primary care. Other health care practitioners, however, may also provide this care. More information on primary care is provided in the *Definitions* section on page four.

In this report, *access to primary care* refers to a patient's access to a family doctor. Populations with family doctors are referred to as *attached*, while those without family doctors are referred to as *unattached*.

In this report, all data were obtained from the 2009 Primary Care Access Survey (PCAS) of 8,234 Ontarians age 16 and older. The long term goal of the PCAS is to measure, on an ongoing basis, access to primary care in Ontario.

The Attached and Unattached Populations

Overall, 7% (736,000) of Ontarians age 16 and older are unattached. Compared with adults, children (newborn to 15 years of age) are significantly less likely to be unattached. Currently, 4% of children do not have family doctors, which represents 98,000 children across the province.

Figure 1 shows that, at the Local Health Integration Network (LHIN) level, for the adult population, the highest rates of attachment are among residents of the South East and Hamilton Niagara Haldimand Brant

(HNHB) LHINs. Here, rates are significantly higher than the provincial average. Conversely, in the North West and North East LHINs, attachment rates are significantly lower than the provincial average.

Comparison of the Attached and Unattached Populations

Table 1 compares the proportion of Ontario residents who have family doctors with those who do not by sociodemographic, health status, and chronic

Key Findings

- Children are more likely to have family doctors than adults.
- Population characteristics differ between attached and unattached populations.
- Most unattached patients previously had family doctors.
- The attached population is more likely to utilize primary care, yet when patients need immediate care, the unattached population is more likely to receive care sooner.
- Being female and having an income of greater than \$29,999 are the strongest predictors of attachment.

Figure 1: Proportion and 95% confidence interval of attached adults, by LHIN, 2009

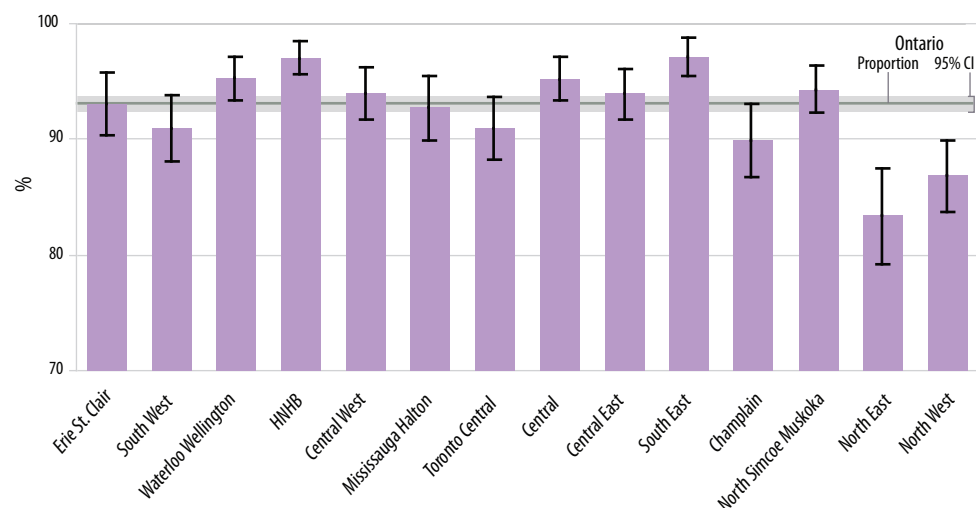


Table 1: Comparison of sociodemographic characteristics, health status, and chronic condition status among the attached and unattached populations age 16 and older in Ontario, 2009

| Characteristic | % Attached | % Unattached |
|---|-------------|--------------|
| Overall | | |
| Ontario | 93.0 (±0.7) | 7.0 (±0.7) |
| Sex | | |
| Male | 91.2 (±1.1) | 8.8 (±1.1) |
| Female | 94.7 (±0.8) | 5.3 (±0.8) |
| Age Group | | |
| 16-34 | 90.4 (±1.7) | 9.6 (±1.7) |
| 35-64 | 93.4 (±0.8) | 6.6 (±0.8) |
| 65+ | 96.8 (±0.8) | 3.2 (±0.8) |
| Geography of Residence | | |
| Urban | 93.0 (±0.8) | 7.0 (±0.8) |
| Rural | 93.4 (±1.5) | 6.6 (±1.5) |
| Education | | |
| Less than high school | 93.2 (±2.0) | 6.8 (±2.0) |
| High school or higher | 93.0 (±0.8) | 7.0 (±0.8) |
| Income* | | |
| Under \$29,999 | 89.6 (±2.7) | 10.4 (±2.7) |
| \$30,000-\$59,999 | 93.6 (±1.4) | 6.4 (±1.4) |
| \$60,000-\$99,999 | 95.2 (±1.1) | 4.8 (±1.1) |
| \$100,000 or more | 93.0 (±1.8) | 7.0 (±1.8) |
| Immigrant Status | | |
| Canadian-born | 92.6 (±0.8) | 7.4 (±0.8) |
| Established Immigrant | 95.0 (±1.3) | 5.0 (±1.3) |
| New Immigrant | 91.7 (±3.6) | 8.3 (±3.6) |
| Self-Reported Health Status | | |
| Excellent, very good, or good | 93.0 (±0.8) | 7.0 (±0.8) |
| Fair or poor | 92.9 (±1.9) | 7.1 (±1.9) |
| Select Chronic Condition (1 or more) | | |
| No | 91.0 (±1.1) | 9.0 (±1.1) |
| Yes | 95.4 (±0.8) | 4.6 (±0.8) |

*Poststratified to 10-year age groups

condition characteristics.

An assessment of the 95% confidence intervals suggests that when looked at individually, characteristics that significantly increased the odds of having a family doctor include: being female, having one or more chronic conditions, having an income between \$60,000 and \$99,999, and being an established immigrant (i.e., having lived in Canada for 10 or more years). Being under the age of 65 decreased the odds of having a family doctor compared with those age 65 and older.

However, different predictors of attachment are observed once these characteristics are accounted for simultaneously through further analysis using logistic regression. Logistic regression determines the characteristics that are the strongest and most significant predictors of attachment (Table 2). For example, once all variables are accounted for, being an established immigrant and having fair or poor self-reported health are no longer significant predictors of attachment.

Refer to the *Methodology* section on page four for more information about logistic regression.

Following the adjustment, the two strongest predictors of having a family doctor are being female and having an income greater than \$29,999. Both of these predictors more than doubled the odds of attachment. Having a chronic condition also increased the odds of being attached by approximately 100% compared with those with no chronic conditions. Those under the age of 65 remained less likely to be attached than those age 65 and older.

The Unattached Population: Motivation and Attempts to Find Family Doctors

Among respondents who report that they are unattached, the majority state that they previously had a family doctor. When asked why they no longer have one, the most commonly reported reason is that their family doctor retired, moved, or passed away. Seven out of 10 respondents indicate that they have been unattached for two or more years. The majority of unattached respondents say that they want a doctor; however, just three out of five say that they have tried to find one. The most commonly reported approaches to finding a family doctor are:

1. Contacting a doctor or doctor's office to see if the doctor is accepting new patients
2. Contacting another health care provider at a hospital, Community Care Access Centre (CCAC), or public health program to see if the organization can help find a doctor
3. Asking family, friends, coworkers, and others for recommendations of family doctors who may be accepting new patients

Primary Care Utilization among Attached and Unattached Populations

Three types of primary care utilization are described in this report:

Routine care: Refers to regular check-ups or monitoring of ongoing health issues.

Immediate care: Refers to immediate medical care required for urgent health problems, for example when an individual is sick.

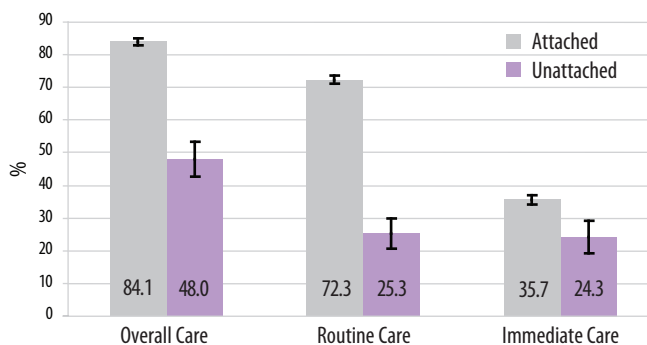
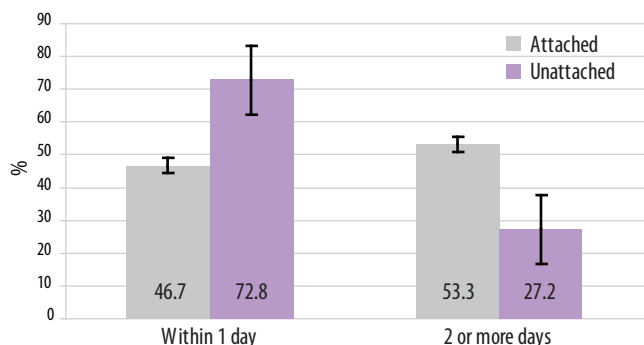
Overall care: Includes routine care, immediate care, care to obtain health information, or for advice regarding whether care is necessary.

Figure 2 shows that the unattached population is

Table 2: Significant predictors of attachment based on logistic regression, reported in odds ratios

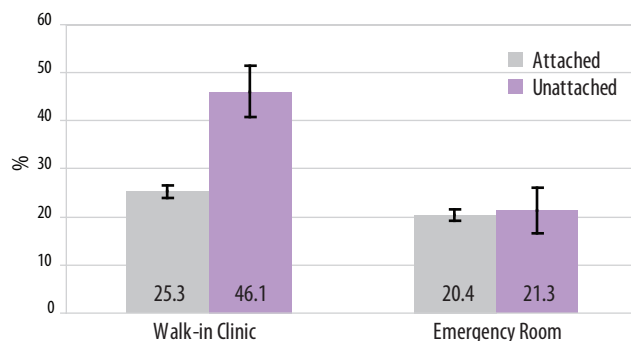
| Characteristic | Comparison Category | Odds Ratio | Interpretation: The odds of being attached are... |
|--------------------------|-----------------------------------|------------|---|
| Female | Male | 2.1 | ...110% higher for females than males. |
| Has a chronic condition | Does not have a chronic condition | 2.0 | ...100% higher for those with a chronic condition than without. |
| Age 16-34 | Age 65+ | 0.5 | ...50% lower for those age 16-34 than those age 65 and older. |
| Age 35-64 | Age 65+ | 0.6 | ...40% lower for those age 35-64 than those age 65 and older. |
| Income \$30,000-\$59,000 | Income less than \$30,000 | 2.0 | ...100% higher for those with incomes between \$30,000 and \$59,000 than for those with incomes less than \$30,000. |
| Income \$60,000-\$99,000 | Income less than \$30,000 | 3.0 | ...200% higher for those with incomes between \$60,000 and \$99,000 than for those with incomes less than \$30,000. |
| Income \$100,000+ | Income less than \$30,000 | 2.4 | ...140% higher for those with incomes greater than \$100,000 than for those with incomes less than \$30,000. |

significantly less likely than the attached population to have received overall care from family doctors in the last 12 months (48% versus 84%). The unattached population is also significantly less likely to have received routine care from family doctors in the last 12 months. This difference is particularly profound: 47% more attached patients sought routine care compared with the unattached population.

Figure 2: Utilization by type of care among the attached and unattached populations in Ontario, 2009: proportion and 95% confidence interval**Figure 3:** Time to immediate care among the attached and unattached populations in Ontario, 2009: proportion and 95% confidence interval

In the last 12 months, the unattached population is also less likely to have obtained immediate care than the attached population (24% versus 36%). However, in comparison with the attached population, the unattached population is significantly more likely to have received immediate care within one day (73% versus 47%). This reality is likely the result of significantly higher use of walk-in clinics among the unattached population. Compared with the attached population, the unattached population is almost twice as likely to have used walk-in clinics in the last 12 months (Figure 4).

Figure 4 also illustrates that the unattached population is not significantly more likely to have visited an emergency room (ER) in the last 12 months. These results challenge the notion that the unattached population uses ER care instead of having regular family doctors.

Figure 4: Utilization of walk-in clinics and emergency rooms among the attached and unattached populations in Ontario, 2009: proportion and 95% confidence interval

Methodology

Data Source: The PCAS is a voluntary telephone survey developed by the Ministry of Health and Long-Term Care (MOHLTC) and is currently conducted by the Institute for Social Research (ISR), an independent research institute based at York University. The survey began in January 2006 and covers the household population aged 16 and older in Ontario. The sample is allocated equally among the 14 LHINs.

Analysis: Except for the estimates of attached and unattached children, all analyses were restricted to individuals aged 16 and older. All estimates were weighted to accommodate for design effects and poststratified by sex and age to reflect the Ontario population. Statistical significance was based on assessment of 95% confidence intervals with non-overlapping intervals indicating statistical significance.

Logistic regression was used to further determine the sociodemographic and health characteristics that are the strongest predictors of attachment. Logistic regression is a statistical technique that involves finding the best model to describe an outcome—here, attachment—as a function of the presented characteristics. The results of the logistic regression are presented as odds ratios, which measure the strength of the association between attachment and the sociodemographic and health characteristics, and are also used to determine statistical significance.

Limitations: All data are self-reported and are therefore subject to recall errors, and over or under-reporting. The sample design excludes households without telephones, some households that only use cellular phones, and people living in some institutions.

Definitions

Family doctor: Refers to family doctors, family physicians (FPs), general practitioners (GPs), and medical doctors and does not include dentists, eye doctors, gynecologists, obstetricians, or specialists that respondents may also see for chronic health problems, for sports-related injuries, or for other ongoing health problems.

Attached population: Refers to the population with regular family doctors.

Unattached population: Refers to the population without regular family doctors.

Primary care: Care provided at the first point of contact between a patient and the health care system. This care is most often provided by GP/FPs but may also be provided by specialists, nurse practitioners, and others. In Ontario, the Primary Care Model refers specifically to different models of physician service delivery such as Family Health Teams. Primary care is distinguished from Primary Health Care, which may include health promotion, disease prevention, and community development.

Immigrant status: Categorized as immigrant (born outside of Canada) and Canadian-born. The immigrant population is subdivided into established immigrants (living in Canada for 10 or more years) and new immigrants (living in Canada for less than 10 years).

Selected chronic conditions: Refers to arthritis, asthma, cancer, diabetes, heart disease, high blood pressure, or respiratory problems such as emphysema. Respondents may have one or more of these conditions.

Self-reported health status: Respondents are asked to rate their health in relation to other people their age. Respondents who rate their health status as excellent, very good, or good are determined to be in better health than respondents who rate their health as fair or poor.

For More Information

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