

Access to Primary Care in Ontario: 2008

Health Analytics Branch, Health System Information Management and Investment Division

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Introduction

This is the first in a series of reports produced by the Health Analytics Branch that will provide an overview of access to primary care in Ontario. *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 of this report on page three.

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 January 1 to December 31, 2008 Primary Care Access Survey (PCAS) of 8,300 Ontarians 16 years of age and older. The purpose of the PCAS is to measure, on an ongoing basis, access to primary care in Ontario.

Comparison of Attached and Unattached Populations

Overall, 7% (732,000) of Ontarians 16 years of age and older do not have family doctors. Compared with adults, children (newborn to 15 years of age) are significantly less likely to be unattached. Currently, only 4% of children are unattached; however, this proportion still equates to 100,000 children without family doctors.

Figure 1 shows that attachment rates vary at the Local Health Integration Network (LHIN) level. The highest rates of attachment in the

adult population are among residents of the Hamilton Niagara Haldimand Brant (HNHB) LHIN. Here, attachment rates are significantly higher than the provincial average. Conversely, attachment rates in the North West and North East LHINs are significantly lower than the provincial average.

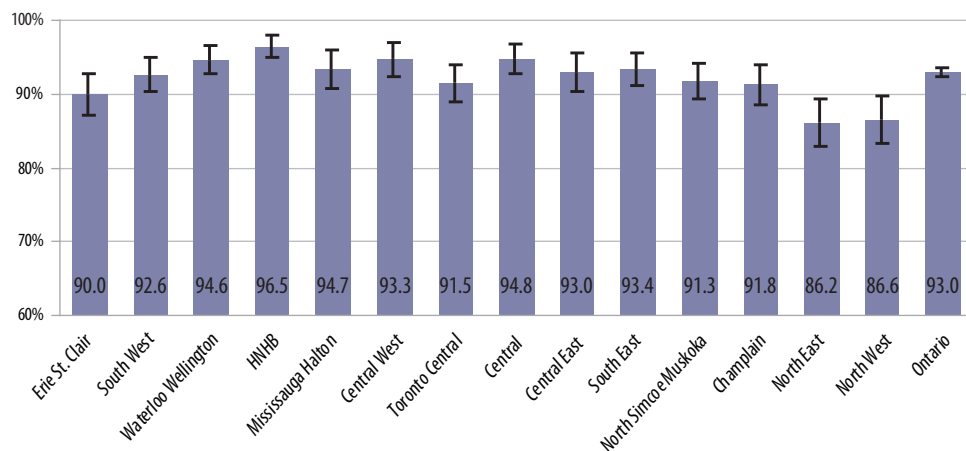
Comparison of Sociodemographic, Health Status and Chronic Condition Characteristics of Attached and Unattached Populations

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

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.

Figure 1: Proportion and 95% confidence interval of adults who have family doctors, by LHIN, 2008



proportion of Ontarians who have family doctors is significantly higher among females compared with males (94% versus 92%). Ontario residents age 65 and older are also significantly more likely to be attached compared with residents age 16 to 34 and age 35 to 64 (96% versus 91% and 93% respectively). Established immigrants – those who have lived in Canada for ten or more years – are significantly more likely to have family doctors compared with Ontario residents who were born in Canada (95% versus 93%). The PCAS shows that there are marginal differences in attachment rates when analyzed by geography of residence, education, self-reported health status or chronic conditions; however, these differences are not statistically significant.

The Unattached Population: Motivation and Attempt to Find Family Doctors

Among respondents who reported that they are unattached, the majority state that they previously had family doctors. When asked why they no longer have a family doctor, the most commonly reported reasons

Table 1: Comparison of sociodemographic characteristics, health status and chronic condition status among the attached and unattached populations age 16 and older in Ontario, 2008

Characteristic	% Attached	% Unattached
Sex		
Male	91.6 (±1.1)	8.4 (±1.1)
Female	94.3 (±0.8)	5.7 (±0.8)
Age Group		
16-34	91.1 (±1.6)	8.9 (±1.6)
35-64	93.1 (±0.8)	6.9 (±0.8)
65+	96.2 (±1.0)	3.8 (±1.0)
Geography of Residence		
Urban	92.7 (±0.8)	7.3 (±0.8)
Rural	94.3 (±1.3)	5.7 (±1.3)
Education		
Less than high school education	93.6 (±1.8)	6.4 (±1.8)
High school or higher	92.8 (±0.7)	7.2 (±0.7)
Immigrant Status		
Canadian-born	92.5 (±0.8)	7.5 (±0.8)
Established Immigrant	95.2 (±1.2)	4.8 (±1.2)
New Immigrant	90.9 (±3.7)	9.1 (±3.7)
Self-Reported Health Status		
Excellent, very good and good self-reported health	92.8 (±0.8)	7.2 (±0.8)
Fair and poor self-reported health	93.5 (±1.5)	6.5 (±1.5)
Select Chronic Condition (1 or more)		
No	92.2 (±1.0)	7.8 (±1.0)
Yes	93.9 (±0.9)	6.1 (±0.9)

are that their family doctor retired, moved or passed away. Seven out of 10 unattached respondents indicate they have been without a family doctor for two or more years. The majority of these respondents indicate they want a doctor; and just over half say they have attempted 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 with finding a doctor;
3. Asking family, friends, coworkers and others for recommendations on how to find a family doctor.

Primary Care Utilization Among Attached and Unattached Populations

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

1. **Routine care:** Refers to regular check-ups or monitoring of ongoing health issues.
2. **Immediate care:** Refers to urgent health problems that require immediate attention, for instance, when an individual is sick.
3. **Overall care:** Includes routine care, immediate care, care to obtain health information, and for advice regarding whether care is necessary.

Figure 2 shows that the unattached population is significantly less likely than the attached population to have received overall care from family doctors in the last 12 months (54% 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; 45% more attached patients sought routine care compared to the unattached population.

In the last 12 months, the unattached population is also less likely to have obtained immediate care than the attached population (26% versus 35%). However, in comparison with the attached population, the unattached population is significantly more likely to

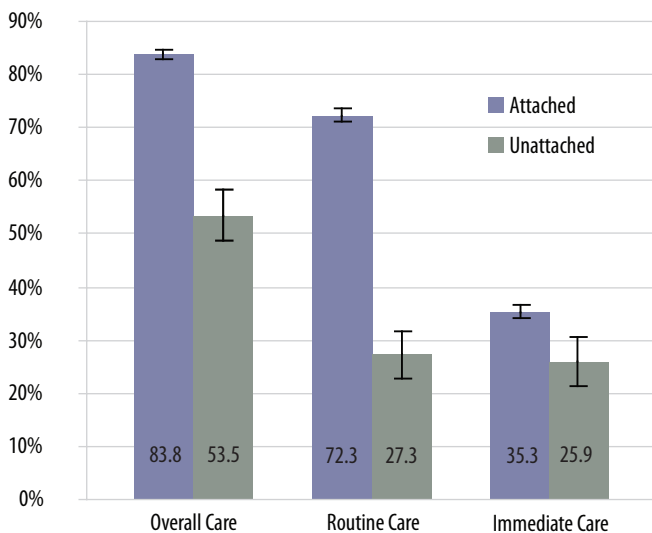
have received immediate care within one day of contacting a doctor (75% versus 44%) (see Figure 3). This reality is likely the result of significantly higher use of walk-in clinics among the unattached population. Compared with the attached population, the unattached population is almost twice as likely to have used walk-in clinics in the last 12 months (see Figure 4).

Figure 4 illustrates that the unattached population is not significantly more likely to have visited an emergency department (ED) in the last 12 months. These results do not support the notion that the unattached population uses ED care instead of regular family doctors. It is important to note that the PCAS does not distinguish whether care at EDs is received to address primary care or other health care needs.

Methodology

Data Source: The PCAS is a voluntary telephone survey developed by the Ministry of Health and Long-Term Care (MOHLTC) and is conducted by the Institute for Social Research (ISR), an independent research institute based at York University, Ontario. Since January 2006, the PCAS surveys the population age 16 and older in Ontario households. For households with children, adult respondents provide information by proxy. The PCAS sample is allocated equally among the 14 LHINs.

Figure 2: Utilization by type of care among attached and unattached populations in Ontario, 2008: proportion and 95% confidence interval



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

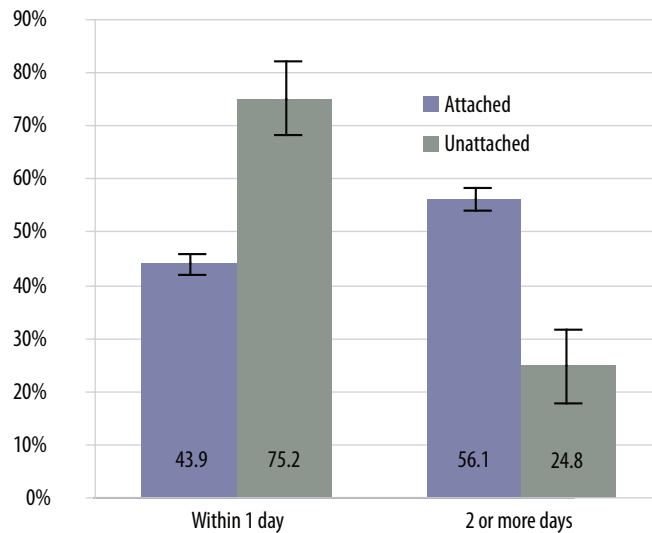
Definitions

Family doctor: Refers to family doctors, family physicians (FPs), general practitioners (GPs) or medical doctors and does not include dentists, eye doctors, gynecologists, obstetricians or specialists that respondents may also see.

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

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

Figure 3: Time to immediate care among attached and unattached populations in Ontario, 2008: proportion and 95% confidence interval



Primary care: Refers to 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.

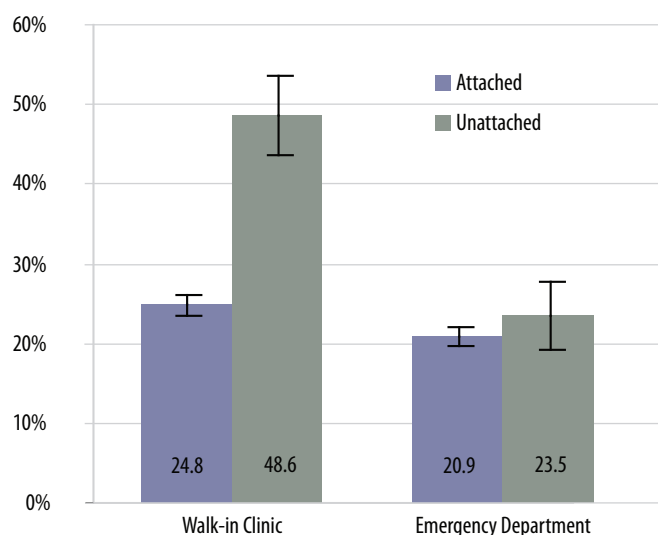
Immigrant status: Respondents are categorized as immigrant (born outside of Canada) or Canadian-born. The immigrant population is further divided into two subcategories: established immigrants (residing in Canada for 10 or more years) and new immigrants (residing in Canada for less than 10 years).

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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Figure 4: Utilization of walk-in clinics and emergency departments among attached and unattached populations in Ontario, 2008: proportion and 95% confidence interval



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