Highlights from the overall narrative report of the population survey on care experiences in Montréal and Montérégie

Odette Lemoine, Brigitte Simard, Sylvie Provost, Jean-Frédéric Levesque, Raynald Pineault, Pierre Tousignant

In 2005, the Population Health and Health Services team, a joint team from Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal and Institut national de santé publique du Québec, conducted a study in the two most populated regions of Québec (Montréal and Montérégie) to evaluate the association between primary care organizational models existing at that time and the population's care experiences. A second study was undertaken in 2010 to understand the evolution of primary care organizational models and how they have performed during the healthcare reform process, and to evaluate the organizational and contextual factors associated with these changes.

The study consists of three interrelated and hierarchically nested surveys:

- A population survey of adults randomly selected among the population of both regions to assess patient affiliation with primary care organizations, use of services, various attributes of patient care experience, preventive care received, and perception of unmet needs
- A survey of primary care organizations to evaluate aspects related to their vision, structure, resources and practice characteristics, as well as primary care service reorganization
- A third survey of key informants from Health and Social Services Centres to assess the organizational contexts within which various organizational models evolve

This summary includes highlights of the population survey results on services utilization by the population, unmet service needs and the assessments of care experiences of respondents who have a regular source of primary care. The findings are presented for all respondents and both study regions, and compare the figures obtained for 2010 to those for 2005. Detailed results are in the full report, available at the Web site of Direction de santé publique de l'ASSS de Montréal and the Institut national de santé publique du Québec (see at the end of the document).

Family physician

From 2005 to 2010, there was

- an increase in the number of individuals who have family physicians (74.6% in 2010 vs 69.1% in 2005).

Among people without family doctors, there was

- an increase in the proportion of individuals who stated that the reason is that they do not need one (37.2% in 2010 versus 17.1% in 2005);
- a decrease in the proportion of individuals who stated that there are no doctors available (37.8% in 2010 versus 56.0% in 2005).

Use of health services in the past two years

From 2005 to 2010, there was

- an increase in the number of individuals who were hospitalized at least once (18.0% in 2010 vs 15.0% in 2005);
- an increase in the number of individuals who attended emergency at least once (34.9% in 2010 vs 31.0% in 2005);
- a decrease in the number of individuals who saw a doctor in a CLSC (20.5% in 2010 vs 22.3% in 2005);
- no change in the number of individuals who saw a doctor in a medical clinic or private office (80.4% in 2010 vs 80.3% in 2005).

Unmet health service needs over the past six months

From 2005 to 2010, there was

- no change in the number of individuals who had unmet needs (18.3% in 2010 vs 17.9% in 2005);
- an increase in the number of individuals who reported the problem was urgent (23.6% in 2010 vs 20.2% in 2005);
- a clear increase in the number of individuals who reported the problem they were having was a new one (57.4% in 2010 vs 44.8% in 2005);
- an increase in the number of individuals who reported they were unable to see a doctor because they could not get an appointment (43.9% in 2010 vs 36.1% in 2005) or because they could not find a doctor who was taking new patients (38.7% in 2010 vs 31.1% in 2005);
- an increase in the number of individuals who reported that the situation had many consequences on various components of their lives (for instance, for the consequence "caused worries", 32.1% in 2010 vs 25.8% in 2005).

These findings apply to both regions.

Care experience in the past two years

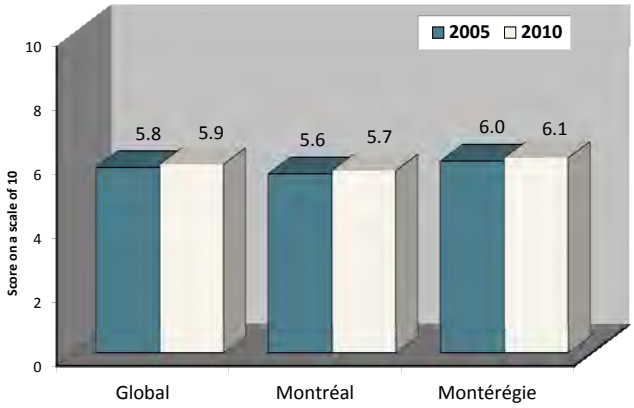
Methodological considerations: The results in this section concern only service users who identified a regular source of primary care. Care experience at the regular source of care is assessed in terms of accessibility (first contact, economic, temporal and accommodation), continuity (of affiliation and informational), comprehensiveness, responsiveness, and outcome of care. Scores are obtained by summing responses to items that compose them, reduced to a scale of 10. The higher the score, the more positive the assessment of the care experience is. When differences between the 2005 and 2010 results are statistically insignificant, the figure background is greyed out.

Accessibility

A health organization is considered to be accessible if it can be easily used, that is, if there are few geographical, organizational, economic or cultural barriers to its use.

First-contact accessibility

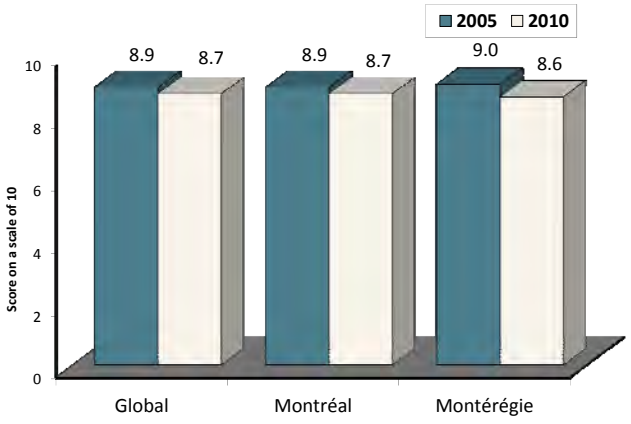
This refers to first medical visit following the person's identifying a service need and seeking care.



Overall first-contact accessibility scores are similar for 2010 and 2005 and remain relatively low, with values of 5.9 and 5.8 respectively; scores were 5.7 and 5.6 in Montréal, and 6.1 and 6.0 in Montérégie. Therefore, values are slightly higher in Montérégie than in Montréal.

Economic accessibility

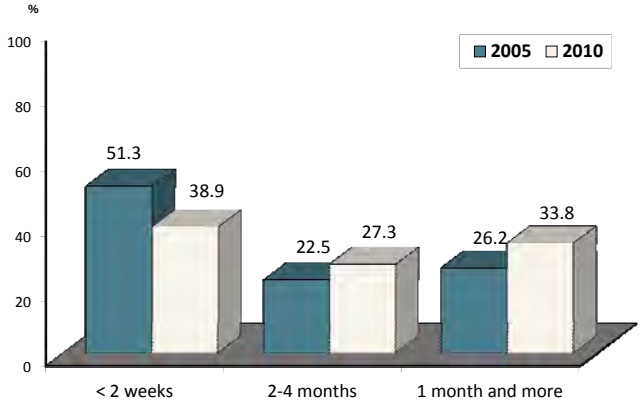
Good economic accessibility means that people do not have to pay fees to receive primary care services.



Although the overall economic accessibility score remains very high, it is significantly less high in 2010 than in 2005; this applies not only to the overall score (8.7 in 2010 vs 8.9 in 2005) but also to scores for Montréal (8.7 vs 8.9) and Montérégie (8.6 vs 9.0). These results indicate that more people had to pay in 2010 to obtain certain primary care services than in 2005.

Temporal accessibility

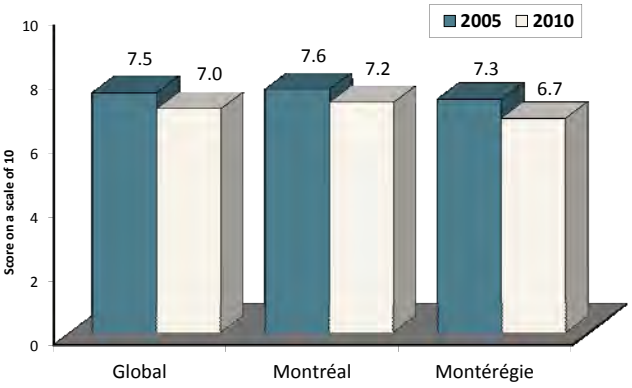
To qualify temporal accessibility, only the distribution of respondents by waiting time for an appointment with the doctor is presented here.



The waiting time for an appointment with a doctor was higher in 2010 than in 2005; only 38.9% of respondents could get an appointment with a physician at their regular source of care in less than two weeks; in 2005, the figure was 51.3%. The increase in waiting times is noted in both regions and points to a decline in temporal accessibility.

Accessibility of accommodation

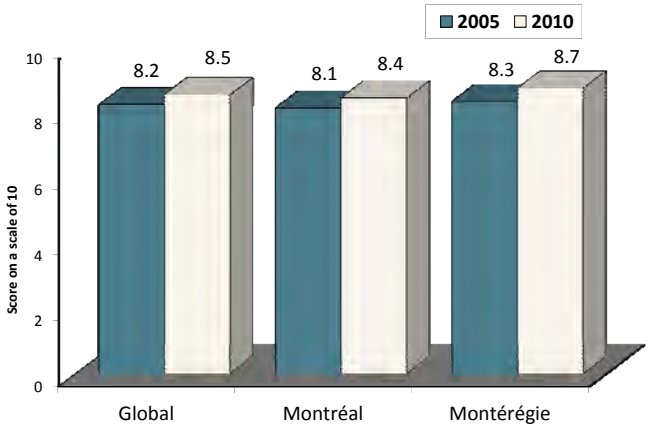
This refers to ease of access to the source of care (e.g. adequate opening hours, ease with which a person can be reached by telephone).



The overall accommodation score is significantly less high in 2010 than in 2005; this applies not only to the overall score (7.0 in 2010 vs 7.5 in 2005) but also to scores for Montréal (7.2 vs 7.6) and Montérégie (6.7 vs 7.3). These results show that individuals have a less favourable assessment of how "accommodating" their regular source of care was in 2010.

Continuity of affiliation

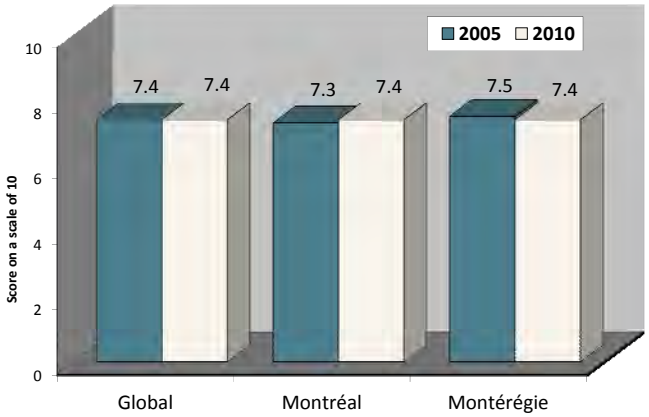
This refers to stability over time of the relationship between the patient and professionals at the regular source of care.



The continuity of affiliation score is significantly higher in 2010 than in 2005; this applies not only to the overall score (8.5 in 2010 vs 8.2 in 2005) but also to scores for Montréal (8.4 vs 8.1) and Montérégie (8.7 vs 8.3). It should be noted that the assessment is more positive in Montérégie than in Montréal.

Informational continuity

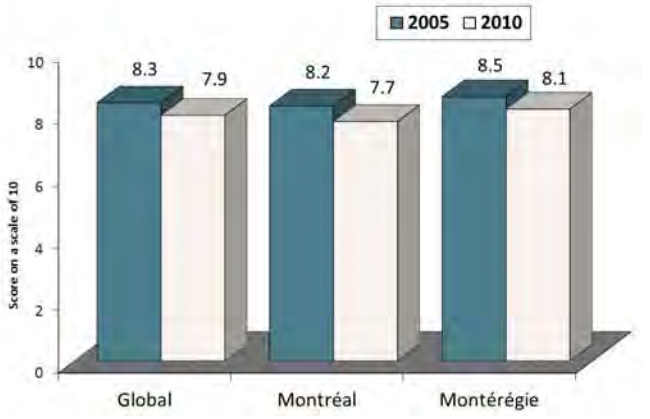
This qualifies how information circulates between care episodes or among various sites where services are provided; it only concerns individuals who have had laboratory tests or who have seen specialists to whom they were referred by their physicians, that is, in this survey, 40% of users of primary care services who have a regular source of care.



The informational continuity score did not change between 2010 and 2005, and this is true for the overall score (7.4), and scores for Montréal and Montérégie.

Comprehensiveness

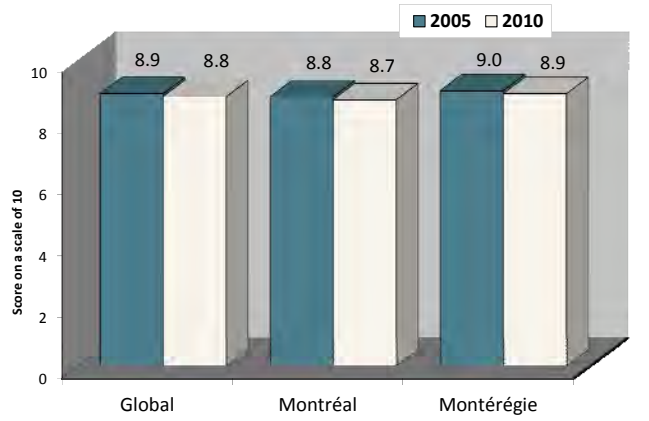
This corresponds to all the services required to meet the majority of a community's everyday health needs. It is generated by the availability of all services needed for a patient within an organization or by the assurance that other services are accessible in other organizations.



The comprehensiveness score is significantly less high in 2010 than in 2005; this applies not only to the overall score (7.9 in 2010 vs 8.3 in 2005) but also to scores for Montréal (7.7 vs 8.2) and Montérégie (8.1 vs 8.5). It should be noted that the assessment is more positive in Montérégie than in Montréal.

Responsiveness

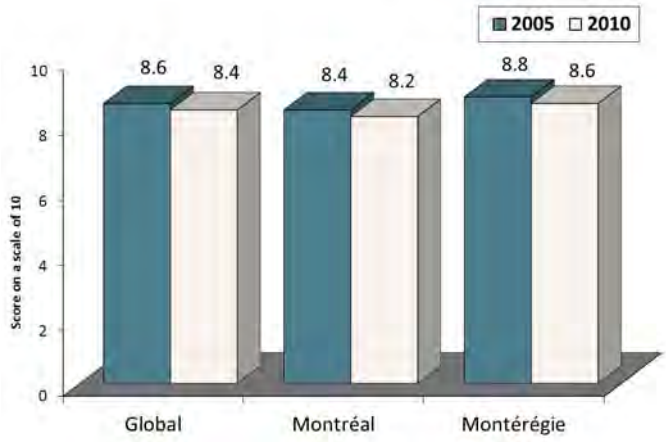
This is defined as the response to a person's legitimate expectations regarding elements or actions unrelated to the technical aspects of treatment such as respect shown and attention given to patients.



The overall responsiveness score is very high and almost identical in 2005 and in 2010; this applies not only to the overall score (8.9 in 2005 vs 8.8 in 2010) but also to scores for Montréal (8.8 vs 8.7) and Montérégie (9.0 vs 8.9).

Outcome of care

This refers to the effects or consequences of services on a person's health, as perceived by the individual. It includes perceived direct consequences on health as well as consequences on health-related knowledge, and intermediary results such as adoption of healthy behaviours.



The overall outcome of care score is significantly less high in 2010 than in 2005; this applies not only to the overall score (8.4 in 2010 vs 8.6 in 2005) but also to scores for Montréal (8.2 vs 8.4) and Montérégie (8.6 vs 8.8). It should be noted that the assessment is more positive in Montérégie than in Montréal.

Conclusion

In light of these initial descriptive results, it appears that patients are becoming more loyal to their regular source of primary care. However, accessibility to this source of care not only has the indices least favourably assessed by respondents but it is also worse in 2010 than in 2005. A reduced perception of the comprehensiveness of care received is also evident, as is a decrease in outcome of care.

Some differences related to the population characteristics observed in 2005 and 2010 (higher level of education, more people reporting to be financially well-off) suggest that we should be prudent when interpreting these descriptive data, especially with regard to care experiences linked to these two characteristics. Multivariate analyses will be performed to control for these variables.

Are some population groups more affected by these phenomenon? Do the results apply to all medical organizational models or to some in particular? Additional analyses will also be conducted to better understand these findings.

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The project has received ethical approval from the research ethics committee of the Agence de la santé et des services sociaux de Montréal, the main committee. The multicentre nature of the research project requires ethical approval from research ethics committees in each health and social services centre in the territories under study.

This document is available on the Web sites of the Direction de santé publique (www.dsp.santemontreal.qc.ca/dossiers_thematiques/services_preventifs/thematique/sante_des_populations_et_services_de_sante/documentation.html) and the INSPQ (www.inspq.qc.ca/publications/).

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