Tania M. Jenkins
McGill University
tania.jenkins@mail.mcgill.ca

Arduous Access:

Does SES Affect Access to Primary Health Care in Quebec?

Poster presented at the Conference on Health over the Life Course, UWO, London, ON, 14-16 October 2009

Amélie Quesnel-Vall
McGill Univer
amelie.quesnel-vallee@mcgil

IRIS

"[T]he primary objective of Canadian health care policy is to…facilitate reasonable access to health services *without* financial or other barriers" (Canada Health Act, R.S. 1985, c.C-6, s.3a)

Background

➢**Primary *Health* Care: (PHC)**
→The envelope of services offered within the context of a medical home, characterized by: First-contact care *and* longitudinality, comprehensiveness, and coordination
(Starfield 1998)

➢**Strained access to (PHC) in Quebec**
→25% of Quebecers lack a family doctor (cf. national average of15%)
→Need for 800 new full-time family physicians to fulfill need

➢**Mixed evidence on SES & access to PHC**
→Income and/or education positively affect access to PHC in some studies
(Eyles et al., 1995; Nabalamba & Millar, 2007; Wilson & Rosenberg, 2004)
→The relationship is either *non-existent or negative* with access in other studies
(Siemiatycki 1980, Kephart, Thomas & MacLean, 1998; Mustard & Frohlich, 1995; Finkelstein, 2001)

➢**Potential vs. achieved access**
Potential: the presence of factors conducive to access
Achieved: actual number of visits to PHC provider

➢**Gaps in the literature**
→ Mixed evidence, lack of Quebec-specific studies, little consideration for *potential* instead of *achieved* access

Objective

Assess the effect of socioeconomic status on Quebecers' likelihood of having a regular medical doctor

Methodology

➢**Data**
Canadian Community Health Survey, 3.1 (2005)
→Sample restricted to adult Quebecers
→Regression sample: 23,502

➢**Method**
Logistic regression
→Population & bootstrap weights
→Odds ratios & predicted probabilities

➢**Variables**
→*Main IVs:* Household income; education
→*Other measures of inequity*: household size, health region, residence, labour status, language, visible minority status, marital status
→*Control variables*: Perceived & evaluated health need, age, sex

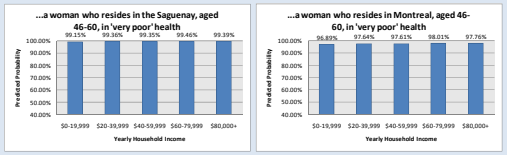
Findings

➢**In*equalities* in access exist, as expected**
→Age
→Being female
→Having chronic conditions
→Having poor self-perceived health
…are all positively associated with greater likelihood of having a regular medical doctor

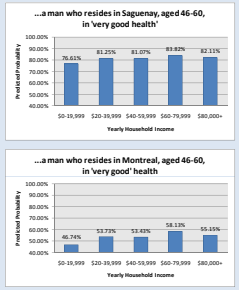
➢**In*equities* in accessing regular physicians *also* exist in Quebec***
→Income (≥ $20,000)
→Household size
→Living in rural regions
→Being married
… are all positively associated with greater likelihood of having a regular medical doctor
*Education was not significant

In other words...

The predicted probability of having a regular medical doctor for…



Bad news: 'Average' , relatively healthy patients in need of regular check-ups are subject to inequities in income and health region



Good news: The oldest and sickest in society have access to a family doctor, *despite* income, or health region

Discussion

➢**Main findings**
→SES (income) does in fact affect access to PHC
→Access is especially difficult for Montrealers, 'healthy' individuals and those with low income

➢**So why does universal coverage ≠ universal *access?***
→Complementary qualitative study highlighted perverse effects of certain health policies on access to PHC in the province – e.g. AMPs
(Jenkins 2009)
✓These policies ensure that those who need care the most (the oldest and sickest) *do* receive it, despite negative predictors of access
✓But they also provide disincentives for GPs to service the general population

→Could social networks be a compelling rationale?
High income → rich social networks → better access to PHC through networks

"It has nothing to do with money. No money changes hands here. In other societies, if you pony up the money you get quick service. It's not the case here; it has everything to do with personal contacts"
—Dr. Alan Pavilanis, Chief of the Department of Family Medicine, St. Mary's Hospital

Acknowledgements/References

• CIHR grant MOP 77800, PI: Quesnel-Vallée
• McGill Institute for the Study of Canada Jo
& Sandra Rotman Prize (2009)

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