

# Experiencing Difficulties Accessing First-Contact Health Services in Canada

## Difficultés d'accès aux soins de santé de première ligne au Canada

*Canadians without regular doctors and recent immigrants have difficulties accessing first-contact healthcare services. Reports of difficulties in accessing care vary by age, sex and region.*



by CLAUDIA SANMARTIN, PHD

*Senior Analyst, Health Analysis and Measurement Group*

*Statistics Canada, Ottawa, ON*

*Adjunct Research Assistant Professor, Dept. of Community Health Sciences,  
University of Calgary*

NANCY ROSS, PHD

*Assistant Professor, Department of Geography, McGill University, Montreal, QC*

*Associate, Health Analysis and Measurement Group, Statistics Canada*

### Abstract

In this study, we identify the significant factors associated with having difficulties accessing first-contact healthcare services. Population-based data from two national health surveys, the Health Services Access Survey and the Canadian Community

Health Survey, were used to identify respondents who required first-contact services for themselves or for a family member during 2003. Fifteen percent of Canadians reported difficulty accessing routine care, and 23% reported difficulties with immediate care. Physician/service availability was the chief reason cited for difficulties accessing routine care, while for urgent care, it was long wait times. Women, younger respondents and residents of eastern Canada and Quebec were consistently more likely to report difficulties accessing both types of these first-contact services, whereas less educated Canadians were less likely to report problems. Canadians without a regular family doctor were more than twice as likely to report difficulties accessing routine care compared to those who had a regular doctor. New immigrants were almost two and a half times more likely to report difficulties accessing immediate care than were Canadian-born respondents. Household income was not associated with difficulties accessing either type of care. The relatively low level of reporting of difficulties by older and less educated Canadians may be related, in part, to more modest expectations about the healthcare system.

## Résumé

Dans cette étude, nous répertorions les principaux facteurs liés aux obstacles à l'accès à des soins de santé de première ligne. Nous avons utilisé des données sur la population provenant de deux enquêtes nationales sur la santé – l'Enquête sur l'accès aux services de santé et l'Enquête sur la santé dans les collectivités canadiennes – pour repérer les répondants qui avaient besoin d'avoir accès à des services de santé de première ligne pour eux-mêmes ou pour un membre de leur famille en 2003. Quinze pour cent des Canadiens ont dit avoir éprouvé des difficultés à avoir accès à des soins de base, et 23 % ont dit avoir eu de la peine à trouver des soins immédiats. Les femmes, les répondants plus jeunes et les résidents de l'Est du Canada et du Québec étaient les plus susceptibles de signaler des difficultés d'accès aux deux types de soins de santé de première ligne, tandis que les Canadiens peu instruits étaient moins susceptibles d'en faire mention. Les Canadiens qui n'avaient pas de médecin de famille étaient plus que deux fois plus susceptibles de signaler des difficultés que ceux qui en avaient un. Les nouveaux immigrants étaient presque deux fois plus susceptibles de signaler des difficultés d'accès à des soins immédiats que les répondants nés au Canada. Il existe un profil sociodémographique indéniable associé au signalement des difficultés d'accès aux soins de première ligne au Canada. Le niveau relativement faible de signalement des difficultés d'accès par les Canadiens plus âgés et moins instruits peut être lié, en partie, à des attentes plus modestes à l'égard du système de soins de santé.

ACCESS TO HEALTHCARE SERVICES CONTINUES TO BE AT THE FOREFRONT OF the health policy debate in Canada. In a recent national consultation, timely access to healthcare services was identified as a key area for health research (Dault et al. 2004). Access to healthcare services can be conceptualized as having two key components: *potential access*, defined as the process of accessing care, and *realized access*, defined as the actual use of healthcare services (Aday and Andersen 1974, 1981). Increasingly, health services data and national health surveys have been used to monitor realized access indicators, such as rates of physician visits, surgery and use of diagnostic tests (Statistics Canada and CIHI 2005; CIHI 2004). Researchers are also using health services data in conjunction with health status and socio-demographic information to clarify who is accessing services and what clinical and non-clinical factors may affect service use (Roos and Mustard 1997; Dunlop et al. 2000; Finkelstein 2001; Glazier et al. 2000; Black et al. 1995; Roos et al. 2003).

Although health services use can tell us about realized access, it cannot inform us about potential access – the experiences of patients in the process of accessing care, including whether or not they face difficulties obtaining the care they need when they need it. Recent concerns about lengthy waits and timely access to care in Canada have shifted the focus towards the need for more information regarding patients' experiences in accessing healthcare services (Sanmartin et al. 2002). Measures of access difficulties have been included as part of a suite of indicators agreed upon by ministries of health across the country to report on the performance of the healthcare system (Performance Reporting Technical Working Group 2004). These performance indicators revealed that up to one in four Canadians requiring healthcare services, such as routine primary care and immediate care for a minor health problem, encountered difficulties. Barriers such as contacting a healthcare provider and long waits were identified as key problems (Sanmartin, Gendron et al. 2004).

There are strong arguments for concern about patients' experiences in the process of accessing care. Those who experience difficulty may delay seeking and obtaining treatment, underuse preventive healthcare services and be at greater risk for the complications of delayed diagnoses. These potential consequences, in turn, may put increased financial pressure on the healthcare system if individuals arrive in the system sicker and stay in it longer. Therefore, it is important to extend the work on access to care beyond the use of services towards a more comprehensive understanding of the process of accessing care.

In this study, we used data from two national health surveys to explore the determinants of potential access to first-contact healthcare services. We examined a range of demographic, socio-economic and health status variables, all hypothesized to be associated with access to care (Andersen 1995) to better understand the characteristics of Canadians reporting difficulties accessing first-contact healthcare services.

## Methods

### Data

The study is based on cross-sectional analysis of data from the 2003 Health Services Access Survey (HSAS). The HSAS was designed specifically to collect additional information regarding patients' experiences accessing healthcare services and was conducted by Statistics Canada as a supplement to the Canadian Community Health Survey (CCHS). The CCHS is a large, cross-sectional survey containing information on the health status and healthcare use of Canadians, with a sample size of 135,575 (Beland 2002). The survey represents approximately 98% of the population aged 15 and older living in private dwellings in the 10 provinces. 36,731 CCHS respondents were selected by stratified random sampling to participate in the HSAS. The response rate was 87%, resulting in a final sample size of 32,005. Data were collected by personal and telephone interviews between January and December 2003.

The study sample includes all those who required the following types of first-contact services for themselves or for a family member in the 12 months before the survey: routine care provided by a family or general practitioner, such as annual examinations or ongoing care for an illness ( $n = 18,339$ ), or immediate care for a minor, non-life-threatening health problem, such as a fever or minor cuts and burns ( $n = 10,113$ ). Immediate care for these minor health problems could have been sought from a variety of providers, including family physicians, walk-in clinics and urgent-care facilities such as hospital emergency rooms. Respondents could be represented in both samples if they required both types of services. Respondents were asked whether they experienced difficulties getting the care they needed for themselves or for a family member (yes/no). All respondents to the HSAS were also asked whether they had a regular family physician (yes/no).

The HSAS data were linked to the CCHS data to obtain respondents' demographic, socio-economic and health status information. Information derived from the CCHS included gender, age, province of residence, rural or urban residence, immigration status, number of children 12 years of age or under in the household, lone-parent status, education, income level and employment status. Lone-parent status was determined using information identifying family relationships within households. Lone parents were defined as either female or male parents living with children under 25 years of age. Education information represented the highest level of education attained by the respondent: less than secondary school graduation; secondary school graduation, no post-secondary education; some post-secondary education; and post-secondary degree or diploma.

Respondents were classified into one of the following four groups based on total household income adjusted for household size: lowest income (<\$15,000 if 1 or 2 people in household; <\$20,000 if 3 or 4 people; <\$30,000 if 5+ people); lower-middle income (\$15,000 to \$29,999 if 1 or 2; \$20,000 to \$39,999 if 3 or 4; \$30,000

to \$59,999 if 5+); upper-middle income (\$30,000 to \$59,999 if 1 or 2; \$40,000 to \$79,999 if 3 or 4; \$60,000 to \$79,999 if 5+); or highest income (>\$60,000 if 1 or 2; >\$80,000 if 3+). Individuals between the ages of 15 and 75 who had worked in the previous year were classified as working either full time ( $\geq 30$  hours per week) or part time ( $< 30$  hours per week). Those over 75 years of age and those who had not worked in the previous year were classified as not working.

CCHS respondents were asked to describe their overall general health status as either excellent, very good, good, fair or poor. Responses were collapsed into three categories: fair/poor, good and very good/excellent health. As a more precise mobility measure, we included the concept of activity limitation. Individuals were asked whether or not they required assistance with a range of activities, such as preparing meals or shopping for groceries or other necessities, owing to health reasons.

## Analysis

We used univariate analyses and logistic regression (weighted) to examine the relation between the two principal outcome measures (difficulties accessing routine healthcare and difficulties accessing immediate care) and various demographic, socio-economic and health status factors. We used the bootstrap technique to determine the significance of the odds ratios (ORs) and to estimate 95% confidence intervals. This technique fully accounts for the design effects of the survey (Davison and Hinkley 1997).

## Results

According to the HSAS results, 15% of Canadians needing first-contact health services reported difficulty accessing routine care, and 23% reported difficulties obtaining immediate care (Table 1). When compared with the general CCHS sample, the linked HSAS subsample had a higher proportion of female respondents and tended to be more highly educated. Individuals requiring routine care tended to be less represented in the youngest age group ( $< 35$  years) and reported poorer health status than did the general CCHS population. Individuals requiring immediate care for themselves or for a family member were more likely to have children under age 12 in the household and to have full-time employment compared with the general CCHS population.

The unadjusted rates for difficulties accessing routine care ranged from a low of 8% for respondents aged 65 years and over to a high of 28% for those without a regular family doctor. For difficulties obtaining immediate care, the rates ranged from 14% among those aged 65 and older to 43% among new immigrants (immigrated  $< 5$  years) (Table 2).

TABLE 1. Characteristics of persons who required first-contact health services (HSAS subsample) and of the general population, Canadian Community Health Survey (CCHS)

	PERCENTAGE OF THE POPULATION		
	ROUTINE CARE SUBSAMPLE (N=18,339)	IMMEDIATE CARE SUBSAMPLE (N=10,113)	GENERAL POPULATION (N=135,575)
<b>Difficulties accessing care</b>			
Yes	14.8	22.7	n/a
No	85.2	77.3	
<b>Gender</b>			
Female	55.9	54.1	49.3
Male	44.1	45.9	50.7
<b>Age group</b>			
<35	24.0	36.7	36.3
35–64	58.3	55.6	49.5
65+	17.6	7.7	14.2
<b>Residence</b>			
Rural	18.5	17.9	18.8
Urban	81.5	82.1	81.2
<b>Region</b>			
East	8.3	8.3	7.6
Quebec	26.7	22.9	24.0
Ontario	38.7	40.3	38.7
West	26.3	28.5	29.7
<b>Immigration status</b>			
Immigrant (<5 yrs ago)	2.2	3.0	3.6
Immigrant (≥5 yrs ago)	18.3	16.3	18.1
Not an immigrant	79.5	80.7	79.3
<b>Number of children ≤12 yrs of age</b>			
>1 child	12.0	19.3	11.8
1 child	12.8	18.1	13.5
None	75.2	62.7	74.7
<b>Lone-parent status</b>			
Yes	4.6	5.4	5.5
No	95.5	94.6	94.5
<b>Education</b>			
Less than high school	20.3	16.8	26.7
High school/Some post-secondary	25.9	26.3	25.9
Post-secondary degree/diploma	53.7	56.9	47.4
<b>Income</b>			
Lowest quartile	6.7	6.5	7.6
Lower-middle quartile	17.8	16.2	16.5

continued

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Upper-middle quartile	30.5	27.9	28.6
Highest quartile	32.1	36.3	30.6
Missing	12.9	13.1	16.8
<b>Job status</b>			
Full time	55.9	65.0	55.7
Part time	13.5	15.6	12.8
Not working	30.6	19.4	31.5
<b>Health status</b>			
Fair/poor	14.1	10.1	11.3
Good	32.3	30.4	30.2
Excellent/very good	53.6	59.5	58.4
<b>Some restriction</b>			
Yes	17.7	12.7	13.6
No	82.3	87.3	86.4
<b>Regular family doctor</b>			
Yes	7.9	11.2	n/a
No	92.1	88.8	
Note: Because of rounding, proportions may not total 100%.			
HSAS = Health Services Access Survey			
n/a = data not available			

**TABLE 2. Unadjusted rates (%) of reporting difficulties accessing routine and immediate healthcare**

	PERCENTAGE OF THE POPULATION	
	ROUTINE CARE (N=18,339)	IMMEDIATE CARE (N=10,113)
<b>Gender</b>		
Female	17.0	26.2
Male	14.3	21.9
<b>Age group</b>		
<35	18.0	26.4
35–64	17.4	24.2
65+	7.6	13.5
<b>Residence</b>		
Rural	16.7	23.7
Urban	15.6	26.5
<b>Region</b>		
East	16.3	24.9
Quebec	18.7	26.1
Ontario	15.4	25.0
West	13.3	21.4

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<b>Immigration status</b>		
Immigrant (<5 yrs ago)	15.8	42.9
Immigrant (≥5 yrs ago)	11.5	23.2
Not an immigrant	16.8	23.6
<b>Number of children ≤12 yrs of age</b>		
> 1 child	15.1	22.8
1 child	17.9	26.8
None	18.2	26.5
<b>Lone-parent status</b>		
Yes	19.2	27.3
No	15.7	24.0
<b>Education</b>		
Less than high school	11.3	18.1
High school/Some post-secondary	14.2	24.5
Post-secondary degree/diploma	18.1	25.7
<b>Income</b>		
Lowest	14.4	29.0
Lower-middle	13.8	23.4
Upper-middle	17.4	22.5
Highest	16.8	25.3
Missing	13.2	23.5
<b>Job status</b>		
Full time	18.3	25.4
Part time	18.1	22.6
Not working	10.4	21.9
<b>Health status</b>		
Fair/poor	16.5	22.2
Good	16.7	25.2
Excellent/very good	15.1	24.0
<b>Some restriction</b>		
Yes	17.8	24.8
No	15.4	24.1
<b>Regular family doctor</b>		
Yes	14.7	23.9
No	28.4	26.5

Over half (54%) of the respondents who experienced problems accessing routine care cited physician and/or service availability as the primary barrier, and 43% cited long waits (Table 3). Conversely, waiting time was the main barrier reported by 61% of those who experienced difficulties accessing immediate care, and 41% cited physician/service availability. Personal reasons, including difficulties with transportation, language or cost, were identified by fewer than 5% of the respondents who had difficulties getting routine or immediate healthcare.



TABLE 3. Reasons for difficulties accessing routine and immediate healthcare

	PERCENTAGE OF THOSE REPORTING DIFFICULTIES	
	ROUTINE CARE (N=2,850)	IMMEDIATE CARE (N=2,693)
Physician/service availability <sup>1</sup>	54.0	40.7
Waiting too long <sup>2</sup>	43.3	60.8
Personal reasons <sup>3</sup>	3.2	4.8
Other	12.9	14.3

## Notes:

1. Includes difficulty contacting a physician or getting an appointment, or services not available in the area or at the time required
2. Includes waiting too long to get an appointment or to see a physician
3. Includes difficulties due to transportation, language, cost or lack of information

## Determinants of difficulties accessing healthcare

### ROUTINE CARE

The logistic regression analysis showed that, among respondents who had trouble accessing routine care, women had significantly higher odds of reporting difficulties than did men (OR 1.33;  $p < 0.05$ ), as did those younger than 65 when compared with those aged 65 and over (OR 1.95 for those  $< 35$ ,  $p < 0.05$ ; OR 1.90 for those  $35 - 64$ ,  $p < 0.05$ ) (Table 4). Residents of eastern Canadian provinces (OR 1.23,  $p < 0.05$ ) and Quebec (OR 1.38,  $p < 0.05$ ) were also more likely to report difficulties accessing routine care than were residents of western provinces. Immigrants who have been in Canada for more than five years were less likely to report difficulties accessing care (OR 0.71,  $p < 0.05$ ) compared with Canadian-born residents. Individuals with less than high school education (OR 0.68,  $p < 0.05$ ) and those with high school and/or some post-secondary education (OR 0.76,  $p < 0.05$ ) were less likely to report difficulties accessing routine care compared to those with post-secondary level education.

As expected, working status was associated with higher odds of reporting difficulties accessing routine care, with persons working full time (OR 1.57,  $p < 0.05$ ) or part time (OR 1.53,  $p < 0.05$ ) being more likely to report difficulties than those who were not working.

We also found poor health status to be significantly associated with having problems accessing routine care. Individuals reporting fair or poor health (OR 1.42,  $p < 0.05$ ) or good health (OR 1.26,  $p < 0.05$ ), or some restriction of activities (OR 1.52,  $p < 0.05$ ) were more likely to report difficulties than were those reporting excellent or very good health, or no activity limitation, respectively. Those without a regular family

doctor were more than twice as likely (OR 2.17,  $p < 0.05$ ) to report difficulties accessing routine care than those with a regular doctor.

We observed no differences in reporting difficulties accessing routine care between rural and urban residents, by number of children under 12 years of age, by lone-parent status or across income groups.

TABLE 4. Results of logistic regression analysis

	ROUTINE CARE (N=17,670)			IMMEDIATE CARE (N=9,786)		
	ODDS RATIO	95% CI	CI	ODDS RATIO	95% CI	CI
<b>Gender</b>						
Female	1.33*	1.13	1.57	1.26*	1.04	1.55
Male						
<b>Age group</b>						
<35	1.95*	1.41	2.72	2.10*	1.40	3.19
35–64	1.90*	1.43	2.56	1.74*	1.18	2.59
65+						
<b>Residence</b>						
Rural	1.04	0.87	1.24	1.30*	1.03	1.60
Urban						
<b>Region</b>						
East	1.23*	1.02	1.47	1.24*	1.01	1.51
Quebec	1.38*	1.12	1.68	1.30*	1.02	1.64
Ontario	1.20	0.98	1.45	1.21	0.97	1.49
West						
<b>Immigration status</b>						
Immigrant (<5 yrs ago)	0.81	0.41	1.65	2.40*	1.26	4.45
Immigrant (≥5 yrs ago)	0.71*	0.55	0.93	1.06	0.79	1.38
Not an immigrant						
<b>Number of children ≤12 yrs</b>						
> 1 child	0.90	0.69	1.11	0.92	0.74	1.16
1 child	1.00	0.71	1.30	1.05	0.80	1.38
None						
<b>Lone-parent status</b>						
Yes	0.99	0.66	1.50	1.18	0.82	1.68
No						
<b>Education</b>						
Less than high school	0.68*	0.55	0.86	0.69*	0.52	0.90
High school/Some post-secondary	0.76*	0.63	0.92	1.00	0.80	1.21
Post-secondary degree/diploma						

continued

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<b>Income</b>						
Lowest	1.02	0.73	1.41	1.11	0.74	1.64
Lower-middle	0.92	0.70	1.19	0.85	0.65	1.13
Upper-middle	1.12	0.93	1.35	0.81	0.66	1.00
Highest						
<b>Job status</b>						
Full time	1.57*	1.24	2.01	1.02	0.80	1.37
Part time	1.53*	1.14	2.07	0.91	0.67	1.27
Not working						
<b>Health status</b>						
Fair/poor	1.42*	1.09	1.81	0.99	0.70	1.39
Good	1.26*	1.05	1.49	1.12	0.89	1.39
Excellent/very good						
<b>Some restriction</b>						
Yes	1.52*	1.20	1.90	1.26	0.93	1.71
No						
<b>Regular family doctor</b>						
No	2.17*	1.69	2.73	1.07	0.79	1.44
Yes						
* $p < 0.05$						

### IMMEDIATE CARE

Among respondents who had problems accessing immediate care, the influences of age, gender and region were similar to the findings for routine care. Women (OR 1.26,  $p < 0.05$ ) and persons under age 65 (OR 2.10 for those  $<35$ ,  $p < 0.05$ ; OR 1.74 for those 35–64,  $p < 0.05$ ) had significantly higher odds of reporting difficulties in accessing immediate care for a minor health problem. Similarly, residents of eastern Canadian provinces (OR 1.24,  $p < 0.05$ ) and Quebec (OR 1.30,  $p < 0.05$ ) were also more likely to report difficulties than were those living in western provinces.

However, unlike the findings for routine care, we found that rural residents were significantly more likely than their urban counterparts to report difficulties accessing immediate care (OR 1.30,  $p < 0.05$ ). In addition, new immigrants ( $<5$  years in Canada) were nearly two and a half times more likely to report difficulties with immediate care compared with the Canadian-born population. Individuals with less than high-school education were significantly less likely than were those with a post-secondary degree to report problems obtaining immediate care (OR 0.69,  $p < 0.05$ ).

The reports of difficulties accessing immediate healthcare were not influenced by income level, job status, the presence of young children, lone-parent status, health status or access to a regular family doctor.

## Interpretation

This study is the first national-level analysis of Canadians experiencing difficulties accessing first-contact health services. Overall, we found that 15% of Canadians who sought routine care and 23% of those who sought immediate care reported difficulties in accessing care for themselves or for family members. Physician and/or service availability and long waiting times were cited as the top two reasons for difficulties accessing both types of services. Compared with other international jurisdictions, Canada ranks among the highest regarding difficulties accessing general and family physicians. In a 2001 multi-country survey conducted by the Commonwealth Fund, 24% of Canadian respondents indicated long waits as a “big problem” when accessing general and family physicians compared with less than 15% in New Zealand and the United States (Blendon et al. 2003). Similarly in 2003, 25% of Canadian respondents indicated that it took six or more days to get an appointment to see a doctor compared with 2% in New Zealand, 7% in Australia, 13% in the United Kingdom and 19% in the United States (Schoen et al. 2004).

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**... 15% of Canadians who sought routine care and 23% of those who sought immediate care reported difficulties in accessing care for themselves or for family members. Physician and/or service availability and long waiting times were cited as the top two reasons for difficulties accessing both types of services.**

As well, residents of eastern Canadian provinces and Quebec were more likely to report problems than those living in Ontario. The regional findings do not seem to be closely related to the supply of general and family physicians given that Quebec, Newfoundland and Nova Scotia have some of the highest levels of physician-per-capita rates. Prince Edward Island and New Brunswick, however, do have lower physician-per-capita rates than the national average (CIHI and Statistics Canada 2003). Income level, on the other hand, was not associated with difficulties accessing first-contact health services. This result supports the notion that universal health insurance is effective at eliminating cost-related barriers to care, unlike in the United States, for example, where income plays a greater role in determining access to care (Blendon et al. 2002; Sanmartin, Ng et al. 2004).

The results of this study identified various demographic, socio-economic and health status factors that were associated with having difficulties accessing care. For both routine and immediate care, women (as compared with men), younger Canadians (as compared with those 65 and over) and those with post-secondary education were consistently more likely to report diffi-

The differences we observed across various subgroups may reflect true differences in experiences accessing first-contact services between women and men, between older and younger Canadians, between those reporting fair or poor and good or better health, between those with more or less education and across different regions. For example, the higher rates of difficulties reported by women and those reporting poorer health may result from their different experiences in accessing the healthcare system (Kazanjian et al. 2004). Women, for example, have more contacts with the healthcare system in Canada than do men and are more likely than men to be the primary care-seekers for dependent children and elderly family members (Advisory Committee on Women's Health Surveillance 1999; Mustard et al. 1998). Similarly, individuals with poorer health status are more likely to require healthcare services compared with those reporting very good health. Consequently, these individuals have more opportunities to experience difficulties accessing care and, therefore, are at higher risk compared with those less likely to need and use healthcare services.

Alternatively, differences in reporting difficulties accessing the healthcare system may be the result of differential expectations across groups. In general, patients evaluate their encounters with the healthcare system against a set of expectations about when and how services ought to be provided (Newsome and Wright 1999; Linder-Pelz 1982). Expectations, therefore, likely play a key role in an individual's determination of whether or not difficulties were experienced. Expectations are shaped by various factors, including social context, demographics and socio-economic status (Thompson and Sunol 1995). Evidence suggests that older and less educated patients tend to have more modest expectations and are less likely to be dissatisfied with their care (Sitzia and Wood 1997). The differences we noted between younger and older Canadians and between more educated and less educated Canadians may be partially explained by higher service expectations among younger and more educated patients.

Our study also identified factors associated with difficulties accessing care that are specific to each type of first-contact service. In particular, we found rural residents and new immigrants to be at higher risk for experiencing difficulties accessing immediate care, whereas persons without a regular family doctor were more likely to report problems obtaining routine care. Urban/rural differences in access to healthcare services have been a longstanding concern in Canada, given the vastness of our country and the high concentration of services in more urban areas. Although access to primary care services in general has been identified as needing improvement (Romanow 2002), our results demonstrate the need to focus more specifically on access to immediate care for persons living in rural areas.

We also identified immigrants as an at-risk group for access to first-contact services. New immigrants were almost two and a half times more likely to experience difficulties accessing immediate care compared with those born in Canada. We saw no differences between new immigrants and Canadian-born respondents regarding access

to routine care. This could be due to the fact that immigrants tend to use these services less frequently and therefore have less opportunity to experience difficulties (Ali et al. 2004). Concerns about access to care among new immigrants have been raised before (Newbold 2005), and the evidence to date suggests that this difficulty might be caused by knowledge barriers such as not always knowing where to go to access services when needed (Neufeld et al. 2002; Steele et al. 2002; Wu et al. 2005). This hypothesis was confirmed through further analysis of the study data, which indicated that new immigrants were 10 times more likely than Canadian-born respondents to identify barriers related to personal circumstances, such as transportation, language, cost or lack of information about where to go for care.

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**... new immigrants were 10 times more likely than Canadian-born respondents to identify barriers related to personal circumstances, such as transportation, language, cost or lack of information about where to go for care.**

Our results clearly indicated that having a regular family physician had a protective effect against having problems accessing routine care but was not associated with difficulties obtaining immediate care. Respondents without a family physician were more than twice as likely to report that they had difficulties accessing routine care compared with those who had

a regular family doctor. Previous evidence demonstrates that having a regular doctor or regular source of care results in improved access to primary care services such as preventive care (Lambrew et al. 1996; Grumbach et al. 1993; DeVoe et al. 2003; McIssac et al. 2001) and reduces the inappropriate use of services such as emergency rooms (Dunlop et al. 2000; Sarver et al. 2002). In our study, respondents with a regular family doctor, however, were just as likely to face difficulties accessing immediate care as were those without a regular family doctor. This finding is supported by other research showing that even patients with a regular family doctor experience difficulties accessing urgent care when they need it (Love and Mainous 1999; Pereira and Pearson 2003; Mathews and Barnsley 2003). While it is important to have a regular family doctor, having one does not always guarantee that patients will have access to care for all types of services at all times. The study findings support the notion of changes to primary care that seek to expand patient access to a broader range of providers who are available outside routine office hours.

The data used in this study are based on self-assessments of need for first-contact services and of difficulties accessing routine and immediate care in the 12 months

leading up to the survey. This information, therefore, may be subject to recall bias and, in the case of medical needs, has not been clinically validated. Also, compared with the general CCHS population, the HSAS subsample was more educated and affluent. These differences may have influenced the reporting of need for first-contact services and, in turn, limited the generalizability of the findings to the Canadian population at large.

In conclusion, information regarding patients' experiences accessing healthcare services is needed to provide a more complete picture regarding access to care in Canada. The results of this study provide valuable insight regarding potential access to first-contact services. In addition to identifying factors associated with difficulties accessing care, the study also identifies population groups who may be more vulnerable to experiencing difficulties accessing specific types of first-contact services. This information can be used to guide future policy initiatives to improve patients' experiences in obtaining first-contact services in Canada.

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Correspondence may be directed to: Claudia Sanmartin, Senior Analyst, Health Analysis and Measurement Group, Statistics Canada, R.H. Coates Bldg., 24th Floor Section R, Ottawa, ON K1A 0T6; tel. 613-951-6059; fax: 613-951-3959; email: claudia.sanmartin@statcan.ca.

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