QUANTITATIVE RESEARCH

Does socio-economic status or having a chronic condition affect whether family physicians accept a new patient? A Nova Scotia population study

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ABSTRACT

OBJECTIVES: To determine whether socio-economic status (SES) and presence of a chronic condition are associated with the response a prospective patient receives when seeking a family physician (FP).

METHODS: Scripted telephone calls (indicating higher or lower SES and presence or absence of a chronic condition) were made to all 327 FP offices in Nova Scotia (NS) requesting an appointment. The main outcome measures were the responses to callers seeking a FP: being accepted for an appointment or being offered further assistance if not accepted (e.g., walk-in clinic, alternative provider, and telehealth), as well as the callers' perception of the experience as positive, negative, or neutral.

RESULTS: Only 9.9% of offices accepted callers as new patients. There were no statistically significant differences by SES or chronic condition in the proportion of calls resulting in an appointment. Callers indicating high SES were more likely to be provided further assistance than those with low SES ($p = 0.06$), and callers indicating a chronic condition reported a better overall experience than those without ($p = 0.03$).

CONCLUSION: First contact accessibility for prospective new patients was low across NS. Lower SES was associated with fewer offers of additional assistance than higher SES. This is particularly troubling since those with lower SES may need additional support as they may have less access to resources and networks that could provide support. This study signals the need to improve general and equitable accessibility to primary care providers.

KEY WORDS: Primary health care; general practice; chronic disease; social class; access to health care; health equity

La traduction du résumé se trouve à la fin de l'article.

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Primary health care accessibility is a key evaluation indicator for health care delivery in Canada,[1] which has a health care system that is legislated and designed to provide reasonable, universal access without financial or other barriers.[2] Primary health care is intended to be the first point of contact for people into the health system and to contribute to the health of the population beyond the provision of basic medical services; it should reflect and respond to public health information and work across sectors to improve population health and equity.[3] Regions with strong primary health care systems and, importantly, good access to those systems have better population-level health and health equity outcomes.[4]

Previous survey-based research suggests that primary health care in Canada is reasonably accessible; 85% of Canadians (and 89.4% of Nova Scotians) 12 years of age and older report that they have a regular medical doctor.[5] While overall Canadian attachment rates (i.e., patients with a regular family doctor) are generally high, internal health authority data in Nova Scotia (NS) indicate that unattachment is increasing, resulting in more requests of physicians to take on new patients. The question arises as to whether horizontal equity – equal treatment for equal medical need irrespective of other characteristics such as income, race, or place of residence – exists across subsections of specific types of patients:[6] namely, whether those with lower socio-economic status (SES) or a higher burden of chronic disease face increased challenges with first contact access.

SES, an indicator that represents social standing based on education, income, and occupation,[7] is a well-established determinant of health in Canada and in other jurisdictions with universal health care.[8,9] Low SES is associated with higher emergency department use[10,11] and lower access to preventive health services.[12–14] Importantly, there is a high burden of chronic disease among people with low SES,[15,16] and low SES is a risk factor for poor asthma-related health outcomes.[17,18] Further, there are known intersections of both chronic disease status and SES with other social determinants of health.[17,19,20] Primary care providers, including family physicians and nurse practitioners, are positioned

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to manage emergent medical diagnoses (including mental health), to prevent and manage chronic disease, and to assist patients with navigating structures that may affect their social determinants of health, such as housing and access to government-funded services.

With increasing rates of chronic disease and multi-morbidity of an aging population, access for people with chronic disease is a high priority. In a survey of patients with chronic conditions in four western Canadian provinces (Manitoba, Saskatchewan, Alberta, British Columbia), 10% reported having difficulty accessing primary health care, principally the initiation of care, which included difficulty contacting a doctor and difficulty getting an appointment.[21] Relatedly, lower SES is associated with poorer first contact access with general practitioners,[22,23] and people with higher SES are preferentially granted access to primary health care appointments.[24] Notably, low SES is associated with higher rates of hospitalization for chronic conditions that could be managed through outpatient care.[25–27] A qualitative investigation of unattached patients with low SES and chronic disease highlighted themes of participants feeling like undesirable patients because of unsuccessful attempts to find a regular provider and concerns about lack of access to preventive services and discontinuous medical records.[28]

OBJECTIVE

With historically high patient attachment rates in Canada and NS, very little is known about access to primary health care for unattached patients, including whether or not SES or chronic disease status is related to unattached patients' ability to get an appointment with a primary health care provider. Identifying possible horizontal inequities will be necessary for developing successful, targeted interventions to address growing rates of patient unattachment. Building upon previously developed methodology,[24] our study aimed to determine whether SES or the presence of a chronic condition is associated with the response a prospective patient receives when seeking a family physician in NS, Canada.

METHODS

In calls to 327 family physician offices, which represented all 760 family physicians in Nova Scotia, researchers played the role of a patient new to the area seeking an initial appointment. Using methods adapted by Olah et al.,[24] four trained callers followed one of four scripts (each caller conducted one quarter of the calls for each script) indicating either higher or lower SES and presence or absence of a chronic health condition (see Table 1).

The primary outcome was whether the caller was offered an appointment. Secondary outcomes included whether the respondent provided further assistance and whether the caller's perception of the experience was positive, neutral or negative. Further assistance was defined as a referral to any other service or provider. These referrals could include another family physician or nurse practitioner (including one from the same practice), a walk-in clinic, use of the 811 provincial telehealth phone line, or the health authority service to assist in finding a provider. The callers were instructed to consider how they felt about how the respondent spoke to them when determining whether their experience was positive, neutral, or negative.

Table 1. Caller scripts, indicating high or low socio-economic status (SES) and the presence or absence of a chronic condition

Patient scenario	Script
High SES No chronic condition	Hi. I was just transferred to [geographic area] with Scotia Bank and I need a family doctor for annual check-ups. Is Dr. _________ accepting new patients?
High SES Chronic condition	Hi. I was just transferred to [geographic area] with Scotia Bank and I need a family doctor. I have had trouble with my asthma. Is Dr. _________ accepting new patients?
Low SES No chronic condition	Hi. I'm calling 'cause my welfare worker thinks I need a family doctor for check-ups since I just moved back here. Is Dr. _________ taking new patients?
Low SES Chronic condition	Hi. I'm calling 'cause my welfare worker thinks I need a family doctor since I just moved back here. I have had trouble with my asthma. Is Dr. _________ taking new patients?

Responses were recorded in an Access database, and chi-square analyses were carried out using SPSS (v 21).

This study received the approval of the Capital District Health Authority (now the Nova Scotia Health Authority) Research Ethics Board.

RESULTS

Several offices (7%, $N = 24$) were unreachable despite five attempts on different days of the week at various times of day. Table 2 shows the results of the primary and secondary outcomes for each of the individual patient scenarios.

Among those calls that resulted in an appointment ($N = 30$, 9.9%), there were no statistically significant differences by SES ($p = 0.75$) or chronic condition ($p = 0.48$) alone. The results of the 4×2 chi-square analysis of scripts by acceptance were not statistically significant ($p = 0.54$). Overall, of callers accepted for an appointment, the majority were those playing the role of a patient with higher SES and a chronic condition (33.3%, $N = 10$), while the lowest percentage were those with higher SES and no chronic condition (16.7%, $N = 5$). The comparison of acceptance rates between these two scripts was not statistically significant ($p = 0.16$) (Figure 1).

In total, 65 offices offered assistance after declining a caller an appointment. This assistance was offered to 40 callers (61.5%)

Table 2. Results of telephone call by socio-economic status (SES) and chronic condition status

	Outcome		
	Practice accepted new patient	Practice offered other assistance	Caller had a subjectively positive experience
Total practices ($n = 303$)	9.9% (30)	21.5% (65)	34.7% (105)
Patient scenario			
High SES	5.0% (15)	13.2% (40)	19.5% (59)
Low SES	5.0% (15)	8.3% (25)	15.2% (46)
Chronic condition	5.6% (17)	10.6% (32)	21.1% (64)
No chronic condition	4.3% (13)	10.9% (33)	13.5% (41)

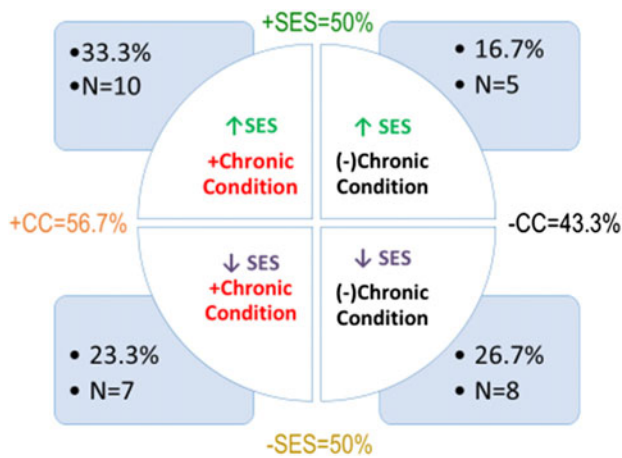

Figure 1. Number and percentage of patients offered an appointment, by socio-economic status (SES) and chronic condition (CC) status

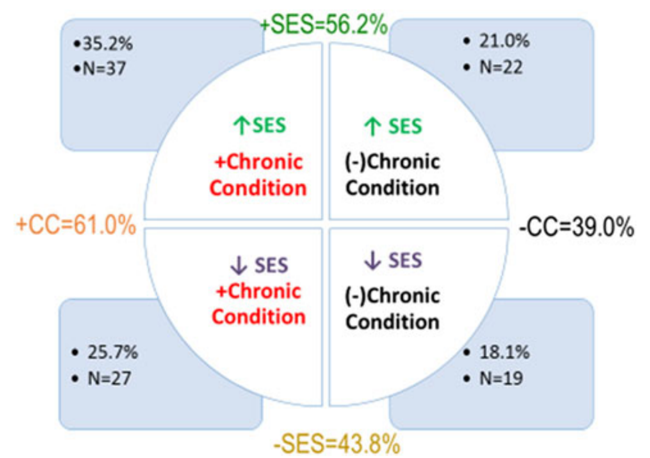

Figure 3. Number and percentage of patients reporting a subjectively positive experience, by socio-economic status (SES) and chronic condition (CC) status

playing the role of a patient with higher SES, as compared with 25 (38.5%) callers providing a lower SES background ($p = 0.11$). Further assistance was offered to 32 (49.2%) of those reporting a chronic condition vs. 33 (50.8%) ($p = 0.89$) of those not reporting a chronic condition (Figure 2).

Of callers who reported a subjectively positive experience, 56.2% ($N = 59$) played the higher SES role and 43.8% ($N = 46$) the lower SES ($p = 0.21$), and 61% ($N = 64$) reported having a chronic condition and 39% ($N = 41$) did not ($p = 0.03$) (Figure 3). There were no significant differences between chronic condition and SES for callers who reported negative experiences.

DISCUSSION

First contact accessibility for prospective new patients was very low across NS. Seven percent of offices were unreachable and, of those contacted, <10% offered an appointment to our callers. Although

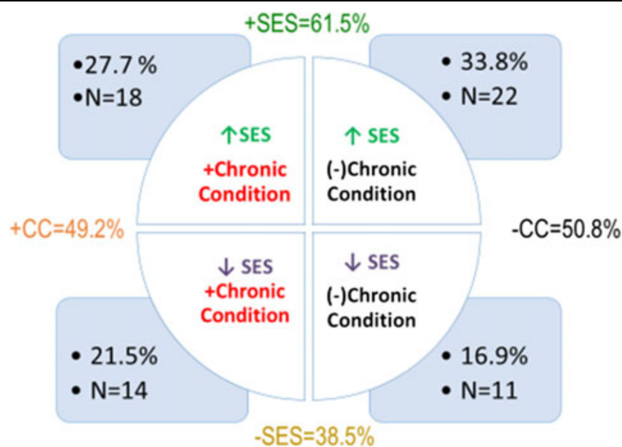

Figure 2. Number and percentage of patients offered further assistance after being declined an appointment, by socio-economic status (SES) and chronic condition (CC) status

there was a tendency for callers using the chronic condition scenario to be offered an appointment more often than those without, the small number of appointments offered in total limited our ability to observe statistically significant differences; a larger study population, possibly obtained through inquiring about every physician in the province and not just one in each practice, may have yielded statistical significance in these observed differences. However, the mechanics of contacting all physicians within offices were not possible in this study design because of repeating scenarios to the same receptionist. It should be noted that all offices in the province were contacted, so the results are not based on a sample and should be considered robust. None of the respondents offered the option of an appointment with a different provider in the same office, which might be expected if there was capacity within the practice. If a patient divulging a chronic condition increases the likelihood of being given a first appointment, it may be that in an environment of increasing provider scarcity providers are prioritizing prospective patients by perceived need. Although these data are not statistically significant, this observed result is aligned with results from a similar study in Ontario.[24]

The SES of the caller and presence of a chronic condition did influence whether callers were offered further assistance. Lower SES as compared with higher SES was associated with less additional assistance offered, which is particularly troubling, as those with lower SES and less access to other resources and networks may be in need of receiving additional support.

The presence of a chronic condition improved the experience of callers, in that the person answering the phone was perceived to be sympathetic, even if that person could not offer an appointment. The significance of this, while subjective, is indicative of two outcomes. First, from the perspective of prospective patients, who are likely making several calls to find a new primary care provider, the more pleasant experience may make them less likely to give up trying to find a provider if they divulge information about their personal health conditions. From the respondent's perspective, it appears that learning of a caller's health conditions may motivate a kinder response, even if a first appointment is not offered, further

indicating that these practices are indeed at capacity and front-desk staff do not have the ability to advocate for the admission of new patients.

This study was strengthened by the use of a list provided by the Nova Scotia Department of Health and Wellness of all practising family physicians, which was derived from provincial billing data. We called 327 offices, representing all 760 family physicians in the province; it is important to note that this was a census of family physician offices in the province rather than a sample. The results may be considered reflective of the population of primary care offices in NS without the hazard of sampling bias. Moreover, the methods were built on those of a previous study in Ontario,[24] with the improvement of identifying "asthma" as the chronic disease requiring care (rather than "back pain" and "diabetes" for the chronic condition scenario used in the Ontario study). The change to asthma avoids potential confounders that could be associated with conditions used for incentive billings (which are additional fees billed for care for diabetes, chronic obstructive pulmonary disease, and ischemic heart disease) or the potential reluctance for the prescribing of opioids for back pain or caring for a patient with addictions.

A limitation of our study is that our callers asked for an appointment with only one of the physicians per office and did not specifically ask if another physician at that office was available. This may over or underestimate the possible rate of providers accepting new patients (overall, or differentially across SES and chronic disease groups), depending on the responses of the remaining providers in the practices. Since most shared practices share receptionists, we assume that the receptionist would have offered an appointment with another provider in the practice, if one were available, as an alternative to the one the caller inquired about. However, the respondent never offered the option of making an appointment with an alternative provider at the same practice. Thus, it is possible that the rate of accepting new patients is even lower than reported here.

The findings of this study, especially the overall low (<10%) acceptance rate for patients seeking an appointment, signal the need to improve accessibility to primary care providers broadly. This could be accomplished through increasing the capacity of current providers plus adding more providers where necessary. Provider capacity may be improved by implementing an advanced access model, such as reserving 35% of appointments for advanced booking and leaving the other 65% open for same-day access.[29,30] Current trends of collaborative practice and interprofessional team care, such as the addition of a family practice nurse, may also help increase capacity. Offices that cannot take on new patients should aim to consistently provide information to prospective patients to assist them in finding other sources of primary care, which could include local registries for unattached patients, listings of other providers accepting new patients, location and contact information of local walk-in clinics, and referral to telehealth services.

With a key finding being that a minority of callers, regardless of SES or chronic condition, reported positive experience of their call to book an appointment, a program to address awareness and training for primary health care reception on how to manage prospective patient calls may be beneficial. Since having a regular primary care provider is associated with better outcomes for patients and lower costs to the health care system overall, it would behoove us to ensure that the process of finding a provider does not discourage prospective patients to the point at which they abandon the task.

To equitably increase patient attachment rates, more research is needed to understand the possible inequities in first contact access. This study showed non-significant but emerging trends that callers with lower SES may be less likely to receive additional support and more likely to have a negative experience in seeking health care; furthermore, having a chronic condition may be a facilitator for access to primary health care. Further quantitative and qualitative research is needed into the specific demographics, needs, and outcomes of local unattached patient populations. Additionally, a qualitative study of front-desk reception staff in primary care settings might help us understand the system-level factors and individual perspectives that influence how prospective patient calls are handled. This could include individual interviews with reception staff as well as a participant observational study. In the meantime, it is imperative that front-line care providers, support staff, and primary health care policy-makers work to provide a first-come first-served approach to accepting new patients, regardless of SES or chronic condition, and offer referral services as needed.

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RÉSUMÉ

OBJECTIFS : Déterminer si le statut socioéconomique (SSE) et la présence d'un état chronique sont associés à la réponse reçue par un patient éventuel qui cherche un médecin de famille (MF).

MÉTHODE : Des appels téléphoniques scriptés (mentionnant un SSE élevé ou faible et la présence ou l'absence d'un état chronique) ont été placés auprès des 327 cabinets de MF de la Nouvelle-Écosse pour demander un rendez-vous. Les principaux indicateurs de résultat étaient les réponses données aux personnes ayant appelé pour demander un MF : l'offre d'un rendez-vous, l'offre d'assistance supplémentaire si un rendez-vous n'était pas disponible (p. ex. service de consultation sans rendez-vous, autre dispensateur, ligne télésanté) et la perception de l'expérience (positive, négative ou neutre) par la personne ayant appelé.

RÉSULTATS : Seulement 9,9 % des cabinets ont dit accepter de nouveaux patients. Il n'y a eu aucun écart significatif selon le SSE ou l'état chronique dans la proportion d'appels ayant donné lieu à un rendez-vous. Les personnes ayant appelé en mentionnant un SSE élevé ont été plus susceptibles de se faire offrir de l'assistance supplémentaire que celles ayant mentionné un faible SSE (p = 0,06), et les personnes ayant appelé en mentionnant un état chronique ont dit avoir eu une meilleure expérience dans l'ensemble que celles n'ayant pas mentionné d'état chronique (p = 0,03).

CONCLUSION : L'accessibilité au premier contact pour les nouveaux patients éventuels était faible partout en Nouvelle-Écosse. Le faible SSE était associé à un moins grand nombre d'offres d'assistance supplémentaire que le SSE élevé. C'est particulièrement troublant, car les personnes de faible SSE peuvent avoir besoin d'aide supplémentaire; en effet, elles peuvent avoir moins accès aux ressources et aux réseaux susceptibles de les appuyer. L'étude indique qu'il est nécessaire d'améliorer l'accessibilité en général et l'équité d'accès aux dispensateurs de soins primaires.

MOTS CLÉS : soins de santé primaires; médecine générale; maladie chronique; classe sociale; accès aux soins de santé; équité en santé