

PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (<http://bmjopen.bmj.com/site/about/resources/checklist.pdf>) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

TITLE (PROVISIONAL)	Sociodemographic differences in patient experience with primary care during COVID-19: results from a cross-sectional survey in Ontario, Canada
AUTHORS	Agarwal, Payal; Wang, Ri; Meaney, Christopher; Walji, Sakina; Damji, Ali; Gill, Navsheer; Yip, Gina; Elman, Debbie; Florindo, Tiffany; Fung, Susanna; Witty, Melissa; Pham, Thuy-Nga; Ramji, Noor; Kiran, Tara

VERSION 1 – REVIEW

REVIEWER	Patel, Kunal Centre for Health and Social Care Research, London
REVIEW RETURNED	05-Oct-2021

GENERAL COMMENTS	<p>General:</p> <ul style="list-style-type: none">• Overall, I liked reading this paper. I have made some major points below and some specific ones. The paper gives great insight to what patient's have experienced in the GTO area during the pandemic. I would strongly suggest that this is NOT a paper about virtual technologies and their use, but rather the 'patient experience' to health access. The paper should be re-written with less focus on 'virtual' and more on this – would even suggest a title change. If based on the 'experience' which the authors actually emphasize in their writing, this would be a stronger paper. The virtual aspect is a side piece. E.g a paper on the patient experience in the GTO and how it affected access to the primary care provider, based on this data is more relevant considering what we are reading.• It would be good to know at what phase of the pandemic this data relates to? Yes, you mention the months of collection, but how does this relate to what was actually happening in the GTO at the time? This is an important discussion point and limitation – would the data be the same now or at different points of the pandemic or even very early on? Would it be different pre and post vaccine availability? Points to consider.• Be very clear that your 'patient' experience' is profoundly different to the majority of people during the pandemic. Key word - pandemic, i.e global. Therefore, you must distinguish this work in the context of wealthy society and western medicine, as it cannot really be applied to other parts of the globe yet. This is particularly the case as you look at socio-demographic factors, which vary globally but also within Canada e.g urban vs rural in Canada – did you consider this?• Concerned that telephones are being considered virtual care here. There are clear differences between virtual care, telephone calls and even telehealth. It is not clear how telephone data and use can be counted in a paper focusing on virtual care? E.g
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	<p>Europe, during the pandemic has really utilized basic telephone calls as well as telehealth (video calls) and virtual where the budget allows – so, can the authors justify counting normal telephone calls as ‘virtual’. I do not think so and this needs to be corrected.</p> <p>Specific:</p> <ul style="list-style-type: none"> • Important to hear about the demographics and economic situation in the areas that were studied. As this is an urban study, would be good to provide this context, therefore explaining why these three regions have such data. E.g some of the regions are much higher in population in terms of ethnicity and immigrants, how does this affect what you saw? E.g Markham. We know, from previous data that being from the BAME population, you are at higher risk of COVID but also have more difficulties in terms of health access -this must be discussed further. • P8 line 10 – note that health systems with good technological structures and funding were able to move to virtual. The majority of the world could not and has not, namely some countries in the middle east, many countries in sub-saharan Africa and SE asia and some in latin America. Therefore it is not the majority, but rather well funded, predominantly western based health systems. • Introduction – define what is considered virtual care? Major point: is the telephone really virtual care? Many in digital space would distinguish telephone from virtual, as telephone technology has been around for decades, virtual not so much. So what does this paper mean by virtual and therefore can telephone data really count? • P9 line 10 – experiences • P10 line 45 – you use the present tense here indicating the survey is already in use (is emailed every quarter) – if so, tell the reader more about the survey, what is it? What is its purpose? How has it been validated? If you created this survey yourselves, how did you validate it? • P11 line 20 – why French? I thought this was the GTO area? If so, this needs to be justified as to why this data was counted, as it can be an anomaly amongst the rest, as they are all English based surveys • Ethics statement – you should publish your ERB number to show that this was actually ethically approved
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REVIEWER	Kemp, Emma Flinders University, FHMRI
REVIEW RETURNED	01-Nov-2021

GENERAL COMMENTS	<p>Peer review ‘Sociodemographic differences in patient experience with virtual care during COVID-19’</p> <p>Thank you for the opportunity to review this manuscript, for which I find the topic to be particularly relevant to considerations in health care during the pandemic and post-pandemic era.</p> <p>The manuscript is well written from the abstract onwards.</p> <p>The introduction clearly outlines relevant background and sensibly leads to the research gap and objectives of the study. References are relevant and up to date.</p> <p>The methods section of the paper is thorough and clearly outlines all information needed to be able to appraise the study.</p> <p>Results are well written, and tables are well set out. As a small improvement, it would help the reader to follow the tables better if</p>
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	<p>there was some indication in the tables of which demographic categories were significantly associated with lower/higher levels of visits, endorsement of modalities, etc., than the categories – this is explained thoroughly in text, but it may be helpful to have this indicated in the table, e.g., by bolding these categories.</p> <p>The discussion appropriately interprets study results, and offers a reasonable explanation for higher use but lower comfort with virtual modes of delivery among those with financial issues and in poor health, i.e., despite the increased necessity of using these modalities to access health care, these patients were uncomfortable with these modalities compared with other patients. Suggested directions for further research exploring reasons why this is the case are appropriate, particularly the emphasis on factors other than technology access.</p> <p>A particular strength of this study is the large sample size. The authors have correctly identified the limitations relevant to generalizability including English language and mode of delivery (email); while these could be of concern, I agree that the fact that demographics confirm a diverse sample, in addition to the large sample size, means that results of this study are remain important and relevant considering there is still representation of sociodemographic diversity. The authors have correctly identified that reported results may be an underestimate of true differences. An additional limitation that may be worth pointing out is that using self-reported financial issues as an indicator of financial status could miss those who are not willing to identify as having financial issues, even if they are experiencing financial stress.</p> <p>Overall, this paper is a well written and helpful addition to the literature on digital health equity.</p>
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VERSION 1 – AUTHOR RESPONSE

Reviewer #1

Feedback	Response
<p>The paper should be re-written with less focus on ‘virtual’ and more on this – would even suggest a title change. If based on the ‘experience’ which the authors actually emphasize in their writing, this would be a stronger paper. The virtual aspect is a side piece. E.g., a paper on the patient experience in the GTO and how it affected access to the primary care provider, based on this data is more relevant considering what we are reading.</p>	<p>We have edited the paper based on this helpful comment. The title of the paper has been changed to “Sociodemographic differences in patient experience with primary care during COVID-19” to emphasize the focus on the patient experience.</p> <p>We have also adjusted the introduction and conclusion to further highlight the papers focus on patient experience.</p>
<p>It would be good to know at what phase of the pandemic this data relates to. Yes, you mention the months of collection, but how does this relate to what was actually happening in the GTO at the time? This is an important</p>	<p>We have clarified in the Study Population and Recruitment section that the survey responses were collected during the first wave of COVID-19 in the GTA region.</p>

<p>discussion point and limitation – would the data be the same now or at different points of the pandemic or even very early on? Would it be different pre and post vaccine availability? Points to consider.</p>	<p>The limitation section states that the survey responses only reflect experiences during the early stages of the pandemic, and preferences may have evolved over time.</p>
<p>Be very clear that your ‘patient’ experience’ is profoundly different to the majority of people during the pandemic. Key word -pandemic, i.e., global. Therefore, you must distinguish this work in the context of wealthy society and western medicine, as it cannot really be applied to other parts of the globe yet. This is particularly the case as you look at socio-demographic factors, which vary globally but also within Canada e.g., urban vs rural in Canada – did you consider this?</p>	<p>We have clarified in the Limitations section that are results are not reflective of the experience of patients in low resource settings.</p>
<p>Concerned that telephones are being considered virtual care here. There are clear differences between virtual care, telephone calls and even telehealth. It is not clear how telephone data and use can be counted in a paper focusing on virtual care? E.g., Europe, during the pandemic has really utilized basic telephone calls as well as telehealth (video calls) and virtual where the budget allows – so, can the authors justify counting normal telephone calls as ‘virtual’. I do not think so and this needs to be corrected.</p>	<p>We have edited our introduction to specify that virtual care includes phone, video and secure messaging. We have added several references that support a definition that includes telephone as part of virtual care.</p>
<p>Important to hear about the demographics and economic situation in the areas that were studied. As this is an urban study, would be good to provide this context, therefore explaining why these three regions have such data. E.g., some of the regions are much higher in population in terms of ethnicity and immigrants, how does this affect what you saw?</p>	<p>We have edited the section on Study design and setting, to describe the demographics of the GTA region.</p>
<p>P8 line 10 – note that health systems with good technological structures and funding were able to move to virtual. The majority of the world could not and has not, namely some countries in the middle east, many countries in sub-Saharan Africa and SE Asia and some in Latin America. Therefore, it is not the majority, but rather well funded, predominantly western based health systems.</p>	<p>Based on this helpful comment, we have amended this sentence in the Introduction, to specify that the shift to virtual care happened in developed nations.</p>

Introduction – define what is considered virtual care? Major point: is the telephone really virtual care? Many in digital space would distinguish telephone from virtual, as telephone technology has been around for decades, virtual not so much. So, what does this paper mean by virtual and therefore can telephone data really count?	We have clarified our definition of virtual care for this paper, including telephone use, and added references to support this definition.
P9 line 10 – experiences	We have edited “experience” to “experiences”.
P10 line 45 – you use the present tense here indicating the survey is already in use (is emailed every quarter) – if so, tell the reader more about the survey, what is it? What is its purpose? How has it been validated? If you created this survey yourselves, how did you validate it?	We have added more detail in Study Design and Survey Design section to clarify that the survey is an ongoing survey designed to jointly support QI efforts across clinics. The Survey Design section lists the existing surveys that informed our survey design, and the iterative development process we used.
P11 line 20 – why French? I thought this was the GTO area. If so, this needs to be justified as to why this data was counted, as it can be an anomaly amongst the rest, as they are all English based surveys	We have clarified in the Study design and setting section that one of the clinics included in the study provides services in both French and English.
Ethics statement – you should publish your ERB number to show that this was actually ethically approved	This initiative was formally reviewed by institutional authorities at Unity Health Toronto and deemed to neither require Research Ethics Board approval nor written informed consent from participants.

Reviewer #2

Feedback	Response
As a small improvement, it would help the reader to follow the tables better if there was some indication in the tables of which demographic categories were significantly associated with lower/higher levels of visits, endorsement of modalities, etc., than the categories – this is explained thoroughly in text, but it may be helpful to have this indicated in the table, e.g., by bolding these categories.	The p-values provide readers with insight into which demographic variables have statistically significant differences between categories. We are unable to provide additional granularity in the table based on the statistical approach used.

<p>An additional limitation that may be worth pointing out is that using self-reported financial issues as an indicator of financial status could miss those who are not willing to identify as having financial issues, even if they are experiencing financial stress.</p>	<p>The results section and tables show the response rates for participants who chose not to specify if they have financial difficulties.</p> <p>We have added more detail to the discussion section, highlighting that those who responded “don’t know/prefer not to answer” when asked about financial difficulties, have response trends similar to those who endorsed financial troubles, when asked about virtual care.</p>
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VERSION 2 – REVIEW

REVIEWER	Patel , Kunal Centre for Health and Social Care Research, London
REVIEW RETURNED	09-Mar-2022

GENERAL COMMENTS	<p>Reads as an interesting paper and the authors have addressed the reviewers concerns. An interesting paper that provides a perspective of how demographics, in the Canadian setting have affected health access.</p> <p>Just some typo/grammar errors, so paper needs to be checked again, some examples below:</p> <p>p6 -, which was send to patients with birthday during - presume this should be birthdays? also maybe be more scientific and state 'a date of birth' rather than 'birthday'</p> <p>p12 - our experience data? is it our experience or our data?</p>
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REVIEWER	Kemp, Emma Flinders University, FHMRI
REVIEW RETURNED	06-Mar-2022

GENERAL COMMENTS	<p>This paper is a well written and helpful addition to the literature on digital health equity. The authors' minor revisions have improved this paper and I have no further comments to add to my previous review.</p>
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VERSION 2 – AUTHOR RESPONSE

Dear Ms. Amy Branch-Hollis,

We are glad that the reviewers were pleased with our previous revisions. We have gone through the document to correct the grammar and typos as per the second reviewer’s suggestion and updated the title according to the journal’s preferred format.

Thank you again for considering our manuscript for publication in BMJ Open. We look forward to hearing from you soon.