Unmet Needs for Primary Care in a Context of Universal Healthcare System: The Case of Québec

Background Access to care in a universal health care system depends on need rather than income or wealth. Although healthcare is the responsibility of the provinces in Canada, the federal government set mechanisms to warrant universal access nationwide. Exploratory analysis of the Canadian Community Health Survey (2002) confirms that ability to pay does not constitute a major barrier to access, while other predisposing factors and characteristics of the health system service delivery (waiting time, untimely care) still constitute significant barriers to satisfactory access to health care when needed.

Descriptive studies show that in Quebec, one in five individuals (19%) of those who required routine care experienced difficulties accessing care (Sanmartin et al. 2004). Among all provinces Québec has the lowest rate (76% According to results of the 2003 Health Service Access Survey) of access to a family physician, and a higher proportion than in most provinces experience difficulties accessing routine and immediate health care for minor health problems. Although access to specialized service and non-emergency surgery is comparatively free of difficulties in Québec, the province has the lowest proportion of Canadians accessing a specialized service and non-emergency surgery.

Analytical studies which aim to identify the determinants of access to healthcare in Quebec are rather rare compared to other provinces. Research focused on the case of Ontario, for example, raised concerns about preferential access to specialized care. Access to cardiovascular and specialist care is claimed to be income dependent (Dunlop et al. 2000), and access to invasive cardiac procedures dependents on neighbourhood income (Alter et al. 1999). Although contested on a methodological ground (Finkelstein 2001) these findings fed the debate about the healthcare system. The Canadian Medical Association (CMAJ editorials 1999), for example, made reference to these findings to point out to small cracks in the Canadian healthcare though the system overall is characterised as an equitable edifice.

Given its size and the composition of its population, the health regions of Québec constitute an ideal setting for analytical studies that contribute to fill the gap in health research about health behaviour, and health services especially targeting vulnerable persons and social groups.

Objectives and conceptual framework Referring to the behavioural model of access to healthcare as conceptual framework (Fig. 1), we analyse self-reported unmet needs for care in Québec with special focus on elderly population. Based on the philosophical assumption that access to healthcare is a human right (Kehrer 1972), Andersen (1968) developed the behavioural model of access to healthcare. Since its inception, the behavioural model of access stimulated a plethora of empirical studies and access to healthcare and health services utilization in the US and Canada. Although its predictive power has been criticized (Rundall 1981), theses works led to substantial changes and extension of the model that increased its complexity and comprehensiveness. In its current formulation, the model provides a powerful analytical tool to disentangle the causal relationships between health outcome and the covariates. We refer to this model

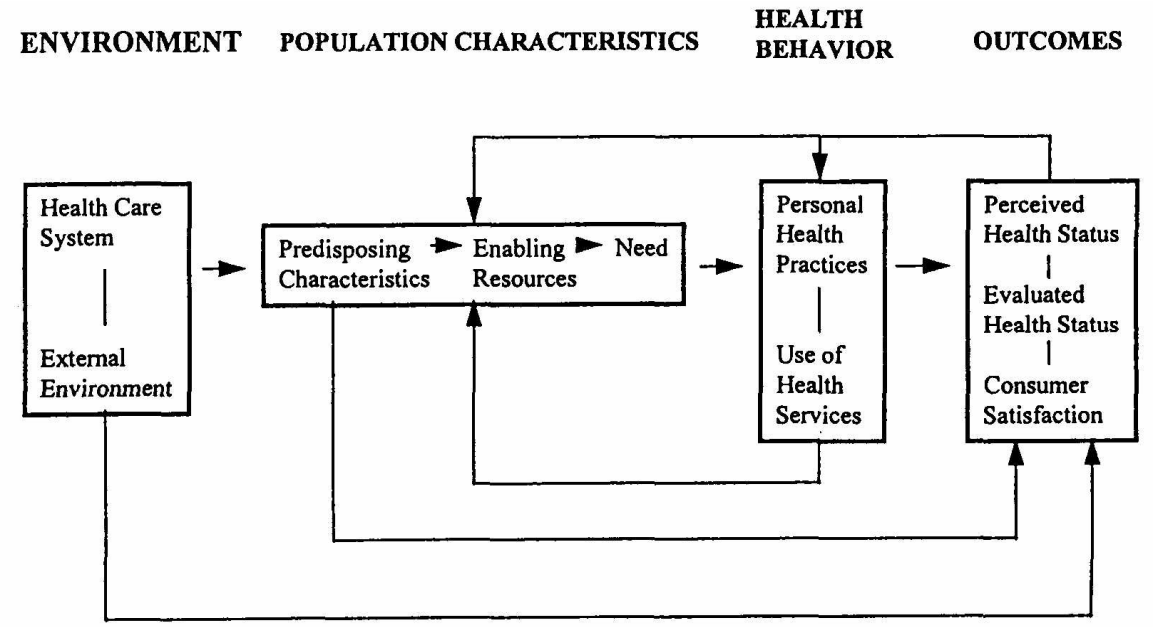
to select, define, and operationalize our outcome and explanatory variables, and select the appropriate methods of statistical analysis.

Data Data for this study come from three sources. Individual level data come from the Canadian Community Health Survey, cycle 2.1 (2003). CCHS provides data for health regions across Canada. It includes information on a wide range of topics, including general health and use of health services. It also provides information on the socio-demographic characteristics of the population. The sub-sample we extracted for the health regions of Québec is composed of 27599 respondents aged 12 years or older, residing in households. The aggregated data come from the census 2001 of Canada and provide the socio-economic characteristics of the health regions. The province's health service also provides few but pertinent population indices such as the Pompalon's deprivation index. We combine data from all three sources to create a dataset suitable for multilevel analysis.

Methods The descriptive part of this work consists in providing socioeconomic profiles of Québec's health regions, followed with the characteristics of the individuals based on survey data. The analytical work consists in modeling unmet needs for routine and primary care as binary outcomes using the hierarchical dataset we construct from census and survey data. A series of logistic regressions models are fitted to the data to test the significance of barriers to access.

Expected results A salient feature of social life in Québec is the co-existence of several ethnic and linguistic communities under an integrating social policy that warrants universal coverage of necessary medical care needs. This integrated diversity provides an ideal setting for testing hypotheses about non-financial barriers to access. We expect this study to yield results that point to promising paths for further investigations.

Figure 1: The Behavioral Model of Access to Healthcare



Source: Andersen 1994, p. 8

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