DO NEW AND TRADITIONAL MODELS OF PRIMARY CARE DIFFER WITH REGARD TO ACCESS? (PUBLICATION)

BAUKJE MIEDEMA, JULIE EASLEY, ASHLEY E. THOMPSON, ANTOINE BOIVIN, KRIS AUBREY-BASSLER, ALAN KATZ, WILLIAM E. HOGG, MYLAINE BRETON, DANIÈLE FRANCOEUR, SABRINA T. WONG, WALTER P. WODCHIS

CONTEXT

Over the past decade, primary care (PC) has undergone substantial changes that vary among provinces in Canada. In some provinces, reformed models of PC have been widely adopted based on different funding models, whereas other regions have retained more traditional models of PC such as fee-for-service and solo practices. Despite the lack of consistency among the various models across the provinces, many reformed models prioritize working collaboratively with other PC physicians or health care providers to enhance integration and coordination of care. A few studies have compared reformed and traditional models of care; however, it is not clear if patients or providers perceive one model more favourably than another.

OBJECTIVES

This study aimed to examine access to primary care in new (reformed) and traditional models using 2 dimensions of conceptualization of access to PC: availability, accommodation and affordability. Levels of physician involvement in the patient's overall health and well-being was also assessed.

METHODS

An international survey examining the quality and costs of primary health care (the QUALICOPC study) was conducted in 2013 and 2014 across the 10 provinces in Canada. Each participating practice filled out the Family Physician Survey (FPS) and the Practice Survey (PS), and patients in each participating practice were asked to complete the Patient Experiences Survey (PES). One question from the FPS was used to assess whether the participating physicians practised in a new or traditional model of care. There were 17 items from the PES and the PS that measured the availability & accommodation dimensions (e.g., opening hours too restricted, difficulty seeing the family doctor during evenings, nights, and weekends, etc.). Five items from the PES measured affordability (e.g., difficulty to get health care because could not leave work, could not afford tests or examinations, etc.). Finally, 5 items on the PES measured physician involvement (e.g., patients were involved in treatment decisions, doctor also focussed on personal non-medical problems, etc.).

FINDINGS

Of the 759 practices, 407 were identified as having new models of care and 352 were identified as traditional. New models of care were distinct with respect to payment structure, opening hours, and having an interdisciplinary work force. Although there was no difference between the new and traditional models of care with regard to affordability, patients in new models of care practices reported easier access to other physicians in the same practice, whereas patients from traditional models reported seeing their regular family physicians more frequently. Patients attending practice under new models of care reported higher involvement in their treatment plans and physician interest in patients overall health and well-being.

CONCLUSIONS

Access to PC is an important component of the health care system and good access to PC continuously translates into better health outcomes for the population. The current findings reveal that physicians who practise under the new model of PC were distinct from those who did not. However, this did not translate into better access for patients, although there were some differences between the 2 types of practices. Hence, we can conclude that despite the different models of PC, patients who have PC physicians have similar experiences and report excellent involvement of those physicians.

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