Centre for
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Primary Health Care Experiences and Preferences: Research highlights

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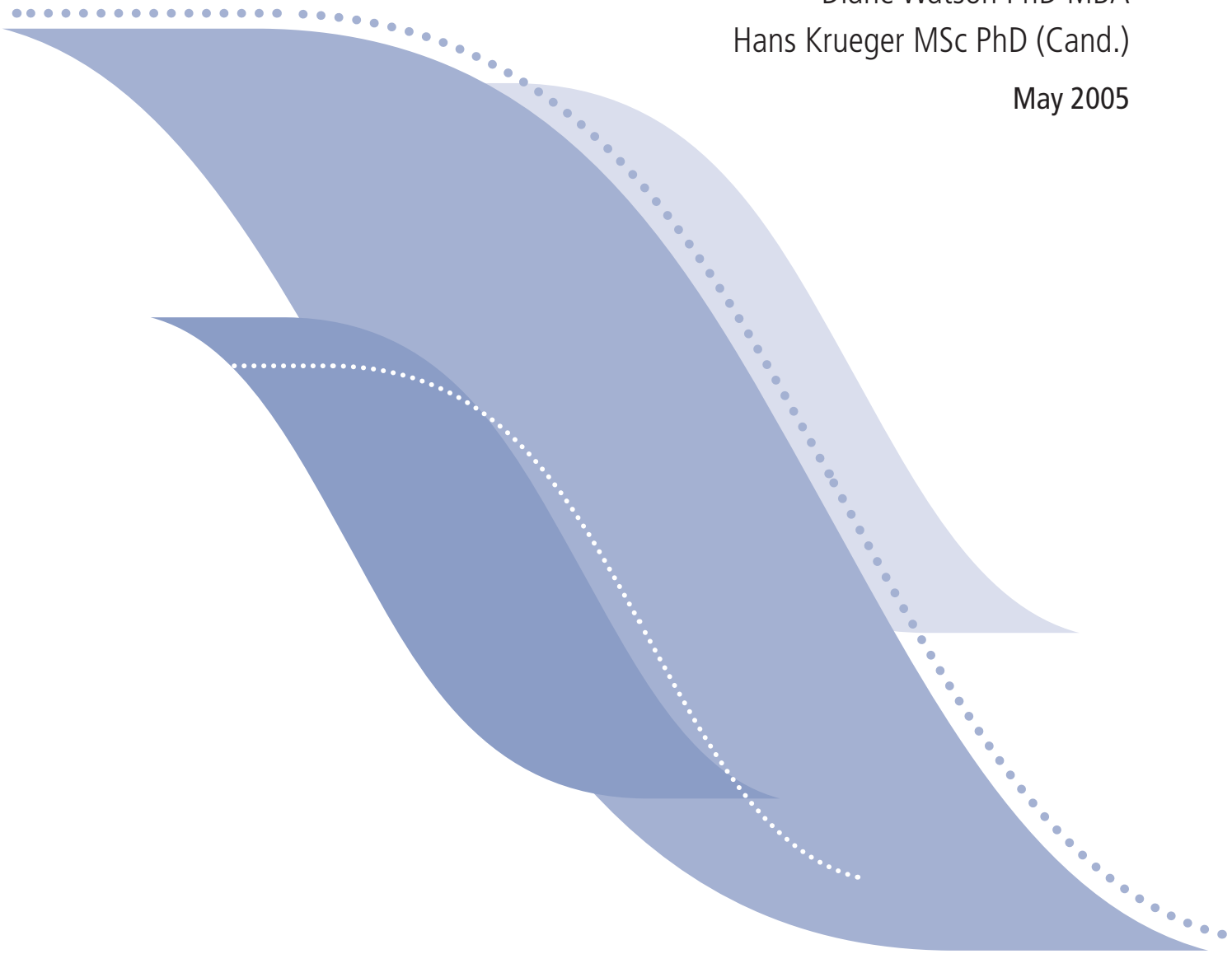

College of Health Disciplines
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About CHSPR

The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based at the University of British Columbia. CHSPR's mission is to stimulate scientific enquiry into issues of health in population groups, and ways in which health services can best be organized, funded and delivered. Our researchers carry out a diverse program of applied health services and population health research under this agenda.

CHSPR aims to contribute to the improvement of population health by ensuring our research is relevant to contemporary health policy concerns and by working closely with decision makers to actively translate research findings into policy options. Our researchers are active participants in many policy-making forums and provide advice and assistance to both government and non-government organizations in British Columbia (BC), Canada and abroad.

CHSPR receives core funding from the BC Ministry of Health Services to support research with a direct role in informing policy decision-making and evaluating health care reform, and to enable the ongoing development of the BC Linked Health Database. Our researchers are also funded by competitive external grants from provincial, national and international funding agencies.

Much of CHSPR's research is made possible through the BC Linked Health Database, a valuable resource of data relating to the encounters of BC residents with various health care and other systems in the province. These data are used in an anonymized form for applied health services and population health research deemed to be in the public interest.

CHSPR has developed strict policies and procedures to protect the confidentiality and security of these data holdings and fully complies with all legislative acts governing the protection and use of sensitive information. CHSPR has over 30 years of experience in handling data from the BC Ministry of Health and other professional bodies, and acts as the access point for researchers wishing to use these data for research in the public interest.

For more information about CHSPR, please visit www.chspr.ubc.ca.

Executive Summary

Across the nation, there have been substantive investments and activities to renew primary health care in response to factors such as growing concerns among Canadians and health care providers. One key ingredient to renewal efforts is information about the expectations and preferences of key stakeholders, particularly citizens and family physicians.

This document is intended to highlight evidence from across Canada to help primary health care decision makers identify priorities for local research on the expectations and preferences of citizens for the organization of primary health care; the expectations and preferences of family physicians on models of delivery; and ongoing temporal shifts in patterns of use and delivery of primary health care.

Citizen experiences and societal expectations:

- Canadians are increasingly concerned about access to primary health care.
- Canadians are concerned about quality of primary health care.
- Canadians expect specific changes to primary health care.

Family physician experiences and preferences:

- The population to physician ratio has stabilized.
- About half of Canada's doctors are in family practice, but the physician workforce is becoming increasingly specialized.
- There are fewer and fewer medical students interested in family practice.
- The physician pool is aging and there are few younger family physicians.
- The number of female family physicians is increasing.
- The majority of family doctors are paid on a fee-for-service basis, but this reality is shifting.
- Experiences and preferences for different methods of remuneration are tied to age and, to a lesser extent, gender.
- Family physicians now prefer blended models of remuneration.
- Interdisciplinary collaboration is increasingly being considered as a way to address perceived primary health care provider supply gaps.
- Family physicians mainly work in an office setting and are increasingly practicing in groups.
- Family practices are increasingly unavailable to new patients.
- Younger family physicians are providing fewer services per annum and older family physicians are providing more.
- Family physicians work long hours, but there has been a modest decline in their work week.
- Family physicians are reducing the comprehensive scope of services they once delivered.
- Many family physicians are satisfied with their professional life, but fewer are satisfied with their relationships with other providers or the balance between personal and professional committments.
- Middle-aged physicians are more dissatisfied with their professional life and the balance between work and personal life.
- Family physicians have been dissatisfied for some time.

Citizen Experiences and Societal Expectations

Canadians want to be included in important public policy decisions

- Based on various "citizen dialogues" regarding health policy there is strong evidence that Canadians' "views on accountability (are) linked to their faltering trust in governments and others in positions of power. They call for greater transparency in decision making and greater inclusion of the public in helping make those decisions… they do want a space where their voices can be heard, along with stakeholders and experts" (**1**, p. iv).

Canadians are increasingly concerned about access to primary health care

- In 2001, 15% of Canadians who had used health care services in the previous year reported that they were sometimes unable to obtain such services when they needed them. In 1989, 2% of citizens reported these concerns (**9**).
- In 2001, 88% of Canadians reported having a family physician. Among those who did not have a family physician, 63% indicated they had not tried to contact one and 29% cited reasons related to physician availability (**18**). In 2003, 86% of Canadians reported having a family physician (**14**).
- In 2001, 11% of Canadians reported difficulty accessing routine care and 19% had difficulty accessing immediate care for a minor health problem. In 2003, 16% reported difficulty accessing routine care and 24% had difficulty accessing immediate care for a minor health problem (**14, 18**).

- In 2001 and 2003, the top four barriers to accessing immediate care for a minor health problem during regular hours were getting an appointment, lengthy waits in offices, waiting too long for an appointment and contacting a physician. Performance in all these areas declined between 2001 and 2003 (**14, 18**).
- In 2003, only 48% of Canadians reported being satisfied with access to care in the community and 43% were satisfied with the timeliness of that access (**13**).
- In 2004, 86% of Canadians felt there was a shortage of doctors (**13**).

Canadians are concerned about quality of primary health care

- In 2001, 53% of Canadians who had a regular family physician reported that the quality of care they received was excellent. An additional 39% rated their care as good

and 7% reported that it was fair or poor (**18**).

- In 2004, 68% of Canadians in an international survey rated the quality of care received from their primary care doctor as excellent or very good. This compares to 74% in New Zealand, 71% in Australia, 64% in the UK and 61% in the US (**15**).

Table 1: Citizens' experience in five countries with access and quality of primary care (% and Canada's rank in brackets).

Quality of Care	Can	Aus	NZ	UK	US
Good access outside of weekdays	29 (3)	25	46	30	23
Physician listens carefully	66 (4)	71	74	68	58
Physician takes enough time	55 (4)	63	66	58	44
Physician clear about diagnosis, etc.	70 (3)	73	73	69	58
Physician clear about treatment	55 (3)	61	59	52	45
Physician invites input	36 (3)	43	41	27	29

- In 2004, satisfaction with access and quality was moderate to low (**15**). (Table 1)

Canadians expect specific changes to primary health care

- In 2002, when asked to deliberate about various options to sustain their health care system, Canadians recommended interdisciplinary teams to provide more coordinated primary health care, and that they be supported by a central information system (**8**). These deliberations also suggested that:
- Canadians are attracted to the idea that primary health care teams would not only provide more coordinated, cost-effective care, but also that such teams would have a greater incentive to focus on wellness, prevention and patient education. They understand this will require changes in the behaviour of citizens, providers and governments (**8**).
- Canadians see the team approach, led by doctors, as the "centrepiece of the health care system" because it would be "responsive to individual needs, structured to emphasize wellness and prevention, and would offer integrated and coordinated care through a team of various professionals" (**8**, p. 32,37).
- Canadians identify interdisciplinary teams as the solution to the current challenge of finding a family doctor and "some hoped that a supportive and collegial team would reduce the burden on doctors, prevent burnout, and encourage health professionals to locate and stay in rural and remote areas." Through teams, Canadians expect professionals to share, criticize and use data and information, and thereby attain efficiency gains in the health system (**8**, p . 37).

- A majority of Canadians (74%) would prefer that their family doctor work as part of a team rather than practice on his/her own (**9**).
- Canadians report that they would be satisfied seeing a general or specialized nurse, who works with a doctor, for routine health care services (e.g. ear or throat infections, immunizations), to manage diabetes or monitor high blood pressure, and to check progress on a surgical wound (**9**).
- In 2003, Canadians strongly supported (70%) the idea of collaborative care, defined as "a team including a doctor, nurse, pharmacist, or other health care provider who would collectively provide care" (**13,** p. 25). They also expressed the belief that collaborative care would improve quality of patient care (73%) and expedite access to care (69%), but they are not clear on how collaborative care will change the costs of service delivery (**13**).
- In 2004, fully 86% of Canadians supported requiring health professionals to work in teams; as well, 69% favoured requiring people to register with one doctor (**13**).

Family Physician Experiences and Preferences

We will use the Results-Based Logic Model for Primary Health Care to structure the descriptive analyses of the experiences and preferences of family physicians in Canada.

This model is available at www.primary-care.chspr.ubc.ca.

Health Human Resources

The population to physician ratio has stabilized

- In the course of the 1990s, perceptions about physician supply shifted almost overnight from surplus to shortage (**5**). This is striking in light of the fact that the ratio of supply in 2003 (477 population per physician) was virtually the same as in 1993 (467 population per physician), and that the ratio has actually declined dramatically over the longer term (**4**). Clearly, there are reasons for concern that these ratios do not illuminate (**21**).

About half of Canada's doctors are in family practice, but the physician workforce is becoming increasingly specialized

- In 2001, there were approximately 29,000 family physicians in Canada. This represents 51% of physicians, down from 53% in 1993. This level of supply is similar to that of France and Australia, but well above the US and Germany (20-30%) (**3**).
- Medical students are increasingly selecting careers as specialists. The proportion of family physicians among those entering practice in the early 1990s was about 80%; in 2000, it was about 45% (**5**, p. 20).
- The decreasing pool of family physicians may have unintended consequences. Recent research has shown that population health is better in communities that have a higher proportion of primary care physicians relative to specialists (**17**).

There are fewer and fewer medical students interested in family practice

- In 2002, there were 428 first-year training positions in family medicine. While most were filled, fewer than 30% of graduates indicated that this area of medicine was their first choice (**3**).
- In 2002, 20% of medical students in Alberta and British Columbia identified family

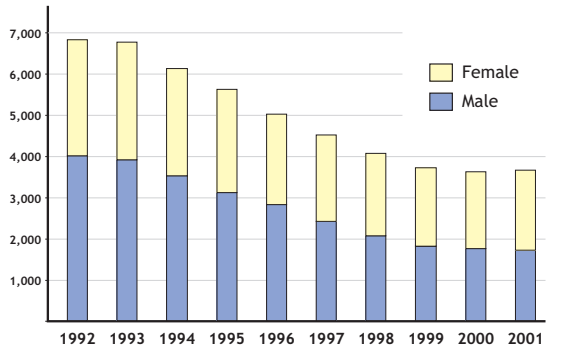
medicine as their first career option, and about half ranked family medicine in their top three choices. "Students who identified family medicine as their first choice tended to be older, to be concerned about medical lifestyle and to have lived in smaller communities at the time of completing high school; they were also less likely to be hospital oriented. Moreover, students who chose family medicine were much more likely to demonstrate a societal orientation and to desire a varied scope of practice" (**26**, p. 1920).

- In 2004, the proportion of medical students opting for family medicine as a first choice had dropped from 32% in 1994 (n=423) to 26% in 2004 (n=339) (**7**).

The physician pool is aging and there are few younger family physicians

- In 2001, the number of family physicians under age 35 who worked in six provinces in Canada was significantly less than the number of family physicians in this age bracket 10 years prior (Figure 1) (**19, 22**).

Figure 1: Count of Family Physicians under 35 years of age



source: (**19**)

- There is a decline in the proportion of physicians under age 35. The peak proportion in 1988 was 22%; in 2000 it was 13%. In contrast, the over 65 cohort has grown from 7% in 1981 to 11% in 2000 (**5**).
- An aging workforce has resulted in a gradual annual increase in the average age of family physicians (**3**).
- The aging physician pool has a number of implications. For example, younger physicians are more likely to offer emergency department and obstetrical services (**5**). Younger family physicians also provide many fewer visits and office assessments per annum than older family physicians (**19, 21**).

The number of female family physicians is increasing

- The total number of female family physicians has increased since 1992, whereas the number of male family physicians decreased. Accordingly, females now represent a larger proportion of the family physician workforce (**19**).

Table 2: Number of Family Physicians (1992 and 2001)

Family physicians	1992	2001
Males	20,254	18,969
Females	7,193 (26%)	9,524 (33%)
Total	**27,447**	**28,493**

- The changing balance between male and female family physicians is largely due to a sharp decline in younger male physicians. Since 1999, female family physicians have outnumbered males in the under 35 category (**19**).

Policy Decisions and Preferences

The majority of family doctors are paid on a fee-for-service basis, but this reality is shifting.

- Fee-for-service (FFS) still dominates as the remuneration method for family physicians, though the trend suggests a shift to alternative payment methods (12). (Table 3)

Table 3: Percentage of family physicians earning 90+% from fee-for-service (FFS)

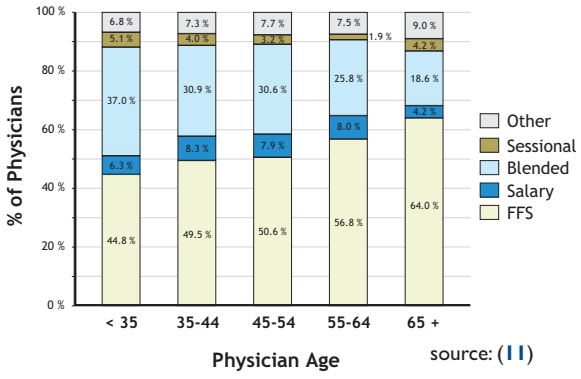
1998	1999	2000	2001	2002	2003
65	63	64	61	59	58

- In 2004, 57% of family physicians received 90% or more of their income from fee-for-service (11).

Experiences and preferences for different methods of remuneration are tied to age and, to a lesser extent, gender

- In 2004, there was a substantive age differential in remuneration experiences among all physicians. Forty-five percent of younger physicians received fee-for-service, compared to 64% of older physicians (Figure 2) (11).

Figure 2: Physician Remuneration Experience, by age

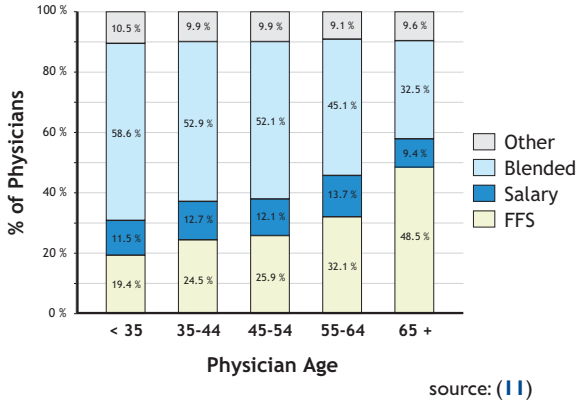


source: (11)

- In 2004, 49% of all female physicians received 90% or more of their income by fee-for- service compared to 54% of males (11).

- In 2004, there were substantive age differences in remuneration preferences among all physicians. Nineteen percent of younger physicians preferred fee-for-service, compared to 48% of older physicians (Figure 3) (11).

Figure 3: Physician Remuneration Preference, by age



source: (11)

- In 2004, 22% of all female physicians preferred fee-for-service remuneration, compared to 32% of males (11).

Family physicians now prefer blended models of remuneration

- In 2004, 25% of family physicians preferred fee-for-service as a method of remuneration, 51% preferred blended payment, and 11% preferred salary only (11).

Management Decisions, Activities and Preferences

Interdisciplinary collaboration is increasingly being considered as a way to address perceived primary health care provider supply gaps

- The Primary Health Care Transition Fund (2001-2006), the Health Accord (2003) and the Ten-Year Plan to Strengthen Health Care (2004) establish a unifying national policy framework for investments in interdisciplinary collaboration in primary health care (**20**).
- In 2004, physicians identified the following approaches to address current issues related to physician shortages (**13**) (Table 4):

Table 4: Approaches to address physician shortages and physicians recommending (%)

Increase medical school enrolment	89%
Better models of health care delivery	76%
Train & delegate to professionals	69%
More international medical graduates	64%

Family physicians mainly work in an office setting and are increasingly practicing in groups

- In 2001, 73% of family physicians worked mainly in a private office or clinic, and almost 80% spent at least some time in that practice setting (**10**) (Table 5, above).
- In 2004, 60% of family physicians worked in group practice settings, 25% worked in solo practice, and 4% worked in a practice network (**11**).

Table 5: Proportion of family physicians by practice setting (%)

Main Setting	% of family physicians
Private office / clinic	73
Community clinic	7
Emergency department	7
Hospital in-patient	3
Walk-in clinic	3
Teaching unit	3
Nursing home	1
Other	4

Family practices are increasingly unavailable to new patients

- In 2004, 60% of family physicians partially or completely closed their practices to new patients (**10, 11**) (Table 6).

Table 6: Proportion of family physicians taking on new patients (%)

	2001	2004
Practice is completely closed	5%	18%
Partially closed with some restrictions to accepting new patients*	68%	42%
Practice is completely open	24%	20%

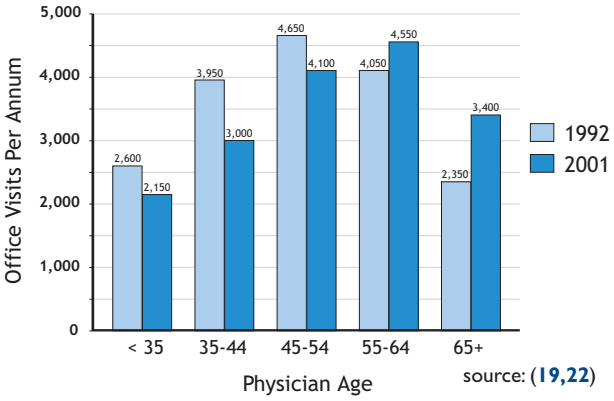
*Typical restrictions are friends/family of current patients, referrals from other physicians

Clinical Decisions, Activities and Preferences

Younger family physicians are providing fewer services per annum and older family physicians are providing more

- In 2003, family physicians under age 45 provided, on average, 8.8 fewer hours of direct patient care each week than physicians of the same age group in 1982. This represents a 21% decrease (**2**). In 1997, younger and older family physicians worked roughly the same hours each week (**16**).
- In 2001, younger family physicians provided many fewer office visits/assessments than their same-age predecessors did ten years previously, and older family physicians provided many more (Figure 4) (**19, 21**). These temporal shifts in workload are gender neutral (21) and also exist when workloads are measured on the basis of work time (**22**).
- In 1992, every soon-to-retire family physician carried a workload slightly less than each new physician, but in 2001, each soon-to-retire family physician carried a workload 1.6 times higher than each new physician (Figure 4) (**22**).
- This scenario is accentuated if one considers family physicians that might retire between the ages of 55 and 64 years (early retirees). In 1992, early retirees delivered 4,050 office assessments per annum, a workload 1.5 times higher than each new physician. By 2001, early retirees carried workloads 2.1 times higher than each new physician (Figure 4) (**22**).

Figure 4: Physician office visits by age (1992, 2001)



Family physicians work long hours, but there has been a modest decline in their work week

- In 2004, the average family physician had a 49-hour work week. In 1998, the average family physician had a 52-hour work week (**11, 12**) (Table 7).

Table 7: Family physician weekly work hours

Year	Family physician weekly work hours*
1998	52.1
1999	52.5
2000	51.0
2001	51.1
2002	51.6
2003	50.9
2004	49.2

- In 2004, 17% of family physicians reported that they reduced weekly work hours over the past two years, and 8% increased them. A further 25% planned to reduce work hours over the next two years, whereas only 4% planned to increase them (**11**).

*Not counting on-call hours

Service Qualities

Family physicians are reducing the comprehensive scope of services they once delivered.

Between 1992 and 2001:

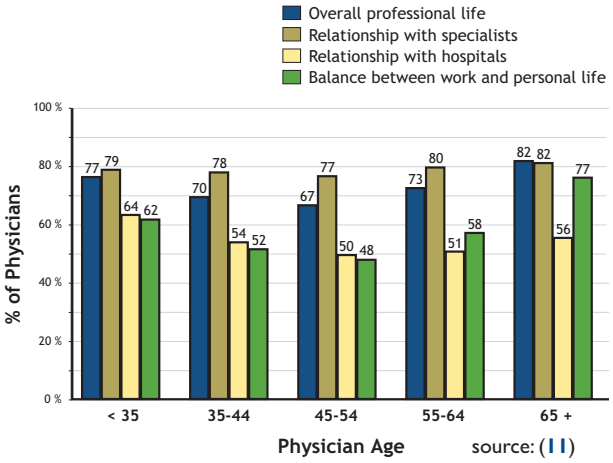
- The proportion of family physicians that participated in certain activities declined, but the average number of such services provided among those who continued to deliver the service increased (**19**).
- The proportion of family physicians that delivered babies went down from 28% to 16%. There was an increase in the number of obstetrical services offered by individual family physicians still providing these services (**19**).
- The proportion of family physicians that provided hospital inpatient care declined from 71% to 62% (**19**).
- The proportion of family physicians that provided mental health care increased substantively (**19, 23**).
- In 2001, one quarter of family physicians saw people with mental health conditions as frequently as the most common conditions seen in primary care (**23**).

Work/Life Satisfaction

Many family physicians are satisfied with their professional life, but fewer are satisfied with their relationships with other providers or the balance between personal and professional commitments

- In 2004, 66% of family physicians reported that they were very or somewhat satisfied with their overall professional life, and 52% reported this level of satisfaction with the balance between personal and professional commitments (Figure 5) (**11**).
- In 2004, 71% of family physicians were very or somewhat satisfied with their relationships with specialists, and 51% were satisfied with their relationships with hospitals (Figure 5) (**11**).

Figure 5: Percent of Physicians who are 'very satisfied' or 'somewhat satisfied' with selected work-related issues



Middle-aged physicians are more dissatisfied with their professional life and the balance between work and personal life.

- In 2004, there was a U-shaped association between physician age and satisfaction with professional life and the balance between work and personal life, with the lowest satisfaction consistently reported by middle-aged physicians (Figure 5) (**11**).

Family physicians have been dissatisfied for some time.

- In 2001, 63% of family physicians felt their workload was heavier than they would like, and 56% felt that family or personal life was suffering because of their career choice (**12**).
- Between 1993 and 1999, the difference between preferred and actual hours of work among family physicians increased (**24**).

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