Canadian Foundation for Healthcare Improvement

# QUALICOPC (Quality and Costs of Primary Care) Canada

## A focus on the aspects of primary care most highly rated by current patients of primary care practices

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## EXECUTIVE SUMMARY

This Pan-Canadian report describes patient and physician perspectives regarding current performance of primary care in each province based on data collected as part of the Quality and Costs of Primary Care (QUALICOPC) study. The QUALICOPC study is an international study of quality and costs of primary care in 34 countries. This report describes results from the data collected in Canada. It includes only data collected from patients and physicians in primary care practices that provide comprehensive primary care.

Two patient surveys were conducted as part of the study; one that asked patients about the importance of various aspects of primary care and the other about patients' experiences with primary care. This report focuses on aspects of primary care that respondents to patient surveys (distributed during visits to primary care physicians) identified as very important aspects of their primary care experience.

Primary care physicians from all Canadian provinces were asked to participate in the QUALICOPC study by a research team in each province. In general, one physician from each primary care practice was invited to participate (23 practices, primarily in Quebec, had more than one physician respondent). Physicians who agreed to participate were sent a package containing four different surveys regarding:

- the practice setting
- the services provided in the practice
- patient values; and
- patient experience.

In each practice, the physician was asked to complete the survey about the services provided and any staff member could complete the practice setting survey. One patient was expected to respond to the patient values survey and nine other patients were expected to respond to the patient experience survey. Physicians returned completed surveys to the research team in each province.

A total of 8,332 patients of 810 primary care physicians in 785 practices across Canada responded to the surveys. A total of 1,160 completed the patient values survey and a different sample of 7,172 patients completed the patient experience survey. Two-thirds (67%) of participating patients were female, and three-quarters (74%) were in good to very good health . The median age of patient respondents was 53. The majority (59%) of participating patients had a post-secondary education, were fluent or native speaking in at least one of Canada's official languages (80%) and were born in Canada (86%).

To our knowledge, this is the largest study to date of patient values and patient experience regarding primary care in Canada in terms of the number of patients. The results reported provide important insight into the experience and values of primary care of the population sampled (as described above): patients who had access to a primary care physician, the majority of whom were in good to very good health. Whether the results reported herein and the associated reported policy implications would extend to other population groups, such those who do not have regular access to a primary care practice, requires further study.

## Patient Values

The patient values survey (PES) presented patients with 56 questions on various aspects of primary care and asked them to rate the importance of each of these aspects. These aspects were then ranked according to the percentage of patients who answered "very important" (reported hereafter as the most highly rated).

The research team categorized the questions from the patient values and patient experience surveys into four dimensions:

1. Continuity and Coordination
2. Communication and Patient-Centred Care
3. Patient Activation
4. Access

Among the 10 most highly rated aspects of primary care in the patient values survey, seven represented aspects of Communication and Patient-Centered Care, and the other three represented aspects of Continuity and Coordination. The 10 most highly rated aspects of primary care (and corresponding dimensions) across all participants are listed in the following table:

| 10 Most highly rated aspects of primary care in Patient Values Survey | Dimension |
|---|---|
| 1. The doctor knows important information about my medical history | Continuity and Coordination |
| 2. I understand clearly what this doctor explains | Communication; Patient-Centred Care |
| 3. The doctor asks questions about my health problems | Communication; Patient-Centred Care |
| 4. The doctor knows when to refer me to a medical specialist | Continuity and Coordination |
| 5. The doctor has my relevant medical records at hand | Continuity & Coordination |
| 6. The doctor involves me in making decisions about treatment | Communication; Patient-Centred Care |
| 7. The doctor treats me as a person and not just as a medical problem | Communication; Patient-Centred Care |
| 8. The doctor takes me seriously | Communication; Patient-Centred Care |
| 9. The doctor listens attentively | Communication; Patient-Centred Care |
| 10. The doctor understands me | Communication; Patient-Centred Care |

Only two of the four dimensions were represented amongst the top 10 highly rated aspects of primary care. However, the sample was limited to patients who had accessed primary care and were willing to take the time to respond to a survey about their primary care provider. In addition, a lower ranking of primary care aspects does not mean that the values are not important. Many of the lower ranked aspects were identified as "important" or "very important" by over 50% of respondents including those in the Access and Patient Activation dimensions.

## Patient Experience

The patient experience survey (PES) distributed as part of the QUALICOPC study asked patients about their experience with the primary care practice and the doctor they were visiting. The research team examined experiences aligned with the two highest rated aspects of primary care for all four dimensions, as well as the highest ranked 10 values overall (shown above).

Results from across Canada suggest that patients visiting primary care practices had predominantly positive experiences with the care they received, specifically on those aspects of primary care that were found to be most important to respondents of the patient values survey. For each of these aspects, between 92% and 99% of all patients surveyed reported positive experiences.

Key findings from the PES related to the four dimensions of primary care are presented below.

### *Continuity and Coordination*

- The single most important aspect of primary care and the second most commonly reported dimension of care amongst the top 10 rated aspects was continuity and coordination of primary care. Canadian research has identified the importance of continuity of care including informational, relational and management continuity and empirical relationships have been identified between higher continuity and better patient-provider communication, reduced use of emergency departments and increased use of preventative and health promotion strategies. Patient experience with aspects of continuity and coordination of care was the most highly rated dimension among respondents. Ninety-nine percent and 98% of patients respectively indicated that the doctor that they visited knew important information about their medical history, and that the doctor had their relevant medical records.

### *Communication and Patient-Centred Care*

- Seven of the 10 most highly rated aspects of primary care reported by participants were related to communication and patient-centred care, highlighting the overwhelming importance of this dimension of primary care to patients who have a personal physician. Patient ratings of their primary care providers were generally very high with over 90% of patients indicating that their doctors achieved the four aspects of care included in the PES related to this dimension.

### *Patient Activation*

- Patient activation has been identified in research as an important outcome of high quality primary care. It has been linked to improvements in patient healthy behaviours, medication adherence, functional status and quality of life, as well as reduced use of emergency departments. It is, however, a relatively new construct in research. Over 95% of respondents in every province replied positively to the question; "after this visit I feel I can cope better with my health problem/illness than before."

### *Access*

- Among survey respondents (who were visiting the primary care practice, most of whom were visiting their own physician at the time of completing the survey), access was not among the most highly rated aspects of primary care. The related experience responses showed that although only a third (or less) of patients were generally able to arrange an appointment with their physicians on the same or next day, over 90% reported that it was easy to obtain an appointment and over 80% reported that they could arrange their appointment as soon as they wanted. Thus, for patients

in the sample surveyed for this research (i.e. people who were visiting a primary care provider and who, for the most part, are in good health), "same or next day access" is not a source of dissatisfaction. On the other hand, immediate access may be very important to some patients who are not sufficiently represented in the survey respondents which would affect the extrapolation of results to general patient populations.

## Interpretation

Surveyed patients were all accessing primary care and most reported that they were visiting their usual care provider. Therefore, these results may not represent those of other patient populations, specifically those who lack, or who have great difficulty accessing, their own primary care physicians. On the other hand, strengths of the study include the large sample and the fact that all ten provinces participated. Not surprisingly, physician participation rates were low which means that the results may not be representative of the family physicians and their patients in each province. Nevertheless, because the recruitment of primary care practices and patients in each province adhered to a similar methodology, provincial results presented in this report are expected to be comparable.

## Conclusion

These data provide the largest source of information about patient values and experience with primary care in Canada. The values indicated to be most important to patients in primary care practices and the generally positive experience ratings of patients should be grounds for some appreciation that most patients who have access to primary care appear to have a very positive experience with their primary care physicians. However, decision-makers need to distinguish between what is important to patients with and without a primary care physician in their efforts to improve the primary care system. Future comparisons to other countries that participated in the QUALICOPC study may also help to understand whether Canadians are able to access and obtain as high quality care as that provided to patients elsewhere around the world.

## PURPOSE

This pan-Canadian report describes patients' (with a primary care physician) and physicians' perspectives regarding current performance of the primary care sector in each province. It uses physician and patient survey data from the Quality and Costs of Primary Care (QUALICOPC) study. The QUALICOPC study was designed to assess primary care in Europe based on access, equity, cost/efficiency and quality of services. The survey results provide information not only on patient experience with various dimensions of primary care, such as how long they had to wait for their appointment and their appraisal of communication with primary care physicians, but also on which aspects of primary care they consider to be most important.

The purpose of this report is to look at key aspects of patient experience in conjunction: Which aspects of primary care are valued most by patients and how well is primary care performing on those aspects across Canada? The report focuses on aspects of primary care that respondents to patient surveys (distributed in primary practices) identified as very important aspects of their primary care experience.

The overarching goal of this project is to determine the effect a strong primary care system has on the performance of the overall healthcare system.[1]

## BACKGROUND

### Primary Healthcare

The term primary healthcare is used to describe a philosophical approach to care delivery. The 1978 Alma Ata Declaration stressed the importance of developing and sustaining primary healthcare as part of a comprehensive health system, with coordination between healthcare and a broad array of other determinants of health.[2]

The QUALICOPC study focused on physician-based primary care. Primary care can be considered one of primary healthcare's core services. For the majority of Canadians, primary care is generally the first point of entry into the healthcare system where their primary care provider delivers person-centred care (not disease oriented) over time for all but the most uncommon conditions and forms the part of the system that integrates or coordinates care provided elsewhere or by others. Optimally, primary care is used to coordinate patient-centred care across a variety of health services, including but not limited to, health promotion, disease prevention, mental healthcare, acute and chronic care, and rehabilitation services.[3]

### Performance Measurement: Patient Experience and Values

Performance measurement in primary care is key for quality improvement efforts, accountability and better understanding of best practices. Although the healthcare performance measurement literature tends to be focused on acute hospitals, evidence suggests that public reporting stimulates quality improvement and results in better outcomes of care.[4,5,6] Hospital leaders report using the information from performance reports to change processes of care and to guide quality improvement[7], and this seems to apply particularly for those in hospitals with lower performance.[8] Primary care performance measurement and reporting is in its infancy in Canada and generally lags behind other sectors (e.g. acute care) but continues to grow. In the absence of formal systems, it is notable that internet physician rating websites are being used by patients.[9,10]

Recently, the Canadian Institute for Health Information (CIHI) noted that the effectiveness of primary care in Canada is largely unknown due to a paucity of available performance measurement data in this area.[11] The most commonly referenced performance information about primary care in Canada is from the Commonwealth Fund's surveys of the general public and of physicians in industrialized nations.[12,13,14,15,16,17] Results of the Commonwealth Fund surveys have raised awareness about Canada's primary care system and its poor performance compared to those of other industrialized countries. The Commonwealth Fund surveys are based on random independent samples of people (from the general public) or of clinicians per country and one of its limitations is the inability to link patient and clinician data. In addition, the Commonwealth Fund surveys were not completed at the time the individual received primary care, potentially resulting in issues in reporting accuracy. QUALICOPC provides a more comprehensive examination of primary care performance from patient and provider perspectives in Canada and 34 other (mostly European) countries.

This report focuses on the patient perspective, which is important to help define high quality care and influence the direction of healthcare reform. Improving patients' experiences may encourage them to be more engaged in the management of their own health.[18] QUALICOPC included surveys to measure both patient experience and the aspects of primary care that patients felt were most important to them. QUALICOPC is also unique in that the patient surveys focus on patients with primary care providers, and are administered at the time of the patient's primary care encounter so that the experience is better recalled.

There is an abundant literature measuring patient experience in healthcare in general, but the literature pertaining to primary care is more limited. There is also less of an understanding of the aspects of quality of care that patients truly value. What is known is that patients in Canada value a range of characteristics from accessibility and continuity to interpersonal communication, technical quality, and whole-person care. A randomized trial in Quebec found that when patients were engaged in setting priorities for healthcare, they highlighted self-care support, access to primary care and interdisciplinary teams (whereas professionals alone placed greater emphasis on patient self-efficacy, collaboration among healthcare organizations and monitoring patient use of emergency departments).[19] Other international work has shown that receiving a thorough examination, obtaining sufficient and appropriate information, and having a friendly doctor are also important to patients.[20,21,22] And when having to choose, one study found patients preferred high technical quality to high interpersonal quality.[23]

# METHODS

## The QUALICOPC Study

QUALICOPC began as a research program funded by the European Union (EU), including 26 member states and five non-EU European countries (Iceland, Macedonia, Norway, Switzerland and Turkey). Three other countries (Australia, Canada and New Zealand) also decided to participate, receiving funding from other sources, bringing the total number of participating countries to 34.[24] It was designed to satisfy the demand for benchmarking performance information and to inform primary care reform through international comparison. The results are based on data collected through the administration of four surveys collecting information on the practice and participating physician's characteristics, as well as patients' values and experience. The target sample for each of the European countries was generally 220 practices with a few smaller countries aiming for samples of 75 practices. A description of the method for developing and validating these surveys by the European team is available elsewhere.[24] Adjustments were made by the Canadian research team to align with the different healthcare systems of the provinces, while remaining as close as possible to the validated European surveys and methodology.

## Data Collection

All 10 provinces in Canada collaborated in the Canadian arm of QUALICOPC. The Canadian Primary Healthcare Research and Innovation Network (http://www.cphcrin-rcrissp.ca/) supported the coordination efforts across the 10 Canadian provinces. Each province was guided by a different individual lead. The majority of provincial teams followed the same survey methodology implemented in other participating countries. In most provinces, the researchers did not hold a list of all eligible physicians. Therefore all physicians who were members of provincial chapters of the College of Family Physicians of Canada (and with the provincial Colleges of Physicians and Surgeons in Manitoba and in Newfoundland & Labrador) were mailed or emailed invitations to participate in the QUALICOPC study. Invitations were distributed by the provincial Colleges, by the provincial researchers, or by sponsor organizations. Interested physicians registered either online or by fax with the provincial research team. Recruitment generally involved between three and five follow-up requests. The recruitment letters identified that only physicians in general (not focussed) primary care practices were eligible and that only one physician from each primary care practice was eligible to participate. The latter restriction enabled the study team to capture the highest number of practices possible and to give a more representative picture of primary care in each province. In Quebec, the provincial lead worked from a list of physicians to randomly select and recruit physicians using geographic stratification. In some cases, Quebec allowed more than one physician from each practice to make sure that geographic areas with fewer practices were well represented or when a physician's address recorded in the list of selected physicians was different from his/her actual place of practice. The Manitoba research team ensured that two-thirds of the participating practices were from Winnipeg. In British Columbia, Nurse Practitioners (NP) were eligible to participate and one NP-led practice is included in the British Columbia results in this report. The target sample was 220 practices (or physicians) in three provinces (Alberta, Ontario and Quebec) and 75 practices in all other provinces (with New Brunswick and Prince Edward Island combined as a single sampling unit). Participating physicians in Canada were compensated $200 for their efforts and disruption to their practices associated with administering the patient survey data collection.

After confirming eligibility and participation, physicians received a package containing four surveys (in English or French, as applicable):

1) the practice setting
2) the services provided in the practice
3) patient values; and
4) patient experience.

The staff at the practice were asked to distribute one patient values survey (PVS) and nine patient experience surveys (PES) to consecutive consenting patients visiting the participating physician. Surveys were distributed on a day, chosen by the physician, that they felt represented their regular practice population. If not enough patient surveys were completed, recruitment was to continue on the physician's next equivalent work day. Because the survey packages contained extra surveys (one extra PVS and two extra PES surveys), some practices provided more than the minimum requested number of surveys. At the same time, some practices provided fewer than the requested number of surveys. We included all completed surveys in the results presented in this report. The participating physician completed the family physician survey (FPS), while either the participating physician or administrative staff completed the practice survey (PS).

Provinces began their recruitment in 2013 with the majority of data collection occurring over the summer. Some provinces continued collecting surveys from practices until the winter of 2014 to achieve their target number of participating practices.

A total of 8,332 patients of 810 primary care physicians in 785 practices across Canada participated in the QUALICOPC study. Of these, 1,160 patients of 778 physicians completed the PVS, rating how important different aspects of primary care were to them (31 physicians did not return PVS surveys). An additional 7,172 patients of 807 primary care physicians completed the PES, reporting on their experience with primary care (3 physicians did not return PES surveys; 1 practice returned only physician and practice surveys). Each of these patient values and patient experience surveys measured four dimensions of primary care including Continuity and Coordination, Communication and Patient-Centredness, Patient Activation and Access. To our knowledge, this is the largest study to date of patient values and patient experience in primary care in Canada.

### Ethics

The participating provincial research lead obtained research ethics for this study from their respective organizations. Providers and patients received information on the study and participation consent letters. Based on standard ethical procedures in each province, patients and providers returned signed informed consent forms, or in some provinces, completion and return of the surveys implied informed consent.

## REPRESENTATIVENESS

Data presented in this report are based on the responses of primary care physicians from each province who agreed to participate in the study. Patients included in this study were all visiting a primary care practice (usually their own). Limited resources were available for provider recruitment which resulted in a participation rate which limits the generalizability of the findings. Nearly all patient survey respondents reported having a primary care provider. This sample therefore does not represent the views of patients who do not have their own primary care providers or who do not read English or French. Recruitment of practices and patients in each province, however, followed a similar process and results presented herein for each province are, therefore, expected to be comparable. Of note, representativeness in Quebec was better ensured through a stratified random sampling technique that accounted for the differences in the number of family physicians practicing in different regions.

## RESULTS

### Overview

The results are presented in three major sections:

1. **Most Highly Rated Canadian Patient Values.** Patients of 810 physicians in 778 participating primary care practices across Canada completed the PVS indicating his/her perceived importance of primary care aspects before, during and after consultation with their family doctor. The PVS provided a restricted list of 56 different primary care aspects for rating on a four-point scale (1= not important; 2=somewhat important; 3=important; and 4=very important). This first section highlights the aspects of primary care that patients most frequently rated as being very important to them.
2. **Patient Values and Experiences in Four Dimensions of Primary Care.** The second Results section of this report summarizes patient experience responses with a particular focus on those aspects of primary care rated as most important to patient respondents. Results are categorized and summarized according to four dimensions of primary care and ordered according to the

aspects most highly valued by patients:

1. Continuity and Coordination
2. Communication and Patient-Centred Care
3. Patient Activation
4. Access

This section reports on the results of patient responses to the PES that are most closely related to the aspects of primary care that patients identified as most important in the PVS. All of the aspects included in the overall top 10, as well as the top two aspects within each of the above dimensions are reported on in this section.

3. **Respondent Profile.** The final results section provides an overview of the characteristics of responding physicians and patients drawn from the survey data to add context to the findings.

## Most Highly Rated Canadian Patient Values

### *Methods*

At least one patient from each participating primary care practice was asked to complete the PVS (see Appendix for a list of all 56 aspects). Responses were received from 1,160 patients across Canada. For each province, the proportion of patients selecting "very important" was calculated for each aspect. These provincial figures were then averaged to create Canada-wide ratings of each aspect, giving equal weight to results from each province. They were ordered and the aspects of primary care most and least valued by the participating patients were identified for Canada.

### *Key Findings*

Figure 1 shows the percent of patients selecting "very important" for each of the 10 most highly rated aspects of primary care in Canada. Communication (e.g. "I clearly understand what this doctor explains") and Continuity and Coordination (e.g. "the doctor knows important information about my medical history and health issues" and "the doctor knows when to refer me to a medical specialist") were most highly valued by the patients who responded to the PVS.

Though there were some differences in the proportion of patients selecting "very important" in different provinces, the 10 most highly rated aspects were very consistent across Canada; at least eight of these aspects were in the top 10 in each province. In all but one case, those values that did not make the 10 most highly rated, remained within the 75$^{th}$ percentile.

The 10 most highly rated aspects of primary care were also fairly consistent even when stratified by chronic disease (yes or no), gender (male or female) and income (as perceived by the patient as being below average, around average, or above average) at the provincial level before creating the Canada-wide ratings. Only one aspect of primary care dropped out of the 10 most highly rated when stratified by chronic disease ("the doctor understands me" was the 12$^{th}$ highest ranked for respondents who also reported no chronic disease). Similarly, only "the doctor takes me seriously" dropped out of the 10 most highly rated aspects of primary care for male respondents. In both of these cases, "the doctor gives clear instructions on what to do when things go wrong" moved up into the 10 most highly rated. When stratified by income, "I am honest and do not feel embarrassed to talk my health problem" moved up slightly and into the 10 most highly rated aspects of primary care for respondents who reported below average income. This replaced "the doctor understands me", which was the 11$^{th}$ highest

rated aspect of primary care for respondents who reported below average income. For respondents who reported above average income, "the doctor treats me as a person and not just as a medical problem" was the 11th highest rated aspect of primary care, whereas "adhering to the agreed upon treatment" moved into the 10 most highly rated.

Figure 2 shows that aspects least valued by patients were related more to the practice than to the physician, such as being able to see another physician or having providers share information about their care needs. It is interesting to note here that the practices of having "extensive operating hours", the patient "being able to see another doctor" and "being able to see other healthcare professionals", were among the 10 least highly valued by patients, implying that at least for patients who have regular access to primary healthcare and of whom the majority are in good health, extended operating hours and availability of other health professionals is not a high priority. This result should not be generalized to other population groups (e.g. those who do not have regular access to a primary care practice) and other locations/times (e.g. emergency rooms during evenings or weekends) without further study.

**Figure 1. Percent of patients rating aspect as "very important" for the 10 most highly rated aspects of four dimensions of primary care**

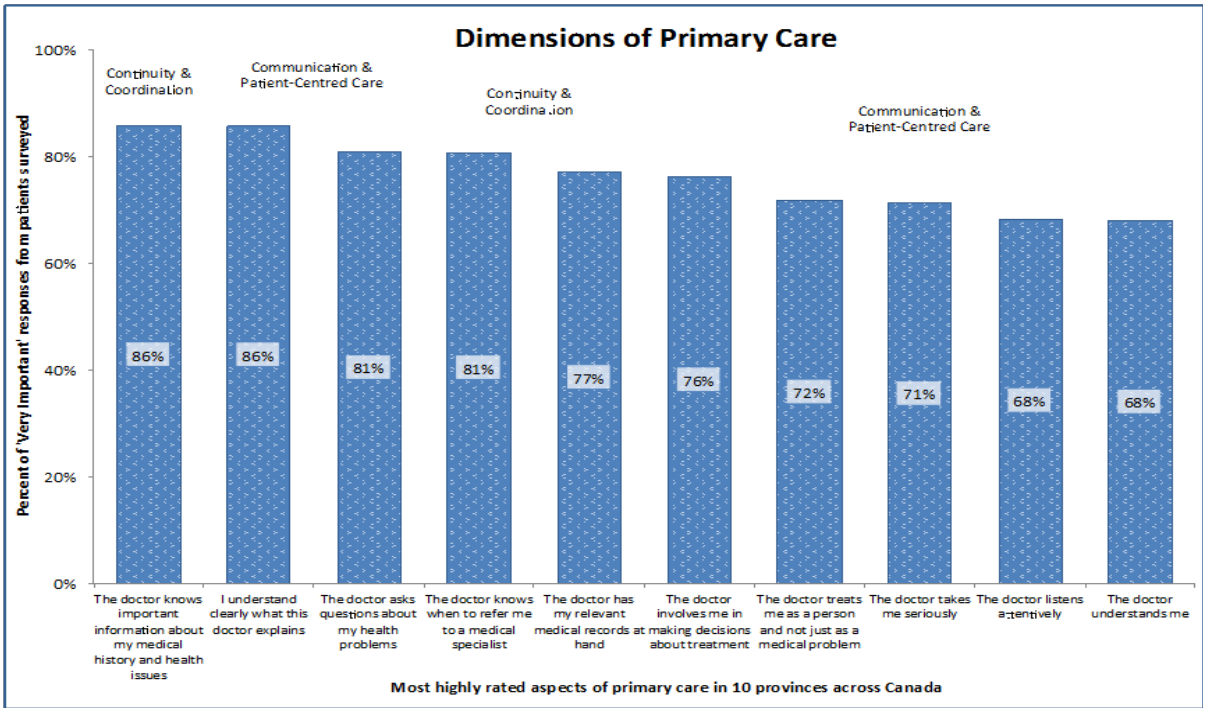
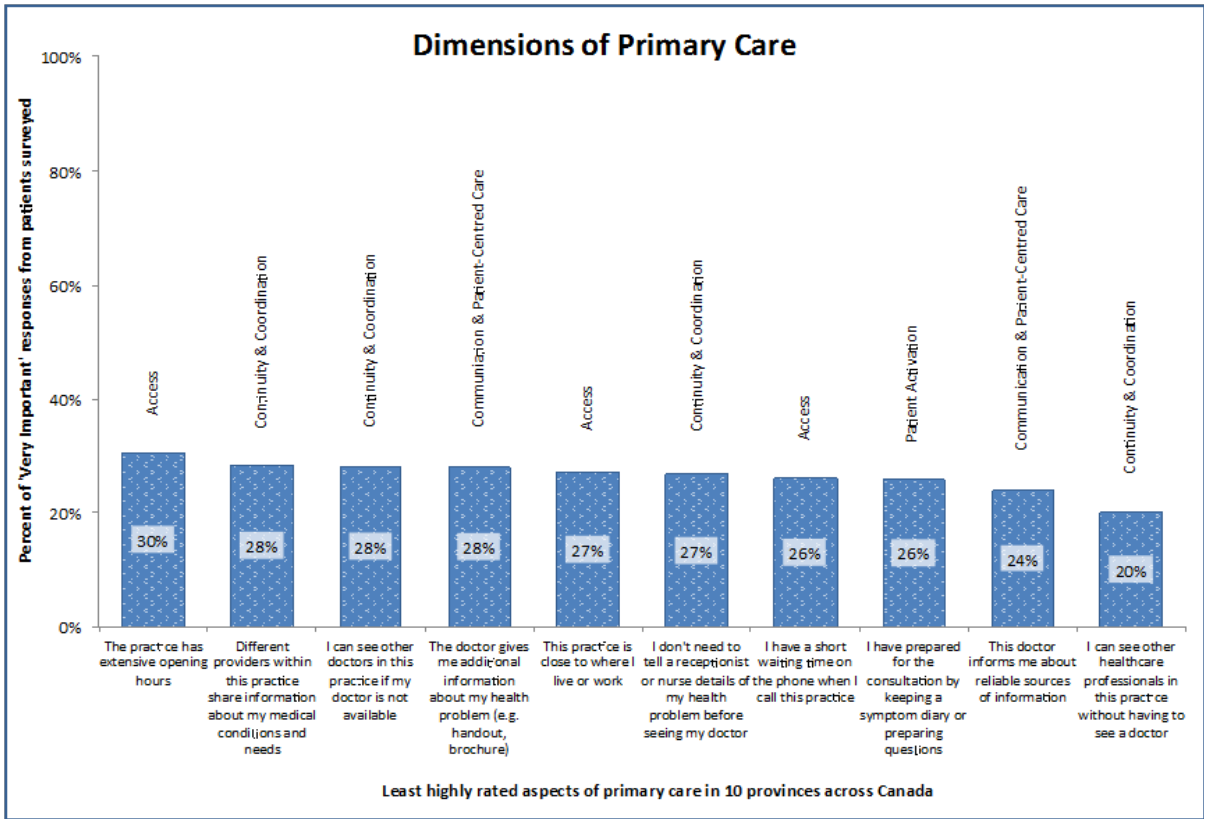


**Figure 2. Percent of patients rating aspect as "very important" for the 10 least highly rated aspects of dimensions of primary care**




## Patient Values and Experiences in Four Dimensions of Primary Care

### *Methods*

This report uses a proposed framework of dimensions of patient experience in primary care adapted from a Canadian report by Wong & Haggerty[17]: Continuity and Coordination, Communication and Patient-Centred care, Patient Activation, and Access. Questions from the PVS were categorized within these dimensions. Patient experiences for the top ten patient values overall and the top two within the Patient Activation and Access dimensions (which were not included in the top 10 values) of primary care are presented in this section. These values from the PVS survey were then matched to questions from the questions in the PES, which was completed by 7,172 patients. The aim of this matching exercise was to see how patients rate their experiences on the most valued aspects for each dimension and for the top 10 values overall. Some questions that were rated as very important in the PVS did not have an equivalent question in the PES. Table 1 presents the highest rated PVS questions from each of the four dimensions of primary care, as well as the top 10 values overall. In addition, the corresponding questions/aspects in the PES are presented with the percentages of respondents who answered "yes" to the questions reported as a positive rating. The overall rank of the PVS and the percent of respondents that considered the question/aspect to be "very important" are also reported. The overall rank is determined by the percentage of respondents that reported the question as being "very important."

**Table 1.** Aspects rated most important in each dimension by patients and corresponding PES questions.

| Dimension | PVS Question | Rank | Percent Very Important | PES Question | Percent Positive Rating |
|---|---|---|---|---|---|
| **Continuity & Coordination** | That the doctor knows important information about my medical history | 1 | 86% | Doctor knows important information about my medical history and health issues | 99% |
| | That the doctor knows when to refer me to a medical specialist | 4 | 81% | Easy to get a referral to a medical specialist | 94% |
| | The doctor has my relevant medical records at hand | 5 | 77% | The doctor had my relevant medical records at hand at today's visit | 98% |
| **Communication & Patient-Centred Care** | That I understand clearly what this doctor explains | 2 | 86% | I understood what the doctor was trying to explain | 92% |
| | That the doctor asks questions about my health problems | 3 | 81% | Doctor asked questions about my health problem | 98% |
| | The doctor involves me in making decisions about treatment | 6 | 76% | The doctor involved me in making decisions about treatment and/or health related goals at today's visit | 96% |
| | The doctor treats me like a person not just as a medical problem | 7 | 72% | <None> | |
| | The doctor takes me seriously | 8 | 71% | <None> | |
| | The doctor listens attentively | 9 | 68% | The doctor listened carefully to me at today's visit | 99% |
| | The doctor understands me | 10 | 68% | <None> | |
| **Patient Activation** | That I am honest and do not feel embarrassed to talk about my health problem | 12 | 64% | <None> | |

| Dimension | PVS Question | Rank | Percent Very Important | PES Question | Percent Positive Rating |
|---|---|---|---|---|---|
| **Patient Activation** | That I feel able to cope better with my health problem/illness after this visit | 13 | 64% | After this visit, I feel I can cope better with my health problem/illness than before | 96% |
| **Access** | That I can get an appointment easily at this practice | 28 | 53% | It was easy to get the appointment | 94% |
| | That I can see another doctor if I think it is necessary | 33 | 46% | <None> | |

**Table 1 note:** Patient experience scores are presented for the two questions/aspects in each dimension with the highest patient rating of importance. More than two questions/aspects are included for some dimensions because all aspects rated in the top 10 are included.

## *Continuity and Coordination of Primary Care in Canada*

This dimension is two-fold encompassing Continuity of Care and Coordination of Care. This report uses the definition of "continuity of care" proposed by Haggerty et al: an ongoing therapeutic relationship between the patient and healthcare provider(s) across healthcare episodes.[25] Included in the definition is the extent to which this relationship supports accumulation of knowledge regarding the patient and delivery of care that is consistent with the biopsychosocial needs of the patient.[25] The basis of this definition is relational continuity, but it also takes into consideration aspects of informational continuity, both of which are sub-dimensions included in the framework developed by Wong & Haggerty.[17] Burge et al argue that having a regular source of care is more important in primary care than any other sector of the healthcare system, noting that improved continuity of care is associated with better patient-provider communication, reduced emergency department visits, and increased use of preventive and health promotion strategies.[26] In fact, having a regular source of care was found to be the most significant factor associated with the use of preventive strategies, even after adjusting for patient financial status and need for ongoing care.[27]

Based on a review, this report uses a proposed working definition of "coordination of care" as the deliberate organization of healthcare services by at least two providers to best meet the patient's needs.[28] These health services may include those available through community health services providers outside of the primary care physician's practice, but also takes into consideration how the practice team collaborates to manage and deliver care. In Canada, primary care is generally the first contact that patients have with healthcare providers and it is used as an entry point into the healthcare system. As such, primary care is optimally placed to coordinate care across a variety of sectors in the healthcare system. Several care coordination initiatives have been implemented and evaluated in North America. These programs are similar in that they are based on primary care and findings suggest that primary care, when used as a coordinating central hub, may be effective in improving management of patient care and reducing use of institutional services, such as emergency department visits.[29,30,31] As Canadian primary care reform shifts towards increased use of multidisciplinary teams and as medically complex patients move across healthcare services, it is important that we understand patient values and experiences within this dimension.

## Patient Values

The PVS survey included 13 questions related to continuity and coordination in primary care, three of which were in the top 10 patient values identified. The two aspects rated most highly were "the doctor knows important information about my medical history" and "the doctor knows when to refer me to a medical specialist"; each were rated as "very important" by more than 80% of respondents. The aspects of continuity and coordination that were not ranked as highly included "I can see other healthcare professionals in this practice without having to see a doctor" and "I don't need to tell a receptionist or nurse details of my health problem before seeing my doctor"; 20% and 27% respectively of all patients surveyed rated these aspects as "very important." Of note, 72% of surveyed Manitobans reported that it was very important that they "have a strong formal agreement with one physician who is the most responsible physician for their care." This aspect was among the top 10 most highly rated aspects of primary care in this province, but was in the 50$^{th}$ percentile nationally.

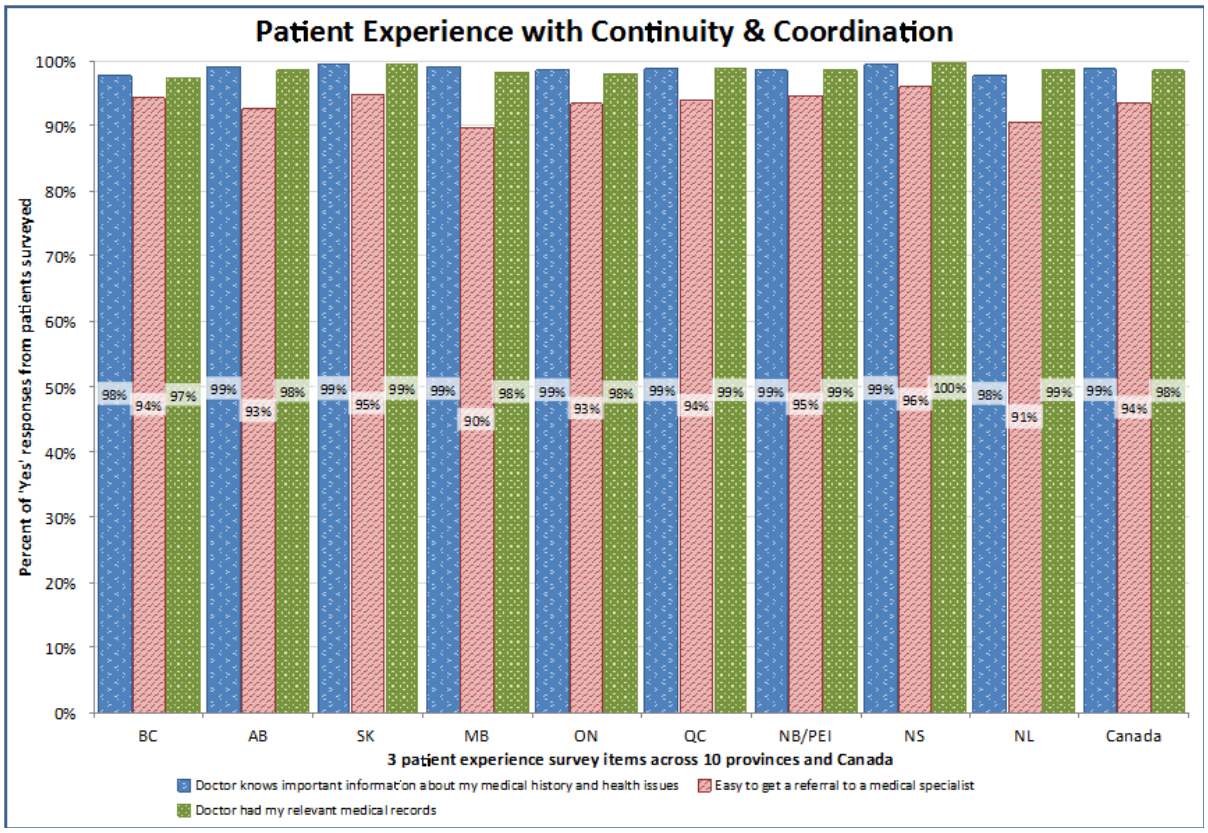
## Patient Experiences

The proportion of surveyed patients whose doctor knows important information about their medical history and health issues, and had their medical records, and who reported that it was easy to receive a referral to a medical specialist, is presented in Figure 3. Positive patient experiences were seen across all 10 provinces, with Canadian averages ranging from 94% to 99% for these measures of continuity and coordination of care. No province reported less than 90% positive patient experiences for any of these measures.

## Summary of Findings

The single most important aspect of primary care and the second most commonly reported dimension of care amongst the top 10 rated aspects was continuity and coordination of primary care. Canadian research has identified the importance of continuity of care including informational, relational and management continuity and empirical relationships have been identified between higher continuity and better patient-provider communication, lower use of emergency departments and higher use of preventative and health promotion strategies. Patient experience with aspects of this dimension was the most highly rated among respondents to the QUALICOPC patient experience survey. Ninety-nine percent and 98% of patients indicated that the doctor they visited knew important information about their medical history and that their doctor had the relevant medical records, respectively. Due to the methods used in the QUALICOPC survey, we do not know how representative these patients are of all patients who visited doctors in the participating practices on the days that the survey was distributed or among all patients across the provinces who visit a doctor on any given day.

**Figure 3**. Patient experience with Continuity and Coordination in primary care




## *Communication and Patient-Centred Care in Primary Care in Canada*

A review of patient-centred care suggests patient-centred care is characterized by patients' involvement in their care and by individualization of care based on one's needs; these features were associated with improved adherence and led to better patient outcomes.[32] Evidence suggests that patient-centred care is valuable in regards to patient experience but also in terms of better patient outcomes and reduced healthcare costs. Positive patient perceptions of his/her interaction with the family physician were associated with a better recovery and emotional health and with fewer diagnostic tests and referrals.[33] More patient-centred care with the family physician was also associated with reduced visits to specialists, fewer hospital admissions and fewer diagnostic and laboratory tests.[34] When patient-centredness is defined as listening to a patient's symptoms, thoughts, feelings and expectations, providing patients with the opportunity to express themselves in this manner was associated with better resolution of patient's symptoms.[35] Stewart et al recommend improvements in patient-centred care as a means to improve efficiency, after finding that more patient-centred care is associated with fewer diagnostic tests being ordered.[36]

Patient-centred care can be defined in a variety of ways, and often includes elements of high quality, whole-person care and patient-provider communication.[37] This definition is adapted from Wong & Haggerty's comprehensiveness of services and interpersonal communication dimensions.[17] The communication and patient-centred care dimension includes values focused on the patients and on the relationship with the physician. The survey questions aim to measure how patients perceive they are being seen and treated more holistically with services that meet their healthcare needs, with consideration of the patient's physical, emotional and social situations, as well as the community

context. This dimension also considers if the care is delivered in a way that supports patient-provider communication, respectfulness to the patient, and the extent to which patients are involved in decisions regarding their own care.

Communication is considered as a key aspect of patient-centred care.[37] Seven of the 10 most highly rated patient values were related to communication and patient-centred care. Communication has been shown to affect healthcare seeking behaviour and health outcomes; research findings suggest that patients who feel disrespected are more likely to delay seeking needed healthcare and have higher non-compliance to the physician's advice.[37] A review of studies on communication between primary care physicians and their patients suggests that a number of communication behaviours such as empathy, explanations or clarification could support positive health outcomes.[38] Effective provider-patient communication is associated with positive health outcomes, including improved health and greater patient reported satisfaction with a variety of primary care models.[39] More specifically, good communication has been found to positively affect emotional health, symptom resolution, function, physiologic measures and pain control.[40]

### Patient Values

The PVS included 26 questions related to communication and patient-centred care in primary care. The two aspects rated most highly were "I understand clearly what this doctor explains" and "the doctor asks questions about my health problems"; each were rated as "very important" by more than 80% of respondents. The elements of communication and patient-centred care that were not highly ranked included "this doctor informs me about reliable sources of information" and "the doctor gives me additional information about my health problem." Only a quarter of all patients surveyed rated the latter two aspects as "very important."

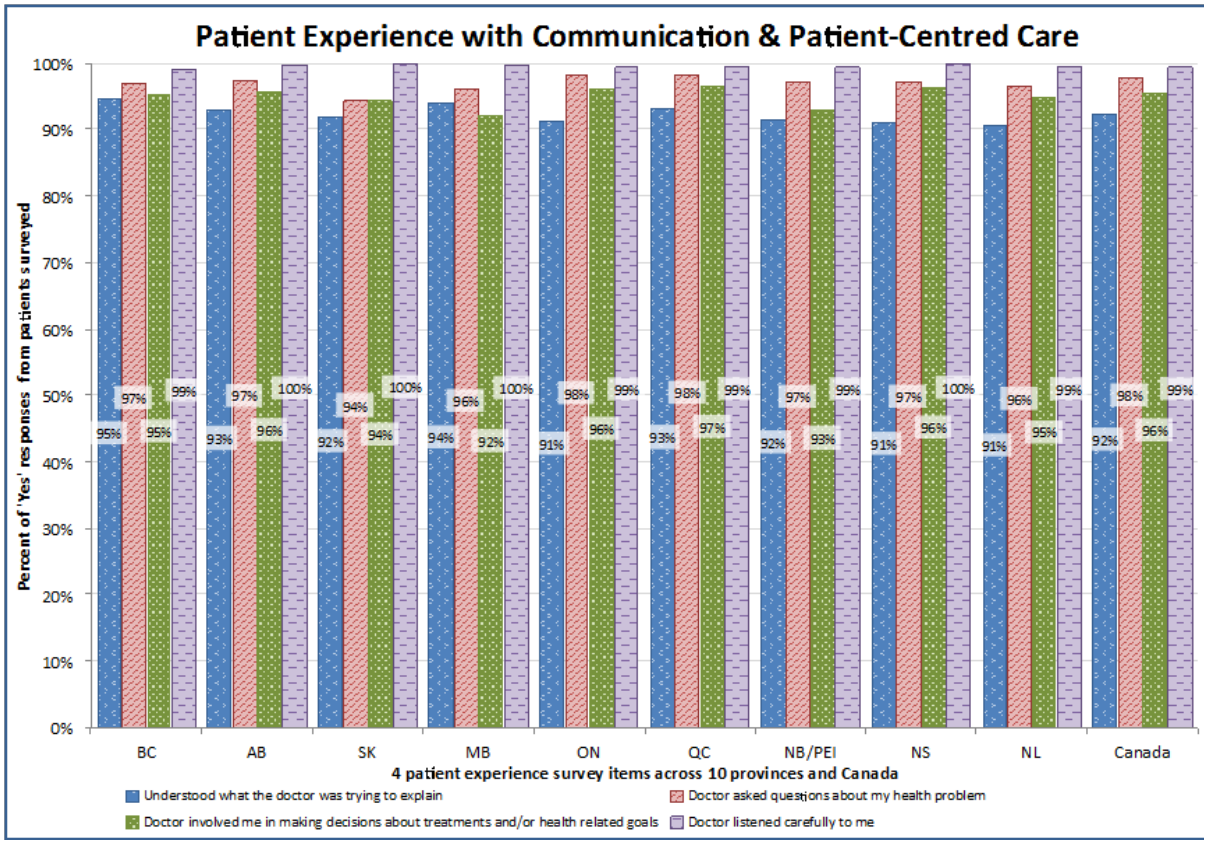
### Patient Experiences

The proportion of surveyed patients who understood what the doctor was trying to explain, whose doctor asked questions about their health problems, whose doctor involved them in decision-making regarding their treatment and/or health-related goals, and whose doctor listened carefully to them are presented in Figure 4. Positive results were seen in all 10 provinces, with Canadian averages ranging from 92% to 99% for these aspects of communication and patient-centred care. In particular, 99% or more of patients in each province felt that their doctor listened carefully to them. No province reported less than a 91% positive patient experience.

### Summary of Findings

Communication and patient-centred care emerged as one of the most highly rated aspects of primary care, highlighting the overwhelming importance of this dimension to patients. Patient ratings of their primary care providers were generally very high with over 90% of patients indicating that their doctor achieved the four aspects of care included in the PES related to this dimension.

**Figure 4.** Patient experience with Communication and Patient-Centred Care in primary care




## *Patient Activation in Primary Care in Canada*

Wong & Haggerty describe patient activation as "people's ability to engage in health behaviors that will maintain or improve their health status".[17] In other words, it means that patients are engaged not only in the decisions regarding their care and treatment but that they actively seek information about their health and make changes to their lifestyle. The positive effect of patient activation could lead to better quality of care and reduced healthcare costs, a relationship that has been examined recently by researchers and policy makers.[41] This interest has led to the development of new measures, such as the Patient Activation Measure (PAM) tool, which was subsequently tested and validated in various healthcare settings, population groups and jurisdictions to measure patient activation.[42,43,44,45,46] There is increasing literature suggesting that patient activation is important in affecting patient health outcomes. Using the PAM, researchers have found that increased patient activation was associated with improvement in various health outcomes, such as health behaviours[45,47] including: lower probability of being obese and smoking;[48] medication adherence; better quality-of-life; as well as improved physical and mental functional status.[49,50] Patient activation was also linked to lower healthcare utilization in terms of emergency department visits.[49] Beyond using the PAM, having patients involved in the decision-making was also associated with better health outcomes for patients with diabetes[51,52] and better blood pressure control for hypertensive patients.[53]

## Patient Values

The PVS included nine questions related to patient activation in primary care, none of which were in the top 10 patient values identified. The two aspects rated most highly were "I am honest and do not feel embarrassed to talk about my health problem" and "I feel able to cope better with my health problem/illness after this visit"; each were rated as "very important" by nearly two-thirds of all respondents. The aspects of patient activation that were not ranked as highly included "I have prepared for the consultation by keeping a symptom diary or preparing questions" and "I can bring a family member or friend to the consultation if I think this is useful." Less than a third of all patients surveyed rated these aspects as "very important." Of note, however, the former was rated "very important" by a higher proportion (45%) of respondents in Quebec.

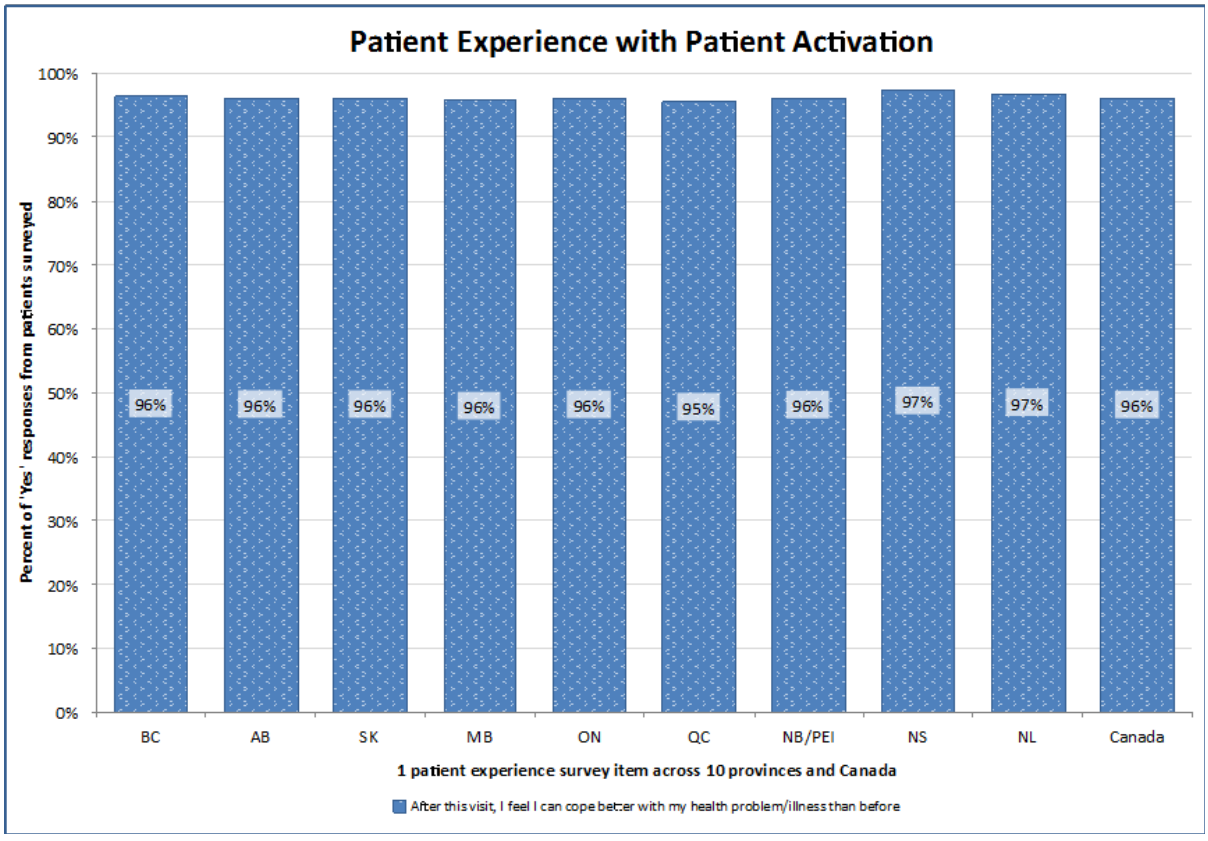
## Patient Experiences

The proportion of patients who felt they could cope better with their health problems/issues after their doctor visit is presented in Figure 5. This measure of patient activation was found to be consistently positive across all 10 provinces, with 96% of survey patients in Canada responding "yes" to this question.

## Summary of Findings

In research, patient activation has been identified as an important outcome of high quality primary care. It has been linked to improvements in patient behaviours, medication adherence, improved functional status and better quality of life, as well as reduced use of emergency departments. Patients themselves did not identify many of the patient activation aspects in the patient values survey as very important aspects of primary care. The QUALICOPC patient experience survey also included very few related aspects and the only one reported here—"after this visit I feel I can cope better with my health problem/illness than before"—received a positive rating by over 95% of respondents in every province.

**Figure 5.** Patient Experience with Patient Activation in Primary Care



## *Access to Primary Care in Canada*

Access is a multidimensional concept that is important to population health and to patients' satisfaction with healthcare. In their framework for patient experience with primary care, Wong & Haggerty[17] suggested a broader perspective—that access be considered as having three sub-dimensions: first contact accessibility, accommodation and economic accessibility. Access to primary care has also been considered using a narrower perspective in terms of physician availability and wait times which have been reported as primary indicators of limited accessibility by Canadians.[54] In a recent study from Quebec, patients rated indicators of access as the highest priority for improvement (particularly those related to physicians accepting new patients and the timeliness of the appointment[19]). Another study found that an aspect of access that is important to patient satisfaction is the amount of time spent with the doctor.[55] In the QUALICOPC study, access was measured through ease of obtaining an appointment, the possibility of seeing another doctor, the clinic having extended hours, awareness of after-hours services, the appointment being on schedule, the possibility of accessing the doctor via telephone or email, the geographical proximity of the clinic and the wait time on the phone when calling the practice.

Access to primary care is important because it leads to improved health outcomes and decreased utilization of more costly services (e.g. emergency departments). A study in the United Kingdom found a higher supply of general practitioners to be associated with lower mortality and decreased hospitalizations.[56]

### Patient Values

The PVS included eight questions related to patients' access to primary care. No aspect of access was among the 10 most highly rated values. Approximately half of all patients surveyed rated "I can get an appointment easily at this practice" and "I can see another doctor if I think it is necessary" as "very important" values. However, they were only the 28th and 33rd highest rated aspects overall. By contrast, "this practice is close to where I live or work" and "I have a short waiting time on the phone when I call this practice" were even less important, with only a quarter of all patients surveyed indicating that these latter two aspects were "important" or "very important."

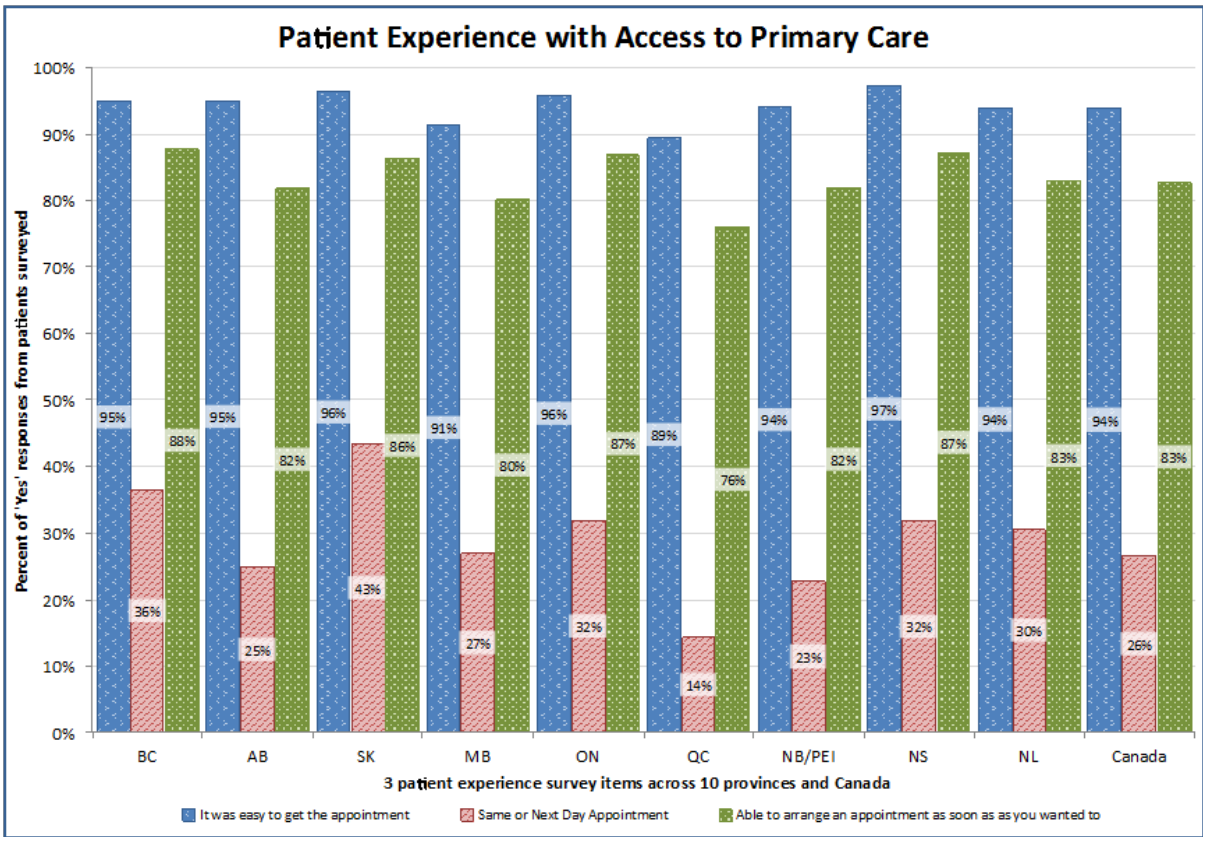
### Patient Experiences

The proportion of patients from each province who found it easy to obtain their appointment, who were seen either the same day or next day and who were able to arrange the appointment as soon as they wanted are presented in Figure 6. Ninety-four percent of patients who responded to the PES reported that it was easy to schedule their appointment. Despite the low level of same day or next day visits (26% in Canada), an important metric of access to primary care, 83% of patients were seen by the doctor as quickly as they wanted.

### Summary of Findings

Among respondents to this survey (who were visiting primary care and mostly their own physician at the time of completing the survey), access was not among the most highly rated aspects of primary care. The related experience responses showed that although only a third or less of patients were generally able to arrange an appointment on the same or next day, over 90% of patients reported that it was easy to obtain a physician appointment and over 80% reported that they could arrange their appointment as soon as they wanted. Thus, the sample of patients surveyed in this study appear to be satisfied with the extent of "same or next day access" to physicians that they are able to obtain. However, this level of satisfaction may not be representative of patients who were not surveyed as part of this research, e.g. those who do not have regular access to a primary care practice.

**Figure 6.** Patient Experience with Access to Primary Care Physician




## RESPONDENT PROFILE

This section provides information on the physicians and patients who responded to the surveys.

Table 2 summarizes the characteristics of the participating physicians across provinces (New Brunswick and Prince Edward Island are combined). The findings are reported by number, percent, median and interquartile range (IQR); the latter two present a more representative portrait of the distribution of physicians who completed the survey. There was a degree of variability across the provinces with respect to physician demographic characteristics (gender, age and birth place); whether or not these characteristics are indicative of actual demographic differences of all primary care physicians in Canada is not clear. The variability across provinces in the proportion of clinics that were part of a new model of primary care and the number of disciplines working in the practice/clinic may be reflective of the fact that some provinces (Alberta, Ontario, Quebec) have implemented reforms to their primary care system, whereas others have not.

**Table 2.** Participating physician/practice profile

| Variable | BC (n = 59) | AB (n = 131) | SK (n = 20) | MB (n = 41) | ON (n = 185) | QC (n = 218) | NB/PEI (n = 55) | NS (n = 60) | NL (n = 41) | Canada (n = 810) |
|---|---|---|---|---|---|---|---|---|---|---|
| Family physician surveys, n (%) of participating physicians | 59 (100%) | 116 (89%) | 20 (100%) | 41 (100%) | 184 (99%) | 218 (100%) | 54 (98%) | 59 (98%) | 41 (100%) | 792 (98%) |
| Practice surveys, n (%) of participating practices | 58 (98%) | 117 (89%) | 20 (100%) | 24 (59%) | 183 (99%) | 218 (100%) | 53 (96%) | 58 (97%) | 41 (100%) | 772 (95%) |
| **PHYSICIAN'S GENDER** | | | | | | | | | | |
| Male, n (%) | 30 (50.8%) | 65 (56%) | 13 (65%) | 23 (56.1%) | 79 (42.9%) | 98 (45%) | 28 (51.9%) | 33 (55.9%) | 30 (73.2%) | 399 (50.4%) |
| Female, n (%) | 29 (49.2%) | 51 (44%) | 7 (35%) | 18 (43.9%) | 105 (57.1%) | 120 (55%) | 26 (48.1%) | 26 (44.1%) | 11 (26.8%) | 393 (49.6%) |
| Physician's age, median (IQR) | 50 (42 - 57) | 47 (39 - 57) | 53 (41 - 58) | 49 (41 - 55) | 50 (41 - 58) | 51 (39 - 57) | 49 (38 - 55) | 55 (45 - 60) | 43 (36 - 55) | 50 (40 - 57) |
| **PHYSICIAN WAS BORN IN CANADA** | | | | | | | | | | |
| Yes, n (%) | 35 (59.3%) | 68 (59.6%) | 10 (50%) | 18 (43.9%) | 122 (66.7%) | 200 (91.7%) | 45 (84.9%) | 42 (73.7%) | 23 (56.1%) | 563 (71.6%) |
| No, n (%) | 24 (40.7%) | 46 (40.4%) | 10 (50%) | 23 (56.1%) | 61 (33.3%) | 18 (8.3%) | 8 (15.1%) | 15 (26.3%) | 18 (43.9%) | 223 (28.4%) |
| **PHYSICIAN'S CLINIC IS PART OF A NEW MODEL OF PRIMARY HEALTH CARE BENEFITING FROM SPECIAL FUNDING OR PART OF A GOVERNMENT-LED REFORM** | | | | | | | | | | |
| Yes, n (%) | 8 (13.6%) | 97 (83.6%) | 5 (25%) | 9 (22%) | 131 (71.2%) | 152 (69.7%) | 5 (9.3%) | 13 (22%) | 0 (0%) | 420 (53%) |
| If yes, years practice has been part of this model, median (IQR) | 9.8 (5 - 20) | 5.2 (4 - 7) | 12.7 (8 - 33) | 4.5 (3 - 5) | 5 (3 - 6) | 5 (3 - 8) | 2 (1 - 5) | 3 (1 - 7) | 0 (0 - 0) | 5 (3 - 7) |
| No, n (%) | 51 (86.4%) | 19 (16.4%) | 15 (75%) | 32 (78%) | 53 (28.8%) | 66 (30.3%) | 49 (90.7%) | 46 (78%) | 41 (100%) | 372 (47%) |
| Estimated size of practice population, median (IQR) | 1,500 (1,000 – 2,000) | 1,500 (1,006 – 2,000) | 2,000 (1,200 – 3,000) | 1,600 (875 – 2,440) | 1,400 (1,000 – 1,800) | 1,000 (500 – 1,800) | 1,500 (1,200 – 2,300) | 2,000 (1,200 – 3,000) | 2,000 (1,200 – 2,500) | 1,500 (1,000 – 2,000) |
| Number of non-physician disciplines working in the practice/ clinic, median (IQR) | 2 (1 - 4) | 4 (3 - 6) | 3 (2 - 5) | 5 (3 - 8) | 4 (3 - 7) | 4 (3 - 5) | 2 (1 - 4) | 2 (2 - 3) | 2 (2 - 5) | 4 (2 - 6) |
| **PHYSICIAN WORKS ALONE OR IN SHARED ACCOMMODATION** | | | | | | | | | | |
| Alone, n (%) | 3 (5.3%) | 13 (11.2%) | 7 (35%) | 8 (19.5%) | 29 (15.8%) | 25 (11.5%) | 26 (48.1%) | 18 (30.5%) | 7 (17.1%) | 136 (17.2%) |
| With other Family Physicians/General Practitioners, n (%) | 53 (93%) | 101 (87.1%) | 13 (65%) | 32 (78%) | 152 (82.6%) | 184 (84.8%) | 24 (44.4%) | 38 (64.4%) | 30 (73.2%) | 627 (79.5%) |
| With medical specialists, n (%) | 5 (8.8%) | 13 (11.2%) | 0 (0%) | 9 (22%) | 20 (10.9%) | 39 (18%) | 3 (5.6%) | 6 (10.2%) | 3 (7.3%) | 98 (12.4%) |
| With other healthcare providers, n (%) | 13 (22.8%) | 23 (19.8%) | 5 (25%) | 16 (39%) | 49 (26.6%) | 60 (27.6%) | 9 (16.7%) | 11 (18.6%) | 6 (14.6%) | 192 (24.3%) |

Table 3 below provides a profile of the patients who responded to either the PVS or the PES by province. The results show that participating patients' characteristics varied across provinces in terms of gender distribution, age, health status, education level and in their or their mother's place of birth. The majority of respondents were female; the proportion of female respondents ranged from 58% in Saskatchewan to 73% in New Brunswick/Prince Edward Island, with an average of 67%. Between 71% (New Brunswick/Prince Edward Island) and 76% (Manitoba) of participating patients from each province rated their health as being "good" or "very good." Fifty percent of Quebec respondents reported having a post-secondary education compared to 65% in British Columbia. The province with the lowest proportion of respondents who were fluent in either French or English was Newfoundland and Labrador (68%) and the one with the highest proportion was Quebec (87%). Only 17% of Albertan respondents reported having below average household income; below average household income was highest among respondents from British Columbia (22%). The proportion of patients who were born in Canada varied from 76% in Ontario to 96% in Newfoundland and Labrador, and between 62% (Ontario) and 95% (Newfoundland and Labrador) of patients' mothers were also born in Canada. Between 3% (Ontario) and 19% (Manitoba) of patients were aboriginal. Proportions of patients who reported living with adults (76%) and with children (30%) were similar across provinces.

**Table 3.** Participating patient profile

| Variable | BC (n = 627) | AB (n = 1,447) | SK (n = 218) | MB (n = 401) | ON (n = 1,980) | QC (n = 2,087) | NB/PEI (n = 566) | NS (n = 636) | NL (n = 370) | Canada (n = 8,332) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Patient experience surveys, n (%) of participating physicians** | 537 (100%) | 1240 (100%) | 185 (100%) | 353 (100%) | 1,698 (100%) | 1,798 (99%) | 497 (100%) | 544 (100%) | 320 (100%) | 7,172 (100%) |
| **Patient values surveys, n (%) of participating practices** | 90 (97%) | 207 (96%) | 33 (95%) | 48 (93%) | 282 (97%) | 289 (97%) | 69 (95%) | 92 (100%) | 50 (85%) | 1160 (96%) |
| **PATIENT'S GENDER** | | | | | | | | | | |
| **Male, n (%)** | 215 (34.6%) | 484 (34.1%) | 91 (42.5%) | 122 (31.5%) | 661 (34.3%) | 685 (33.5%) | 151 (27%) | 194 (31.1%) | 117 (32.1%) | 2720 (33.3%) |
| **Female, n (%)** | 407 (65.4%) | 935 (65.9%) | 123 (57.5%) | 265 (68.5%) | 1268 (65.7%) | 1362 (66.5%) | 409 (73%) | 430 (68.9%) | 248 (67.9%) | 5447 (66.7%) |
| **Patient's age, median (IQR)** | 54 (41 - 66) (n=590) | 52 (37 - 64) (n=1,372) | 56 (42 - 66) (n=204) | 53 (37 - 65) (n=375) | 52 (38 - 64) (n=1,855) | 54 (39 - 64) (n=2,031) | 53 (40 - 64) (n=552) | 56 (45 - 66) (n=608) | 52 (40 - 62) (n=339) | 53 (39 - 64) (n=7,926) |
| **PATIENT'S REPORTED HEALTH STATUS** | | | | | | | | | | |
| **Very good, n (%)** | 104 (16.7%) | 309 (21.6%) | 36 (16.7%) | 105 (26.5%) | 468 (23.9%) | 488 (23.7%) | 117 (20.8%) | 145 (23.1%) | 87 (23.8%) | 1859 (22.6%) |
| **Good, n (%)** | 347 (55.7%) | 769 (53.8%) | 118 (54.9%) | 196 (49.5%) | 1004 (51.3%) | 1023 (49.7%) | 284 (50.4%) | 332 (52.8%) | 176 (48.2%) | 4249 (51.6%) |
| **Fair, n (%)** | 139 (22.3%) | 295 (20.6%) | 53 (24.7%) | 79 (19.9%) | 395 (20.2%) | 475 (23.1%) | 140 (24.9%) | 131 (20.8%) | 90 (24.7%) | 1797 (21.8%) |
| **Poor, n (%)** | 33 (5.3%) | 56 (3.9%) | 8 (3.7%) | 16 (4%) | 90 (4.6%) | 74 (3.6%) | 22 (3.9%) | 21 (3.3%) | 12 (3.3%) | 332 (4%) |
| **PATIENT'S HIGHEST LEVEL OF EDUCATION ACHIEVED** | | | | | | | | | | |
| **Less than grade 10, n (%)** | 32 (5.1%) | 82 (5.8%) | 23 (10.9%) | 45 (11.6%) | 119 (6.2%) | 315 (15.5%) | 51 (9.2%) | 43 (6.9%) | 51 (14.2%) | 761 (9.4%) |
| **Upper secondary education, n (%)** | 185 (29.7%) | 442 (31.3%) | 73 (34.6%) | 139 (35.8%) | 565 (29.6%) | 710 (34.9%) | 170 (30.8%) | 198 (31.9%) | 105 (29.2%) | 2587 (31.9%) |

| Variable | BC (n = 627) | AB (n = 1,447) | SK (n = 218) | MB (n = 401) | ON (n = 1,980) | QC (n = 2,087) | NB/PEI (n = 566) | NS (n = 636) | NL (n = 370) | Canada (n = 8,332) |
|---|---|---|---|---|---|---|---|---|---|---|
| Post-secondary education, n (%) | 405 (65.1%) | 890 (62.9%) | 115 (54.5%) | 204 (52.6%) | 1228 (64.2%) | 1010 (49.6%) | 331 (60%) | 379 (61.1%) | 203 (56.5%) | 4765 (58.7%) |
| **PATIENT'S FRENCH/ENGLISH SPEAKING LEVEL** | | | | | | | | | | |
| Fluently/native speaker level, n (%) | 509 (82.4%) | 1177 (83.8%) | 161 (76.7%) | 288 (74.2%) | 1444 (75.5%) | 1779 (87.3%) | 421 (75.6%) | 483 (78.7%) | 244 (67.8%) | 6506 (80.3%) |
| Sufficiently, n (%) | 66 (10.7%) | 139 (9.9%) | 38 (18.1%) | 61 (15.7%) | 287 (15%) | 150 (7.4%) | 83 (14.9%) | 84 (13.7%) | 78 (21.7%) | 986 (12.2%) |
| Moderately, n (%) | 21 (3.4%) | 41 (2.9%) | 4 (1.9%) | 19 (4.9%) | 79 (4.1%) | 55 (2.7%) | 22 (3.9%) | 23 (3.7%) | 10 (2.8%) | 274 (3.4%) |
| Poorly, n (%) | 12 (1.9%) | 22 (1.6%) | 2 (1%) | 9 (2.3%) | 47 (2.5%) | 40 (2%) | 16 (2.9%) | 8 (1.3%) | 16 (4.4%) | 172 (2.1%) |
| Not at all, n (%) | 10 (1.6%) | 26 (1.9%) | 5 (2.4%) | 11 (2.8%) | 56 (2.9%) | 13 (0.6%) | 15 (2.7%) | 16 (2.6%) | 12 (3.3%) | 164 (2%) |
| **PATIENT'S HOUSEHOLD INCOME** | | | | | | | | | | |
| Below average, n (%) | 135 (21.8%) | 237 (16.9%) | 38 (17.9%) | 74 (19.2%) | 362 (19.1%) | 432 (21.4%) | 108 (19.6%) | 117 (18.8%) | 78 (21.5%) | 1581 (19.6%) |
| Average, n (%) | 342 (55.3%) | 799 (56.9%) | 130 (61.3%) | 228 (59.1%) | 1087 (57.4%) | 1171 (58.1%) | 352 (63.8%) | 397 (63.9%) | 218 (60.1%) | 4724 (58.5%) |
| Above average, n (%) | 142 (22.9%) | 369 (26.3%) | 44 (20.8%) | 84 (21.8%) | 446 (23.5%) | 414 (20.5%) | 92 (16.7%) | 107 (17.2%) | 67 (18.5%) | 1765 (21.9%) |
| **PATIENT'S BIRTH REGION** | | | | | | | | | | |
| Canada, n (%) | 481 (77.5%) | 1163 (82.1%) | 194 (91.9%) | 337 (86.9%) | 1451 (75.5%) | 1930 (94%) | 524 (94.4%) | 594 (95.2%) | 350 (96.4%) | 7024 (86.1%) |
| USA, Mexico, Australia or New Zealand, n (%) | 18 (2.9%) | 23 (1.6%) | 2 (0.9%) | 13 (3.4%) | 24 (1.2%) | 7 (0.3%) | 13 (2.3%) | 11 (1.8%) | 2 (0.6%) | 113 (1.4%) |
| European Union Country, n (%) | 48 (7.7%) | 97 (6.8%) | 7 (3.3%) | 11 (2.8%) | 131 (6.8%) | 32 (1.6%) | 5 (0.9%) | 13 (2.1%) | 6 (1.7%) | 350 (4.3%) |
| Non-European Union Country, n (%) | 11 (1.8%) | 21 (1.5%) | 0 (0%) | 9 (2.3%) | 60 (3.1%) | 14 (0.7%) | 3 (0.5%) | 1 (0.2%) | 1 (0.3%) | 120 (1.5%) |
| Other, n (%) | 63 (10.1%) | 113 (8%) | 8 (3.8%) | 18 (4.6%) | 257 (13.4%) | 71 (3.5%) | 10 (1.8%) | 5 (0.8%) | 4 (1.1%) | 549 (6.7%) |
| **PATIENT'S MOTHER'S BIRTH REGION** | | | | | | | | | | |
| Canada, n (%) | 394 (64%) | 986 (69.8%) | 173 (81.2%) | 293 (75.9%) | 1185 (61.7%) | 1869 (91.3%) | 511 (92.1%) | 566 (90.6%) | 344 (94.8%) | 6321 (77.7%) |
| USA, Mexico, Australia or New Zealand, n (%) | 26 (4.2%) | 43 (3%) | 5 (2.3%) | 15 (3.9%) | 40 (2.1%) | 15 (0.7%) | 14 (2.5%) | 16 (2.6%) | 2 (0.6%) | 176 (2.2%) |
| European Union Country, n (%) | 86 (14%) | 175 (12.4%) | 20 (9.4%) | 38 (9.8%) | 274 (14.3%) | 54 (2.6%) | 12 (2.2%) | 32 (5.1%) | 11 (3%) | 702 (8.6%) |
| Non-European Union Country, n (%) | 28 (4.5%) | 69 (4.9%) | 7 (3.3%) | 18 (4.7%) | 108 (5.6%) | 27 (1.3%) | 5 (0.9%) | 2 (0.3%) | 1 (0.3%) | 265 (3.3%) |
| Other, n (%) | 82 (13.3%) | 139 (9.8%) | 8 (3.8%) | 22 (5.7%) | 313 (16.3%) | 83 (4.1%) | 13 (2.3%) | 9 (1.4%) | 5 (1.4%) | 674 (8.3%) |
| **PATIENT'S ABORIGINAL STATUS (FIRST NATIONS, METIS, INUK)** | | | | | | | | | | |
| Yes, n (%) | 38 (6.2%) | 88 (6.3%) | 22 (10.5%) | 66 (18.9%) | 44 (2.7%) | 149 (7.5%) | 25 (4.6%) | 49 (8%) | 30 (8.6%) | 511 (6.6%) |
| No, n (%) | 576 (93.8%) | 1304 (93.7%) | 188 (89.5%) | 283 (81.1%) | 1599 (97.3%) | 1849 (92.5%) | 520 (95.4%) | 566 (92%) | 320 (91.4%) | 7205 (93.4%) |

| Variable | BC (n = 627) | AB (n = 1,447) | SK (n = 218) | MB (n = 401) | ON (n = 1,980) | QC (n = 2,087) | NB/PEI (n = 566) | NS (n = 636) | NL (n = 370) | Canada (n = 8,332) |
|---|---|---|---|---|---|---|---|---|---|---|
| **PATIENT LIVES WITH ADULTS (18 YEARS AND OVER)** | | | | | | | | | | |
| **Yes, n (%)** | 469 (75.3%) | 1083 (76.7%) | 156 (73.6%) | 282 (73.1%) | 1492 (77.5%) | 1498 (73.5%) | 430 (77.6%) | 474 (76.2%) | 290 (79.9%) | 6174 (75.9%) |
| **No, n (%)** | 154 (24.7%) | 329 (23.3%) | 56 (26.4%) | 104 (26.9%) | 433 (22.5%) | 541 (26.5%) | 124 (22.4%) | 148 (23.8%) | 73 (20.1%) | 1962 (24.1%) |
| **PATIENT LIVES WITH CHILDREN (UNDER 18 YEARS OLD)** | | | | | | | | | | |
| **Yes, n (%)** | 174 (28%) | 413 (29.4%) | 51 (24.5%) | 110 (28.8%) | 649 (33.7%) | 568 (28.5%) | 182 (33%) | 157 (25.4%) | 102 (28.2%) | 2406 (29.8%) |
| **No, n (%)** | 448 (72%) | 994 (70.6%) | 157 (75.5%) | 272 (71.2%) | 1275 (66.3%) | 1425 (71.5%) | 369 (67%) | 461 (74.6%) | 260 (71.8%) | 5661 (70.2%) |
| **PATIENT'S OCCUPATION** | | | | | | | | | | |
| **Employed, n (%)** | 259 (41.6%) | 630 (44.8%) | 92 (43.6%) | 166 (42.8%) | 851 (44.4%) | 898 (44.4%) | 249 (45%) | 244 (39.7%) | 165 (46.5%) | 3554 (43.9%) |
| **Self employed or family business, n (%)** | 84 (13.5%) | 176 (12.5%) | 28 (13.3%) | 34 (8.8%) | 221 (11.5%) | 213 (10.5%) | 52 (9.4%) | 54 (8.8%) | 26 (7.3%) | 888 (11%) |
| **Student, n (%)** | 21 (3.4%) | 55 (3.9%) | 5 (2.4%) | 23 (5.9%) | 83 (4.3%) | 79 (3.9%) | 14 (2.5%) | 19 (3.1%) | 15 (4.2%) | 314 (3.9%) |
| **Looking for a job (unemployed, n (%))** | 19 (3%) | 36 (2.6%) | 5 (2.4%) | 59 (15.2%) | 51 (2.7%) | 46 (2.3%) | 20 (3.6%) | 17 (2.8%) | 10 (2.8%) | 263 (3.3%) |
| **Unable to work due to illness or disability, n (%)** | 76 (12.2%) | 127 (9%) | 17 (8.1%) | 50 (12.9%) | 203 (10.6%) | 172 (8.5%) | 60 (10.8%) | 69 (11.2%) | 40 (11.3%) | 814 (10.1%) |
| **Retired, n (%)** | 189 (30.3%) | 360 (25.6%) | 65 (30.8%) | 138 (35.6%) | 507 (26.5%) | 612 (30.3%) | 156 (28.2%) | 213 (34.6%) | 93 (26.2%) | 2333 (28.8%) |
| **Homemaker, n (%)** | 35 (5.6%) | 138 (9.8%) | 8 (3.8%) | 97 (25%) | 134 (7%) | 99 (4.9%) | 31 (5.6%) | 43 (7%) | 29 (8.2%) | 614 (7.6%) |

## DISCUSSION

Overall, patients reported values related to communication and patient-centred care, and to continuity and coordination dimensions of primary health care as the most important. Access and patient activation were rated as less important compared to other dimensions of care. In general, surveyed patients in all provinces had very positive experiences with the care they received from their primary care physician, particularly on the values that were rated as most important.

Access to primary care was identified as a priority area for improvement during the First Minister's Meeting on the Future of Health Care in 2004 and has been the focus of efforts to reform the delivery of primary care services across Canada. The Commonwealth Fund studies demonstrate that access to primary care in Canada is poorer than in most other nations of similar wealth in terms of finding after-hours care without going to the emergency department, receiving an answer to a health concern on the same day or being able to obtain a same or next day appointment.[57] Given the focus on improving access to care in Canada, it is noteworthy that the PVS questions related to access ranked relatively low in our study, but this finding may be biased by the sample used—i.e. patients who had regular access to a primary care provider/practice, the majority of whom were in good or very good health. There is little doubt that lack of access is extremely important to patients who do not have a family physician, and of course results may be different if sampling occurred in a different

location (e.g. an emergency room during evenings or weekends). The proportion of respondents able to obtain a same or next day appointment (approximately 40%[54]) was comparable to that found in the Commonwealth Fund survey. However, our other questions on access suggest that despite this relatively low percentage, the vast majority of patients still found it was easy to obtain an appointment and reported that they were able to have it as soon as they wanted. A majority of respondents to the QUALICOPC surveys did not feel it was necessary to obtain a same day physician appointment. In addition, our findings are aligned with previous studies from other countries that found that respondents—both from the general population[58] and current primary care patients[21] prefer high technical quality and communication to access. Patients did not consider extensive open hours of a practice/clinic to be a priority.

Some jurisdictions have also focused reforms to primary care on the creation of inter-disciplinary teams, yet, for the patients surveyed in this study who already have access to a primary care physician, this feature was not rated as a "very important" value. A potential explanation for this discrepancy is that patients surveyed may not have needed access to any other type of healthcare provider and hence, did not perceive it as being important. In this sense, government efforts to reform primary care would be characterized as being responsive to evidence of best practices and being ahead of patient values, but again, other population groups not sampled in this research may value access to inter-disciplinary teams.

One may consider the lower rated values as "nice to have" as opposed to necessary. It does not mean that these values would not be appreciated or that accomplishing them would not result in higher patient satisfaction or better patient health outcomes. In fact, the percentage of patients rating values as "not important" was very low. In interpreting the results of this study, it is important to take into consideration that this report focuses on the aspects that were chosen as being "very important" by the largest proportion of survey respondents; however, the difference between "important" and "very important" may be subjective and minimal. Some questions and values may be "very important" to only a few, but many people may consider them "important."

Overall, the results presented here suggest that patients have a better experience with primary care than what was reported in a recent Commonwealth Fund survey, notably in terms of the physician knowing the medical history and involving the patient in the decision-making.[54] One should consider that different survey methodologies were used in the QUALICOPC protocol in that patients responded right after their appointment and, hence, were less subject to recall bias.

It is possible that we did not capture some of the negative experiences with primary care because our sample was limited to those patients visiting a primary care doctor. There are still many people that are not connected to primary care, some of them because they are not able to find a physician despite their higher medical needs and potential vulnerability. To address this issue, some provinces have developed registries where individuals can put their names on a list to be connected with a primary care provider.[59]

People who wished to, and could benefit from, having a provider but were not able to access primary care are not included in our study which may also bias the results regarding the importance placed on access. In addition, patients experiencing an acute illness who may be more likely to seek their acute care elsewhere because of poor access to their family physician may not be included in the survey responses. Patients with an acute illness may be more likely to feel unwell than patients visiting physicians for routine appointments; consequently, of the patients invited to complete the survey, those with acute illness may have been less likely to agree to participate. For both these reasons, we feel that it is best to interpret the results about the importance of timely access to primary care with caution. As well, patients who have had negative experiences with one particular doctor, may

seek care from an emergency department, or may forgo seeking care all together. Other sources of positive response bias lie in the patient and physician recruitment strategy. Patients surveyed may be those who visit their primary care provider more frequently, suggesting a bias towards higher users. However, this concern is partially mitigated by the high percentage of respondents considering their health to be "good" or "very good." Consecutive patients at each practice were asked to participate in the study in order to avoid practices selecting patients to participate in the study. The survey, however, was voluntary. Despite being told there would be no negative consequences from their participation, the patients who agreed to complete the surveys may be those who are more satisfied with the care they receive. Similarly, physician participation was voluntary and not selected based on representation of geographic composition of the provinces (with the exception of Quebec's recruitment approach). As such, participating physicians may represent those with increased interest in quality improvement or performance measurement, and may differ in performance from other primary care providers. Additionally, physicians and staff were able to review the content of the patient values and experience surveys prior to administering the surveys, potentially leading to further positive response bias through the adjustment of their behaviours.

Finally, though this study included all 10 Canadian provinces, it did not include any of the three territories in Canada. The research team considered including the territories in the study, however, sampling and requirement methodologies would have needed to be substantially adjusted to reflect the different context in those regions and this would have taken a considerable amount of additional time. Given this important challenge and the available resources, the territories were not included in this initial study. Nevertheless, this dataset represents the largest survey of primary care patient experience in Canada and the findings represent the views of a large sample of patients in each province.

Previous studies comparing primary care, such as the surveys conducted by the Commonwealth Fund, have raised interest in inter-jurisdictional comparisons. The QUALICOPC survey raises the bar with regard to the number of countries involved, and the comprehensiveness and linking of the surveys. In Canada, the study benefited from the expertise of researchers from across the country. It was also a learning experience for the research team to reflect on for future studies. One such initiative is a five year program of research funded by the Canadian Institutes for Health Research (CIHR) to develop the science of performance measurement in primary care through a project called *TRANSFORMATION – Improving the measurement and reporting of performance in Primary Health Care*.

This report focused on patient values and experience with primary care. However, the data collected through the QUALICOPC surveys included not only the patient reported data but also information on the participating physicians and their respective practices. Each participating practice was assigned a unique number which was printed on each survey, allowing the linkage of data across surveys. This methodology/approach allowed researchers to conduct studies linking patients' experiences in a practice with the characteristics of the practice. There is also an ongoing initiative to link data from the surveys to provincial administrative databases. Some information collected through these surveys is not available elsewhere and its utilization and linkage to other databases will motivate new research and contribute to the development of new knowledge about primary care practices, models and characteristics, as well as how they relate to patient values, experience and outcomes. Examples of ongoing and planned research include using QUALICOPC survey data to identify components of primary care models that are related to improved patient experience or improved patient outcomes (as identified through administrative databases). Canadian researchers and graduate students interested in accessing this database should contact the authors of this report.

## IMPLICATIONS

International comparisons of primary care were first provided by the Commonwealth Fund surveys. Their surveys reported relatively poor performance for Canadian primary care. These results may have influenced governments' decisions to aggressively invest to reform primary care service delivery in Canada. The QUALICOPC study found that the Canadian patients sampled (i.e. those who have regular access to a primary care practice, the majority of whom are in good or very good health), have a reasonably positive experience with primary care, notably in terms of the physician knowing their medical history and involving them in the decision-making process. Distinct sampling methodologies between the Commonwealth Fund and QUALICOPC surveys help explain the differences; for example, in the QUALICOPC protocol, patients responded right after their appointment and, hence, were less subject to recall bias. The QUALICOPC study is also more comprehensive than the Commonwealth Fund surveys in the number of topics covered and the linkability between physicians and patient surveys. The differences in the results between the two approaches reinforce the need for further research to inform decisions and expenditures to reform the primary care system. Given the importance of primary care services to the health and welfare of Canadians and the cost of ongoing efforts to reform these services, further comprehensive measurement of primary care is needed.

The results of the QUALICOPC study can also inform the alignment of efforts to reform primary care service delivery and identify the primary care characteristics most valued by various patient population groups. Despite the fact that the organization of primary care varies across provinces, there was little variation between provinces in patient values and experiences for the sample employed in this research. Some of the provinces have made substantial changes to the organization and structure of primary care during the past several years and patients receiving care from a practice that was one of the newer models were well represented in our sample in these provinces (Ontario, Quebec and Alberta). Although this report did not study, and hence cannot make a clear association between, models of primary care and patient experience, this relationship may be interesting to consider for future research to inform policies on primary care characteristics that may be more supportive of a better patient experience.

Our data suggest that once patients have access to primary care, their experiences are generally very positive. However, data from other studies suggest that accessibility to primary care is poor in Canada relative to other countries[11-16], and that this likely has adverse implications on healthcare costs and population health outcomes.[14,15] Thus, we suggest that policy-makers should continue efforts to improve access to primary care to populations that are currently underserved. Further analysis of the QUALICOPC surveys linked to other data will help clarify the aspects of primary care that are most closely associated with improvements in utilization and outcomes, which may be of even greater interest to policy-makers.

This report is useful to primary care physicians as a baseline assessment of overall patient experience and informs physicians on the aspects of care that are most important to patients who visit primary care practices. Such information could be used by physicians to make modifications to their practice to focus improvement efforts. Further, regularly measuring patient experience with surveys is an effective way to understand whether the healthcare system is responsive to the needs of the patient in providing patient-centred care.

## CONCLUSION

This report summarizes the aspects of primary care that were most valued by patients who responded to a survey that was distributed to participating primary care physician practices in each province in Canada. The findings show that patients who completed surveys in these practices most highly value care aspects related to communication and patient-centred care, and to continuity and coordination.

Through the surveys, patients reported a very positive experience with their primary healthcare physicians in every province. The data presented in this report also shows that there was very little variation across the country in the aspects of primary care that patients found to be most important, as well as little variation in the experiences of patients in different provinces related to these aspects.

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## APPENDIX: PATIENT VALUES SURVEY QUESTIONS

| Domain | PVS Question |
|---|---|
| Access | This practice is close to where I live or work |
| | The practice has extensive opening hours |
| | The doctor offers telephone or email contact if I have further questions |
| | My appointment is on schedule |
| | I know how to get evening, night and weekend services |
| | I have a short waiting time on the phone when I call this practice |
| | I can see another doctor if I think it is necessary |
| | I can get an appointment easily at this practice |
| Communications & Patient -Centered Care | This doctor informs me about reliable sources of information |
| | The people at the reception desk are polite and helpful |
| | The doctor understands me |
| | The doctor treats me as a person and not just as a medical problem |
| | The doctor takes me seriously |
| | The doctor makes me feel welcome by making eye contact |
| | The doctor listens attentively |
| | The doctor knows about my living situation |
| | The doctor is polite |
| | The doctor is not prejudiced because of my age, gender, religion, or cultural background |
| | The doctor is aware of my personal, social, and cultural background |
| | The doctor involves me in making decisions about treatment |
| | The doctor gives me all test results, even if they show no abnormalities |
| | The doctor gives me additional information about my health problem (e.g. handout, brochure) |
| | The doctor gives clear instructions on what to do when things go wrong |
| | The doctor does not make me feel under time pressure |
| | The doctor avoids disturbances of the consultation by telephone calls, etc. |
| | The doctor asks questions about my health problems |
| | The doctor asks me if I have any questions |
| | The doctor asks if I have understood everything |
| | The doctor asks how I prefer to be treated |
| | The doctor asks about possible other problems besides the one I came in for |
| | Respectful during physical examination by not interrupting me |

| | |
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| **Continuity & Coordination** | Psychosocial issues (for example personal worries) can be discussed if needed |
| | I understand clearly what this doctor explains |
| | I have an agreed upon treatment |
| | The doctor knows important information about my medical history and health issues |
| | The practice shares information about my medical condition and needs with other providers |
| | The doctor knows when to refer me to a medical specialist |
| | The doctor has prepared for the visit by reading my medical notes |
| | The doctor has my relevant medical records at hand |
| | I have a strong (formal) agreement with one physician who is the most responsible physician for my care |
| | I don't need to tell a receptionist or nurse details of my health problem before seeing doctor |
| | I can see other healthcare professionals in this practice without having to see a doctor |
| | I can see other doctors in this practice if my doctor is not available |
| | I can see my regular doctor every time |
| | I am informed by the practice when I am due for recommended check-ups, tests, or preventive screening |
| | Different providers within this practice share information about my medical conditions and needs |
| | I know which doctor I will see |
| **Paitient Activation** | I tell doctor what I want to discuss in this consultation |
| | I inform the doctor how the treatment works out |
| | I have prepared for the consultation by keeping a symptom diary or preparing questions |
| | I feel able to cope better with health problem/illness after this visit |
| | I can bring a family member/friend to the consultation if I think is useful |
| | I am prepared to ask questions and take notes |
| | I am open about my use of other treatments, such as self-medication or alternative medicine |
| | I am honest and do not feel embarrassed to talk about my health problem |
| | I adhere to the agreed treatment |