"The primary objective of Canadian health care policy is to...facilitate reasonable access to health services without financial or other barriers" (Canada Health Act, R.S. 1985, c.C-6, s.3a)

**Background**

- **Primary Health Care (PHC)**: The envelope of services offered within the context of a medical home, characterized by:
  - First-contact care and longitudinality, comprehensiveness, and coordination
  - Strained access to (PHC) in Quebec
    - 25% of Quebecers lack a family doctor (cf. national average of 15%)
    - Need for 800 new full-time family physicians to fulfill need
- **Mixed evidence on SES & access to PHC**
  - Income and/or education positively affect access to PHC in some studies
  - The relationship is either non-existent or negative with access in other studies
- **Potential vs. achieved access**
  - Potential: the presence of factors conducive to access
  - Achieved: actual number of visits to PHC provider
- **Gaps in the literature**
  - Mixed evidence, lack of Quebec-specific studies, little consideration for potential instead of achieved access

**Methodology**

- **Data**
  - Canadian Community Health Survey, 3.1 (2005)
  - Sample restricted to adult Quebecers
  - Regression sample: 23,502
- **Method**
  - Logistic regression
  - Population & bootstrap weights
  - Odds ratios & predicted probabilities
- **Variables**
  - Main IVs: Household income, education
  - Other measures of inequity: household size, health region, residence, labour status, language, visible minority status, marital status
  - Control variables: Perceived & evaluated health need, age, sex

**Findings**

- **Inequalities in access exist, as expected**
  - Age
  - Being female
  - Having chronic conditions
  - Having poor self-perceived health
  - are all positively associated with greater likelihood of having a regular medical doctor

**Discussion**

- **Main findings**
  - SES (income) does in fact affect access to PHC
  - Access is especially difficult for Montrealers, ‘healthy’ individuals and those with low income
- **So why does universal coverage ≠ universal access?**
  - Complementary qualitative study highlighted perverse effects of certain health policies on access to PHC in the province – e.g. AMPs (MacLean 2009)
  - These policies ensure that those who need care the most (the oldest and sickest) do receive it, despite negative predictors of access
  - But they also provide disincentives for GPs to service the general population
  - Could social networks be a compelling rationale?
    - High income → rich social networks → better access to PHC through networks
    - “It has nothing to do with money. No money changes hands here. In other societies, if you pony up the money, you get quick service. It’s not the case here; it has everything to do with personal contacts”
      —Dr. Alan Pavlianis, Chief of the Department of Family Medicine, St. Mary’s Hospital

**In other words...**

The predicted probability of having a regular medical doctor for...

- **Good news:** The oldest and sickest in society have access to a family doctor, despite income, or health region
- **Bad news:** ‘Average’, relatively healthy patients in need of regular check-ups are subject to inequities in income and health region

**Acknowledgements/References**