RESEARCH PAPER

What Do People Think Is Important about Primary Healthcare?

Qu'est-ce qui est important pour les gens dans les soins de santé primaires?

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Abstract

The purpose of this study was to inform quality improvement and performance measurement initiatives in primary healthcare based on the perceptions of British Columbia residents. Key features of care were identified during focus group discussions on important areas in primary healthcare, particularly those that could be improved.

Eleven focus groups (n=75) were held. Ninety-six per cent of participants reported that they had a regular primary healthcare provider and had been with that provider for an average of 8.5 years. We conducted a thematic content analysis using a coding scheme based on a logic model for this sector.

Analysis revealed the importance of six domains: accessibility (geographic location and timeliness of appointments), continuity, responsiveness, interpersonal communication, technical quality and whole-person care. Although participants discussed accessibility most frequently, domains more often associated with satisfaction were interpersonal communication and continuity.

Résumé

Cette étude visait à orienter les initiatives d'amélioration de la qualité et de mesure du rendement dans les soins de santé primaires d'après les perceptions des résidents de la Colombie-Britannique. Lors de groupes de discussions, des caractéristiques clés des soins ont été cernées sur les aspects importants des soins de santé primaires, en particulier ceux qui pourraient être améliorés.

Onze (n=75) groupes de discussion ont été mis sur pied en Colombie-Britannique. Quatre-vingt-seize pour cent des participants ont indiqué qu'ils avaient un fournisseur de soins primaires régulier et qu'ils le voyaient depuis 8,5 ans en moyenne. Nous avons effectué une analyse du contenu thématique en utilisant un système de codage fondé sur un modèle logique pour ce secteur.

L'analyse a révélé l'importance de six domaines : l'accessibilité (emplacement géographique et moment des rendez-vous), la continuité, la réceptivité, les communications interpersonnelles, la qualité technique et les soins holistiques. Bien que l'accessibilité ait été le sujet le plus discuté, les domaines procurant le plus de satisfaction étaient les améliorations dans les communications interpersonnelles et la continuité.

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In September 2000, Canada's First Ministers agreed to an Action Plan for Health System Renewal that included a commitment to catalyze reform in primary healthcare (PHC). In response, the Government of Canada (2004) announced the creation of the Primary Healthcare Transition Fund to "support the transitional costs of implementing sustainable, large-scale, PHC renewal initiatives." At that time, leaders agreed to provide regular, comprehensive and public reports to their respective citizens using jointly agreed-upon comparable indicators on health status, health outcomes and quality of service. Over the next six years, initiatives in quality improvement and performance measurement accelerated in this sector. Investments through the Health Accord in 2003 and the 10-Year Plan in 2004 further fuelled these activities.

Quality of healthcare is a multifaceted concept, and measuring it requires assessment from many different perspectives. The Institute of Medicine (2001) identifies six domains of quality: healthcare must be *safe* (avoiding adverse events to patients from the care intended to help them), *effective* (providing services based on scientific knowledge to all who could benefit), *patient-centred* (providing care that is respectful of and responsive to individual patient preferences, needs and values), *timely* (reducing waits for those who receive care and healthcare providers who give care), *efficient* (avoiding waste of equipment, supplies, ideas and energy) and *equitable* (providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status).

One of these six quality domains, patient-centred care, focuses on "the patient's experiences of illness and healthcare and on the systems that work or fail to work to meet individual patients' needs" (Institute of Medicine 2001). Information about patient experiences with PHC and their views on what could be improved can be used, therefore, to identify priorities for quality improvement as well as to create public reports that account for investments in healthcare renewal (Davis et al. 2005).

Increasingly, healthcare decision-makers in Canada and abroad are actively seeking public involvement in health policy decisions regarding healthcare renewal (BC Ministry of Health 2006; Crawford et al. 2002; Ontario Ministry of Health and Long-Term Care 2007; Telford et al. 2004). The involvement of the public in offering their perspectives on care can result in positive changes in organizational culture, quality of care and satisfaction (Crawford et al. 2002; Davis et al. 2005; Donabedian 1992).

Public reports on healthcare system performance are most useful and more likely to be used when they include indicators relevant to target audiences. In order to establish priorities for information among healthcare decision-makers about the progress of PHC renewal, the Canadian Institute for Health Information (CIHI) was commissioned by Health Canada in 2005 on behalf of all governments to achieve national consensus on a core set of indicators for this sector. A broad range of PHC experts from multiple levels of the health system and regions across Canada identified 105 indicators as important. Currently, only 15 could be populated with existing information systems (CIHI 2005). Members of the public were not engaged to determine what was important to them about PHC, although this type of information would now be useful for priority-setting regarding the development of new information systems to measure and monitor this sector.

Evaluation of healthcare involves defining the objective of care, monitoring PHC inputs, measuring the extent to which expected outcomes have been achieved and the occurrence of unintended consequences (Sitzia and Wood 1997). Evaluation of healthcare quality, as perceived by patients, can be one way of measuring performance (Risser 1975; Sitzia and Wood 1997; Van Maanen 1984). Thus, PHC evaluation, or monitoring of PHC performance from a patient perspective, can be undertaken using two different types of feedback: (a) asking about people's experiences with PHC and (b) asking about patients' satisfaction with the service delivered. These types of evaluations can be one way in which to identify problem areas. Moreover, a qualitative examination of patients' experiences may move ideas towards amenable solutions. While qualitative methodologies have been increasingly used to evaluate patient care (Avis et al. 1997; Kirby 2002; Romanow 2002; Wensing et al. 1998), much of what we know about Canadians' perspectives on the quality of PHC is from surveys (Schoen et al. 2004). Therefore, the purpose of this study was to inform quality improvement and performance measurement initiatives in PHC by identifying the features of care that people consider important and could be improved.

Methods

Seventy-five people were recruited to participate in 11 focus groups held across British Columbia in 2005. The locations of groups were selected in consultation with representatives from each of the health authorities, and to ensure variation in population health status and expenditures on PHC services. Premature mortality rates ranged from 2.01 to 7.33 per 1,000 population, and expenditures on general practice services ranged from $172 to $246 per 1,000 population (Watson et al. 2005). Based on site selection, a random sample of telephone numbers from the Canadian Sampler Survey was obtained (ASDE n.d.).

Each telephone number was called a maximum of 10 times at different times of the day and on weekends. Telephone interviewers used a standardized script for recruitment. Participants were eligible if they were English-speaking, 18 to 90 years of age and had visited a PHC provider within the past two years. Prior research indicates that 95% of Canadians visit a general practitioner within this time period (Watson et al. 2004). Participants were given $20 each in appreciation of their time. All procedures were approved by University of British Columbia's Behavioural Ethics Review Board.

Each focus group of six to nine participants averaged 90 and 120 minutes in duration and was conducted according to standard procedures (Krueger 1994). Participants were told that the purpose of the focus group was to hear from them what was important about British Columbia's PHC system. Participants were then asked about the features of care that were important to them when making an appointment and visiting healthcare providers. Important features relative to place of care were also probed. Participants were then asked about ways in which PHC could be improved. We sought and incorporated feedback on the focus group guide from expert researchers who had previously conducted focus groups with members of the public regarding PHC in Canada.

After all the focus group questions were asked, the team member taking notes during the session summarized and read back to participants what was discussed. In order to ensure accuracy, participants then agreed to, added or modified any parts of the summary. All discussions were audio-taped and transcribed. To ensure transcription accuracy, a random selection of the transcripts was compared to audio-tape content. Throughout this manuscript, quotations are attributed to participants from the following health authorities: Fraser Health (FH), Interior Health (IH), Northern Health (NH), Vancouver Island Health (VIHA) and Vancouver Coastal Health (VCH).

PHC was defined for participants as the first point of contact with the healthcare system and as the setting where short-term, acute health issues are resolved and the majority of chronic health conditions are managed (Watson et al. 2004). We used a Results-Based PHC Logic Model (Watson et al. 2004) to guide the development of a coding scheme because it establishes the inputs, activities, outputs and outcomes of this sector, and also defines domains appropriate to understanding efficiency and effectiveness. Each team member independently coded the transcripts using qualitative software (Atlas TI); coding was iterative, and refinements were made based on consensus among authors until a final code definition was established. Next, we independently produced a preliminary thematic content analysis of each of the top 20 codes. The final content analysis combined each member's independent analyses based on consensus of the team. The codes and coded text were verified using both inductive and deductive methods (Strauss 1995).

Text units (TUs), defined as continuous coded text of one focus group participant, are reported in order to provide some perspective on the order of importance among the domains discussed. TUs for the top 20 codes were organized into coding reports using Atlas TI. Coding reports were analyzed to ensure that the themes reported in this paper were present across all focus groups. Moreover, the transcripts were analyzed to examine the extent of text coded in two different domains. "Double-coding" of text was found to be less than 10%. Domains with more TUs were deemed more important than those with fewer TUs. Frequency counts of TUs for each PHC domain were examined to understand which domains were most often addressed in discussions regarding factors that could be improved.

Results

Sixty-five per cent of participants were female; more than half (62%) were 50 years or older. Most participants (96%) had a regular provider and had been with that provider for a mean of 8.5 years. Table 1 summarizes the socio-demographic characteristics of participants.

TABLE 1. Socio-demographic characteristics of focus group participants (n=75)

n=75	**% of Participants**
Female	65
Age	
20–34	9
35–49	29
50–64	43
≥65	19
Ethno-cultural group	
Caucasian	89
First Nation	4
Other	4
Education	
<Grade 12	8
Grade 12	16
Some secondary	37
Diploma or degree	37
Married/co-habiting	66
* Chronic diseases	
Arthritis	41
Hypertension	32
Depression	29
Chronic pain	23
Diabetes	15
Have a regular provider	96
How long with current provider	
Mean months (SD)	102 (90)
+General health (1–5 scale)	
Mean (SD)	2.44 (0.81)
+Satisfaction with usual provider (1–7)	
Mean (SD)	5.3 (1.3)

Note: Where the percentage groups do not add up to 100%, the remaining amount is for no answer.

* Does not add up to 100% since participants could have more than one chronic disease. On average, participants reported having two chronic diseases.

+ A higher score = more of the concept.

Six global domains emerged in all focus group discussions: accessibility (geographic accessibility to and timeliness of services), continuity (informational, relational and management), responsiveness, interpersonal communication, technical effectiveness and whole-person care. Table 2 shows the frequency of text units for each domain and provides some quotations illustrating participants' experiences with these domains.

TABLE 2. Dimensions of primary healthcare important to the public

Primary Health Care Dimensions	Examples (Quotations)	Total Text Units
Accessibility (total)		**130**
Timeliness of scheduling an appointment	"Getting services in a timely manner is the greatest thing we can hope for" (NH); "I don't mind if it's something that's not pressing for a week, but generally I think getting an appointment within two to four days [is acceptable]" (VCH).	69
Geographic accessibility	"I needed physical therapy on my foot in order to qualify for my worker's insurance … however, I had to go to Prince George [where many of the health services are centralized] in the middle of winter. … I refused to go because I'm not driving the highway with something wrong with my foot in the middle of winter" (NH).	61
Continuity (total)		**99**
Information	"Why doesn't the hospital have access to the files at my doctor's office and how come the doctor's office can't access the hospital computer?" (VIHA); "… having one computer system where if I was ill in a different part of the province they could look me up, my history … that would be wonderful" (NH).	44
Relationship	"That's why I don't really like to go to walk-in clinics because you get a different doctor all the time. … they give you a different treatment – sometimes it works and sometimes it doesn't" (IH).	35
Management	"… it's no good seeing somebody different every time. … you start all over again, they change your medication. … it's important to have ongoing care" (all focus groups); "I had my purse stolen, all my medication was stolen … but I couldn't get in to see my doctor to get the prescriptions replaced. I had to see another doctor and he refused to give me my medications. … I had to wait to see my regular doctor" (VIHA).	20

TABLE 2. Continued

Primary Health Care Dimensions	Examples (Quotations)	Total Text Units
Responsiveness (time waiting in office, time spent with provider)	"… the timing is the worse thing … it doesn't matter if you make the first appointment of the day, I know I'll wait" (NH); "I had three little minor issues, I mentioned the first and he [doctor] gave me a prescription. I went on to mention the second and third one and he said, 'Sorry, only one complaint per visit now, you'll have to make another' [appointment]" (VIHA); "… they take you in and kick you out as fast as they [doctors] can" (IH).	**97**
Interpersonal communication	"He [the doctor] wasn't taking certain things seriously. … he was kind of treating me like I had no real concerns" (VCH); "I was being treated … but my problem wasn't being addressed, so I get this new doctor who is questioning very seriously, he gives me a new prescription and my problem changed right around" (IH).	**63**
Technical effectiveness		**46**
Whole-person care	"I would rather do natural stuff, so, even though my doctor is not a big promoter of the natural stuff, he will sometimes suggest it. He knows some of my beliefs and how I feel as a person, not just [see me] as another patient" (NH).	**37**
Other areas of importance		
Additional PHC providers	"I'd back my midwife 100% for anybody having a baby. … if they're properly trained, there's absolutely no reason why they can't practice …" (VIHA).	94
System efficiencies (e.g., drug refills, doctor's notes, employer-required visits)	"… you can only get a prescription for three months, so every three months you have to go back even though it's an ongoing prescription" (NH); "… one of the forms I had to get filled out cost $130 and I had to pay, in cash, before I could get it …" (VIHA).	43

Accessibility

Participants discussed accessibility more often than any other domain of PHC and focused their comments on issues regarding the timeliness of scheduling and geographic accessibility. Waiting time for an appointment ranged from being seen the same day (urgent problems) to one week. Participants agreed that waiting more than one week to visit their provider was unacceptable. Waiting time once in the office was discussed in the context of a provider's responsiveness. Thus, this issue was coded accordingly and is described below. Being able to see their usual provider was important, especially to those who had a chronic illness.

Participants, mainly those living in smaller communities (e.g., <50,000), discussed how geography affected their access to preferred providers and necessary services. People needed to drive to adjacent communities in order to access services: "I have to drive [to another community] to find a woman doctor; there are only about four in this community … and they're not taking any new patients. … it's 45 minutes if I go like mad down the highway" (VIHA). Transportation for people who did not or physically could not drive was seen as an accessibility issue. Travelling for necessary services was a particular concern in winter driving conditions, especially in areas with no street lights and sporadic cell phone coverage. Additionally, sometimes appointments for PHC-related services at regional centres were such that the person had the additional cost of staying overnight and taking time off work.

Continuity

After accessibility, participants spoke most about continuity of care. We coded text units as relating to this domain using a definition that recognizes the following dimensions of continuity: informational (ongoing relevant information exchanged between providers regardless of the site of care), relationship (continuous long-term patient–provider relationship) and management (ongoing management of a health condition) (Haggerty et al. 2003). Participants identified gaps in communication and information among different providers, stating that information technology that permitted access to their health information at any point of care (e.g., provider office, hospital or specialist) across the province would make more efficient use of everyone's time.

RELATIONSHIP CONTINUITY

Building a relationship, over time, with a regular provider was important for participants to feel comfortable receiving care, to have confidence in the provider's treatment recommendations and to build trust. A long-term relationship was seen to create a shared history of interactions and understandings between participants and their providers. This relationship enabled some participants to share information about their health habits or "admit to things done to others" (VCH) that they did not otherwise feel comfortable sharing. Relationship continuity was particularly important for those with an ongoing health problem.

MANAGEMENT OF CARE

Having someone be responsible for and actively manage a participant's overall health was especially important to those who were older and had a chronic condition. Moreover, those who had complex management plans due to multiple co-morbidities, or a complicated medical condition or social situation, did not want to explain this information to multiple providers. Participants wanted their usual provider to manage and plan their ongoing care based on a continuous relationship and their particular health history. Some participants voiced concerns that even though information about their care may be on their chart (e.g., medication for migraine) or relayed to the locum, the actual management and responsibility of their care was left until their usual provider returned.

Responsiveness

Responsiveness of the PHC sector or the ability of the system and usual provider to meet people's healthcare needs was discussed by participants in terms of waiting in the office and the amount of time spent with the provider. Issues related to scheduling those appointments were considered in the accessibility domain. Participants reported waiting in the office anywhere from 25 minutes to three hours. Depending on the context of why people had to wait (e.g., someone needed immediate attention because of an asthma attack, or the provider was delivering a baby), they were more or less willing to wait up to 30 minutes. However, participants felt that advance notification of office waiting times in excess of 30 minutes would increase office responsiveness.

Another aspect of responsiveness was at the provider–patient interface. Participants expected to visit their provider and discuss all or most of their concerns; some participants were asked to discuss only their main health issue. Not being able to do this resulted in participants' perception that providers were not responsive to their needs. Having their provider gain insight into the whole situation or context of the immediate health issue was also deemed important to participants.

Interpersonal communication

Interpersonal communication is a multidimensional domain consisting of communication, shared decision-making and a provider's interpersonal style (Stewart et al. 1999). If providers were perceived as eliciting and understanding concerns, participants felt they were heard and that the provider was caring. It was important that their usual provider actively listen to their concerns. Moreover, participants valued providers who "explained things in a non-medical way" (NH) and did not make them feel rushed during the visit. There was little explicit discussion about shared decision-making; however, participants wanted to be treated respectfully and to have their concerns taken seriously. Participants appreciated providers who addressed their specific situation.

Technical effectiveness

Technical effectiveness refers to tests, treatments and technical competence in performing diagnostic and therapeutic procedures (Donabedian 1992). Participant comments indicate that providers were assumed to be technically effective by virtue of having a medical degree: "… she listens very well, she does the testing, I mean you have to help her sometimes, you know, but she's a fantastic doctor, I mean she's great …") (NH). Participants saw ordering tests or changing a treatment plan based on new information about symptoms as indicating technical effectiveness. All participants agreed that the provider's technical competence was more than just "pushing pills" or ordering blood work, and might entail more extensive testing. Interestingly, providers were more often described as having high technical effectiveness if they had good interpersonal communication skills and a long-term relationship with the participant. When participants believed their concerns or knowledge about their health were not being listened to, or they did not have a long-term relationship with the provider, they perceived the provider as having less technical competence.

Whole-person care

One important aspect of receiving episodic care, regardless of length of relationship with a usual provider, was being viewed by the provider as a person. Participants emphasized that they were people who were connected to families and communities and living within various life circumstances. They did not want to be judged by their provider for having a certain disease or lifestyle, and did not want to be seen as "just a number." To these participants, receiving whole-person care meant the provider was not only treating symptoms but also trying to get to the "root of the problem" (IH).

Satisfaction with care

During focus group discussions, participants most often discussed being satisfied, or not, when they talked about interpersonal communication or the continuity of their care. Participants were satisfied with their care when the provider was friendly, unhurried and respectful. The longer the length of the relationship, the more satisfaction participants had with the provider. Participants mentioned that they were more satisfied with the delivery of services if the provider was perceived as organized. Conversely, participants mentioned dissatisfaction with services when there were questions about the treatment being recommended. For example, one participant said, "I basically had an infection in my finger, this guy [doctor] wanted to take my fingernail off and possibly do minor surgery. … I've had enough infections to know this is not necessary, so I went to another doctor who just gave me some antibiotics and it cleared up in a matter of two weeks" (NH).

Discussion and Conclusions

Across the country, there have been substantive investments and activities to renew PHC in response to growing concerns among Canadians and healthcare providers. Many of these initiatives focus on improving the accessibility and quality of care. We find these efforts align with features of care that people think are important. Adults in British Columbia place importance on accessibility of care. They also mention the following dimensions of the care process as important to quality: continuity, responsiveness, interpersonal communication, technical effectiveness and whole-person care.

In terms of accessibility, participants focused on issues regarding the timeliness of scheduled appointments and geographic accessibility. Interestingly, objectives of the Primary Healthcare Transition Fund (PHCTF) (Government of Canada 2004) relate to 24/7 availability and are silent on issues regarding delays in scheduling appointments or geographic accessibility. However, change management is possible at the clinic level to provide advanced access, thereby reducing waiting times and delays once an appointment is made (Murray and Berwick 2003). More work is needed in helping providers achieve effective advanced access strategies (Goodall et al. 2006).

Our findings suggest that informational, relational and management continuity are also important. Past studies show that younger patients, commuters and those with urgent needs are more willing to trade continuity for faster access to primary care services (Coulter and Magee 2003). Future work is warranted to determine the nature or extent of trade-offs that people are willing to make, such as faster access to care versus information, relationship and management continuity and the impact of this trade-off on health outcomes. As Canada progresses towards increased use of interprofessional teams, a common policy priority, our work suggests that monitoring the degree to which PHC offers a high degree of continuity will assume greater importance.

Participants described relationship continuity and whole-person care as important, and indeed, these are considered distinguishing features of the PHC sector (Stewart 2004). For example, participants emphasized the importance of receiving whole-person care and building a long-term relationship based on mutual respect and trust (Roter 2000; Saba et al. 2006) in which the provider knows the patient's family and situational context. They wanted to develop a relationship with their provider in order to address the underlying cause(s) of their health problem together and not simply treat the disease. As the number of people with chronic diseases increases, along with the trend towards larger group practices in an effort to increase efficiency and services, methods to preserve continuity between the patient and provider will be even more important. Discontinuities in appropriate knowledge and skills, trust and ongoing observation may negatively affect continuity and quality of care (Woodward et al. 2004).

Similar to past studies, these findings suggest that interpersonal processes of care – such as being listened to, cared for and respected – are associated with the perception of high-quality care (Concato and Feinstein 1997; Gerteis et al. 1993; Ngo-

Metzer et al. 2003). Surprisingly, the stated objectives of PHCTF investments in Canada do not address the domains of provider continuity and interpersonal processes of care (Government of Canada 2004). Our findings suggest that quality improvement initiatives and performance reports to Canadians should include these matters. Moreover, given that participants most often discussed satisfaction when they talked about interpersonal communication and continuity of care, these results suggest that interpersonal communication and continuity of care may have the greatest impact on people's reported experiences and satisfaction with the PHC sector.

It may also be that satisfaction with PHC could be influenced by public perception of whether providers delivering team-based care are technically effective. While other PHC constructs identified by participants were also associated with satisfaction, more work needs to be done to determine the associations between patient satisfaction with PHC and Ware's (1983) multidimensional classification of satisfaction, which includes interpersonal manner, continuity of care, technical effectiveness, accessibility/convenience, finances, efficacy/outcomes of care, physical environment and availability. Such research could enable the political, policy, management and practice communities to renew healthcare in ways that align with Canadians' expectations.

A domain important to our participants, but not identified by Canadian experts or stakeholders as a core PHC attribute (Haggerty et al. 2007), was responsiveness of the PHC system. While responsiveness was identified in the PHC logic model (Watson et al. 2004), the examples given by our participants suggested how this construct might be measured. The complexity of the PHC system's responsiveness was evidenced by participants' discussion of the multiple and interrelated PHC domains. These domains were often discussed in relationship with one another, such as accessibility and interpersonal communication or continuity and whole-person care.

This study has several limitations. Even though we used random digit dialling and held focus groups at convenient times, participants had health service utilization profiles more akin to higher than lower users of PHC (Schoen et al. 2004; Watson et al. 2004). Our sample contained more people aged 65 years and older (19%), compared to 13.2% of British Columbians aged 65 years and older (Watson et al. 2005), and most participants (96%) reported having a regular family doctor, compared to 89% of British Columbians reported in the Health Services Access Survey (SanMartin, Gendron, Berthelot et al. 2004). Thus, our results are likely representative of those with more experience with PHC services. Only participants who spoke English and lived in British Columbia were included in this study. Despite these limitations, our results can be used to inform quality improvement and public reports regarding performance, as the participants represent those most likely to require care and to read reports about the PHC sector.

Our results provide evidence from Canadians regarding the features of PHC that are important to them and the ways in which these can be improved. While this information can help in targeting quality improvement initiatives, it could also be used in priority-setting exercises regarding performance measurement to support public reporting. To date, much of the evidence and consensus-based PHC indicators developed by experts and stakeholders across Canada, the United States and the United Kingdom are finely tuned measures of technical quality of care (American Medical Association 2001; CIHI 2005; Healthcare Commission 2006). While information on the technical quality of care is a priority and useful to those responsible for improving the process of care, the results provided by studies such as ours highlight the patient-centred dimension of quality, and augment discussions on measuring Canada's health system performance. These priority domains should be addressed in reports to the public on the performance of the PHC sector.

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