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by Philippe Finès

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Abstract

Background: Person-centred care is a key component of health care quality, and patient perceptions are being increasingly used to evaluate it. Four enabling factors from Andersen's Behavioral Model of Health Services Use are particularly relevant to patients' evaluation of primary care: difficulties getting an appointment, discrimination, wait times and health care provider attitudes. Despite growing evidence on individual factors influencing patient satisfaction, a nationally representative picture of perceptions of and experiences with primary health care in Canada is lacking.

Data and Methods: Data were drawn from the 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care. The population was composed of adults who had at least one medical visit for non-urgent primary care in the year before the interview. Explanatory variables comprised sociodemographic characteristics, health and experience with health care in the year before the interview. Logistic regression models were built—separately for respondents aged 18 to 64 and aged 65 and older—to determine the factors associated with the probability that the last non-urgent visit was rated as excellent or very good.

Results: The following were all associated with a high probability of rating the last non-urgent visit as excellent or very good: high satisfaction with wait time; high frequency of visits during the year; absence of difficulty getting an appointment; absence of perceived discrimination; access to own regular health care professional; and self-reported general health that was excellent, very good or good. In addition, rating the last visit as excellent or very good was strongly associated with agreement on statements about the health care professional's attitude.

Interpretations: Assessment of primary care does not depend much on health status or sociodemographic characteristics, but it is associated with the interaction of the patient with the health care system, particularly satisfaction with wait time and perception of the attitudes of the health care professional.

Keywords: Andersen's Behavioral Model of Health Services Use framework, attitudes of the health care provider, evaluation of health care, patient-centred care, patient's experience

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What is already known on this subject?

- Person-centred care is central to health care quality.
- Patient perceptions are being increasingly used to evaluate health care quality, particularly in primary care.
- Andersen's Behavioral Model of Health allows for the inclusion of enabling factors to analyze the patient's experience with the health care system.

What does this study add?

- A patient's assessment of their last non-urgent primary care medical visit as excellent or very good was essentially related to their interaction with the health care system, much more than their sociodemographic characteristics or their health.
- For both age groups (18 to 64, and 65 and older), experiencing no wait times, no difficulties, or no perceived discrimination contributed to a high probability of rating the last non-urgent primary care medical visit as excellent or very good.
- Not being racialized, having more than one chronic condition (for those aged 18 to 64 only), having an in-person visit or being disabled (for those aged 65 and older only) also increased the probability of rating the visit as excellent or very good.
- Agreement with statements regarding positive attitudes of the health care professional—especially statements about time spent with the patient and careful listening to the patient—was strongly associated with the rating of the visit.

Introduction

A person-centred approach is a key aspect of quality of care[1] because, as a component of the patient experience, it integrates all interactions between patients, their families, caregivers, and health care professionals (HPs).[2] In fact, patient-centredness is one of six pillars that define high-quality health care.[3] Indicators of person-centred care thus ensure the accountability of health care systems to the people they aim to serve.[4] Because patients have expectations regarding the care they receive, based on the social, cultural, political, and economic context,[5] their perception of the health care system is an indicator of the gap between what they expect and what they observe. Therefore, interviewing patients should help identify what is important in high-quality care.[6] Consequently, patient perception is being increasingly used to measure the quality of care.[7]

For patients' evaluation of health care quality, four elements that are considered enabling factors in Andersen's Behavioral Model of Health Services Use framework[8,9] are particularly relevant. First, difficulties getting an appointment include all problems encountered by the patient when trying to contact HPs.[10] Second, discrimination before or during the appointment contributes to the gradient in access to care.[11] In Canada, Indigenous people,[12,13] Black people[14,15] and new immigrants[16] can experience discrimination in health care, potentially resulting in poorer health outcomes than in the general population. Language-based discrimination can also have an effect.[17] A survey of almost 200,000 patients in Ontario showed that, for French-speaking patients, receiving health care in French (compared with English) was associated with an odds ratio lower than 1 for undesirable events and mortality in hospital.[18] Third, long wait times, particularly in Canada,[19,20] to get a consultation for primary care21 or for specialists[22] may influence perceptions of health care quality.

The fourth essential element for evaluating health care from the patient's perspective concerns the attitudes of HPs. For example, family physicians—who are responsible for their patients' health, including referring them to specialists[23] and monitoring tests and procedures—are expected to possess strong patient-centred care skills,[24] in accordance with the principles of this approach.[25] These skills include taking the time to listen to the patient, demonstrating professionalism and respect, involving the patient in medical decisions, and being able to deliver bad news when necessary.[26] These attitudes are essential for all HPs involved in a person's care, not just general practitioners.

A recent national study found that the most important primary care attribute was having an HP who knows the patient very well.[21] Also, having a regular family doctor was found to be critical for building trust and transparency in the patient–provider relationship.[27] Although patients' perceptions of physician assistants in Ontario were generally positive, that evidence is limited to a small sample across four family medicine centres, restricting its generalizability.[28] Those results are partial and do not provide a current national picture of satisfaction with primary health care in Canada. This study aims to fill this gap by building a model for satisfaction with primary health care using data drawn from a nationally representative health survey on perceptions of and experiences with health care in Canada. The results of this study should inform researchers and policy makers on the relative importance of factors that influence patients' perceptions of the health care they receive.

Data and methods

Data are from the 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care (SHCAE-PSC).[29] The SHCAE-PSC is a cross-sectional survey that collects information related to health care access and experiences using the health care system. Its target population is all people aged 18 years or older living in private residences in Canada's ten provinces. This survey uses a stratified two-stage sample. In total, 64,037 units selected for the 2024 SHCAE-PSC were in scope for the survey, and

33,535 individuals responded, resulting in a response rate of 52.4%. The questions in the patient experience module are based on a previous Organisation for Economic Co-operation and Development questionnaire and on a survey from the Canadian Institute for Health Information (CIHI). However, while the CIHI survey and many other patient experience surveys ask about hospital in-patient care, the SHCAE-PSC asks about primary care. The topics and questions were developed by researchers from Statistics Canada, Health Canada, the Public Health Agency of Canada and CIHI.

In the survey, non-urgent primary care is defined as visits that can include routine care such as check-ups and prescription refills, as well as issues that need immediate care but are not emergencies, such as an infection, a fever, a headache, a sprained ankle, vomiting or an unexplained rash. Only respondents who consulted an HP for a non-urgent visit in the year before the interview were analyzed; these 26,055 respondents represent 23.8 million individuals. Analyses were done on observations with no missing values for any of the variables presented in this section; 2,247 observations were not used because of missing values, mainly for HP consultation frequency, because the question for this variable was asked only to respondents and not to their proxies. The final sample has 23,808 observations, which represent 22.0 million individuals in the Canadian population. Respondents were asked about their last non-urgent primary care visit: "Overall, how would you rate the quality of this consultation?" Response choices were excellent, very good, good, fair or poor. They were dichotomized, a common practice in health analysis,[30] and the outcome of interest comprised the "excellent" or "very good" responses.

The analyses were conducted on two separate groups, one aged 18 to 64 years and the other aged 65 years and older, because preliminary analyses had shown different results for these two groups. First, cross-tabulations were built to determine whether each of the variables was significantly related to the outcome. Chi-square tests were run to compare the proportion of the analyzed outcome among categories of explanatory variables. Then, in each group, a logistic regression model was built to determine the probability of reporting the outcome. All analyses, including estimating adjusted odds ratios (AORs) and their 95% confidence intervals (CIs), were done using the sample weights for point estimates and the bootstrap weights for estimation of variance. They were conducted in SAS 9.4 using SUDAAN procedures to account for the complex survey design.

With Andersen's Behavioral Model of Health Services Use framework, predisposing factors included sociodemographic variables; enabling factors included the patient's interaction with the health care system before the interview, the wait time before the last non-urgent primary care visit in the year before the interview and the patient's interaction with the health care system during that last non-urgent visit; and need included health variables. The small sample size prevented the use of a non-binary category when defining gender. Therefore, gender had two categories: men+, which included men and some non-binary people, and women+, which included women and some non-binary people. Age was grouped into five strata: 18 to 34, 35 to 49, 50 to 64, 65 to 84, and 85 and older (the first three age strata made up the age group 18 to 64, and the last two age strata made up the age group 65 and older). Respondents' education had three categories: less than high school, high school and postsecondary. Household income quintiles were derived using adjusted before-tax family income, accounting for household size, and grouped into five national categories. Geography of residence was classified as urban or rural, based on population centre status. Immigrant status had two categories: non-immigrant, and immigrant or non-permanent resident. Population group had three categories: Indigenous; non-Indigenous, racialized (if the respondent was South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean or Japanese); and non-Indigenous, non-racialized. Among the Indigenous population, no distinction was made between First Nations people (living off reserve), Métis and Inuit, because the samples for these groups were too small to be considered separately.

Self-reported general health and self-reported mental health were grouped into two categories: one combined excellent, very good and good; the other combined fair and poor. Perceived life stress was also grouped into two categories: at most a bit stressful (which combined not at all stressful, not very

stressful and a bit stressful) and very stressful (which combined quite a bit stressful and extremely stressful). Satisfaction with life was grouped into three categories: very satisfied or satisfied, neither satisfied nor dissatisfied, and dissatisfied or very dissatisfied. The number of chronic conditions drawn from a list assessed in the survey (see Appendix Table 1) was grouped into three categories (none, one and two or more). Being a person with a disability had two categories: yes and no.

Respondents were asked, "In the past 12 months, how many times have you consulted a health care provider for a non-urgent primary health care need?" Responses were grouped into two categories of health care provider consultation frequency: one to four visits and five or more visits. Respondents were asked whether they experienced difficulties accessing health care (during the 12 months before the interview), with 13 response options (see Appendix Table 2); reported difficulties were grouped into three categories: none, one, and two or more. Respondents were also asked whether they felt discriminated against (during the 12 months before the interview) for any of 15 possible reasons (see Appendix Table 3); perceived reasons for discrimination were grouped into two categories: none and one or more.

Wait time was defined by the answer to the following question: "How long did you have to wait between the time you requested care and when you consulted your health care provider?" Values were grouped into three categories: 0 (that is, the same day) to 3 days, 4 to 29 days, and one month or more. Satisfaction with the wait time was assessed based on the answer to the following question: "How satisfied were you with the wait time?" Answers were grouped into three categories: very satisfied or satisfied, neither satisfied nor dissatisfied, and dissatisfied or very dissatisfied. Life affected by wait time was defined by the answer to the following question: "To what extent has your life been affected by waiting to consult your health care provider?" Answers were categorized as not at all affected or affected (which combined the categories of extremely, very, moderately or slightly affected).

The last subset of variables describes the attributes of the last visit. The purpose was defined as routine if, among the possible reasons for the visit, the respondent mentioned only "a regular check-up or routine appointment," "medication or prescription refill," or "routine care for a chronic condition," and defined as non-routine if the respondent mentioned at least one reason among "consultation or treatment of a new health concern, illness or injury"; "non-routine care for a chronic condition"; or "referral to a specialist or other professional." The type of visit was defined as either in-person or virtual. The type of access had three categories: has a regular HP and had the last medical visit with this HP, has a regular HP but had the last medical visit with someone different, and does not have a regular HP.

Respondents were asked whether they agreed with eight statements about their interaction with their HP on their last visit for non-urgent primary health care. These statements are listed in Table 4. For each of these statements, responses were grouped into two categories: the first combined strongly agree, somewhat agree, and neither agree nor disagree, and the second combined somewhat disagree and strongly disagree. Given their strong individual associations with the outcome, these statements were examined separately from the logistic regression models to avoid multicollinearity and to preserve the interpretability of each item.

Results

Characteristics of the analyzed population

The included population was mostly composed of women (54%), predominantly had a postsecondary education (73%), lived mostly in urban areas (85%), and was mostly non-immigrant (70%) and non-racialized (70%) (Table 1). More than 80% of respondents rated their general health and mental health as excellent, very good or good. Life stress was perceived as at most a bit stressful for 74%, and 82%

were very satisfied or satisfied with life. More than 50% reported at least one chronic condition, and most (85%) declared that they were not disabled. Most (82%) had had one to four visits during the year before the interview, 56% had not had difficulty getting an appointment and 92% had not perceived any sign of discrimination.

Table 1
Percentage of people who had a non-urgent primary health care visit in the year before the interview by selected characteristics, household population aged 18 and older, Canada excluding the territories, 2024

	Had a non-urgent primary health care visit in the year before the interview (N=21,995,291)		
		95% confidence interval	
Characteristics	percent	from	to
Sociodemographic variables			
Gender			
Men+	45.6	44.9	46.3
Women+	54.4	53.7	55.1
Age group			
18 to 34 years	21.8	20.8	22.7
35 to 49 years	28.9	27.8	29.9
50 to 64 years	24.7	24.0	25.4
65 to 84 years	22.7	22.2	23.2
85 years and older	2.0	1.7	2.3
Education			
Less than high school	6.1	5.6	6.7
High school	21.4	20.5	22.4
Postsecondary	72.5	71.4	73.5
Income quintile			
Quintile 1 (lowest)	18.3	17.4	19.3
Quintile 2	19.4	18.5	20.4
Quintile 3	20.0	19.0	20.9
Quintile 4	21.2	20.3	22.1
Quintile 5 (highest)	21.2	20.3	22.1
Geography			
Urban	84.9	84.1	85.6
Rural	15.1	14.4	15.9
Immigrant status			
Non-immigrant	70.0	68.9	71.1
Immigrant or non-permanent resident	30.0	28.9	31.1
Population group			
Indigenous	2.3	2.0	2.6
Non-Indigenous, racialized	27.2	26.1	28.4
Non-Indigenous, non-racialized	70.5	69.4	71.6
Health variables			
Self-reported general health			
Excellent, very good or good	85.0	84.1	85.8
Fair or poor	15.0	14.2	15.9
Self-reported mental health			
Excellent, very good or good	83.2	82.2	84.1
Fair or poor	16.8	15.9	17.8
Perceived life stress			
At most a bit stressful	74.1	73.0	75.1
Very stressful	25.9	24.9	27.0
Satisfaction with life			
Very satisfied or satisfied	81.6	80.6	82.6
Neither satisfied nor dissatisfied	9.1	8.5	9.9
Dissatisfied or very dissatisfied	9.2	8.5	10.0
Number of chronic conditions			
None	42.8	41.7	44.0
One	26.4	25.4	27.5
Two or more	30.7	29.7	31.8
Disability			
Yes	14.5	13.7	15.3
No	85.5	84.7	86.3

Notes: HP stands for health care professional. Indigenous people include First Nations people living off-reserve, Métis and Inuit. Groups could not be presented separately because of the sample size.

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

Table 1
Percentage of people who had a non-urgent primary health care visit in the year before the interview by selected characteristics, household population aged 18 and older, Canada excluding the territories, 2024 (continued)

	Had a non-urgent primary health care visit in the year before the interview (N=21,995,291)		
		95% confidence interval	
Characteristics	percent	from	to
Interaction with the health care system in the year before the interview			
Health care provider consultation frequency			
One to four times	81.7	80.8	82.6
Five or more times	18.3	17.4	19.2
Number of difficulties to get appointment			
None	56.4	55.2	57.6
One	21.3	20.3	22.3
Two or more	22.3	21.3	23.3
Number of perceived reasons for discrimination			
None	92.4	91.7	93.0
One or more	7.6	7.0	8.3
Wait time before the last non-urgent primary health care visit in the year before the interview			
Wait time			
0 to 3 days	42.9	41.7	44.1
4 to 29 days	45.2	44.1	46.4
One month or more	11.9	11.1	12.7
Satisfaction about wait time			
Very satisfied or satisfied	60.3	59.2	61.5
Neither satisfied nor dissatisfied	21.1	20.1	22.1
Dissatisfied or very dissatisfied	18.6	17.6	19.5
Life affected by wait time			
Yes	52.9	51.8	54.1
No	47.1	45.9	48.2
Last non-urgent primary health care visit in the year before the interview			
Purpose of the visit			
Routine	50.5	49.3	51.6
Non-routine	49.5	48.4	50.7
Type of visit			
In person	81.6	80.7	82.4
Virtual	18.4	17.6	19.3
Type of access			
Has regular HP, met regular HP	74.1	73.2	75.1
Has regular HP, met other HP	12.8	12.1	13.6
No regular HP	13.0	12.3	13.8
Overall quality rating			
Excellent or very good	70.4	69.3	71.5
Good, fair or poor	29.6	28.5	30.7

Notes: HP stands for health care professional. Indigenous people include First Nations people living off-reserve, Métis and Inuit. Groups could not be presented separately because of the sample size.

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

While 87% of respondents had waited less than one month for a visit, most respondents (60%) were very satisfied or satisfied with the wait time, while life was affected by the wait time for slightly more than half of respondents. Percentages did not vary significantly between the routine and non-routine categories of visit purpose. Most visits were made in person; in most cases, the visit was with the patient's own HP.

Sociodemographic and health variables

Among the group of persons aged 18 to 64, 67.7% (CI: 66.4%, 69.1%) rated their last visit as excellent or very good, compared with 78.5% (CI: 76.8%, 80.2%) among those aged 65 and older (throughout the rest of this section, see Table 2 for ages 18 to 64 and Table 3 for ages 65 and older). Further analysis was stratified for these age groups based on this difference. Among those aged 18 to 64, being racialized was associated with a lower probability of assessing the visit as excellent or very good (AOR=0.77 [CI: 0.62, 0.96]). Among those aged 65 and older, having a high school education was associated with a lower probability of assessing the visit as excellent or very good (AOR=0.75 [CI: 0.58, 0.96]).

Table 2
Rating the last non-urgent primary health care visit as excellent or very good by selected characteristics, household population aged 18 to 64 who had a non-urgent primary health care visit in the year before the interview, Canada excluding the territories, 2024 (N=16,565,771)

	(A) Cross-tabulations of the percentage of people who reported this rating			(B) Logistic regression model for the probability of reporting this rating		
		95% confidence interval			95% confidence interval	
Characteristics	percent	from	to	AOR	from	to
Full sample	67.73	66.35	69.08	...	...	...
Sociodemographic variables						
Gender						
Men+	67.97	65.92	69.96	0.99	0.85	1.14
Women+ (R)	67.53	65.67	69.33	1.00	...	...
Age group						
18 to 34 years (R)	62.84 ‡‡	59.96	65.64	1.00	...	...
35 to 49 years	67.13	64.70	69.48	1.15	0.96	1.39
50 to 64 years	72.74	70.87	74.55	1.16	0.95	1.41
Education						
Less than high school	67.05	58.44	74.66	0.84	0.55	1.28
High school	68.12	64.98	71.10	0.89	0.73	1.09
Postsecondary (R)	67.66	66.09	69.20	1.00	...	...
Income quintile						
Quintile 1 (lowest)	67.34	63.41	71.05	1.15	0.90	1.47
Quintile 2	68.67	65.30	71.86	1.21	0.97	1.51
Quintile 3	65.88	62.64	68.98	0.91	0.74	1.12
Quintile 4	67.13	64.26	69.87	0.98	0.81	1.20
Quintile 5 (highest) (R)	69.45	66.93	71.86	1.00	...	...
Geography						
Urban (R)	67.16 †	65.64	68.65	1.00	...	...
Rural	71.30	68.08	74.32	0.94	0.78	1.13
Immigrant status						
Non-immigrant (R)	70.47 ‡‡	68.98	71.92	1.00	...	...
Immigrant or non-permanent resident	61.56	58.65	64.39	0.93	0.75	1.15
Population group						
Indigenous	68.36 ‡‡	61.10	74.83	1.12	0.80	1.58
Non-Indigenous, racialized	60.53	57.62	63.37	0.77 *	0.62	0.96
Non-Indigenous, non-racialized (R)	71.11	69.57	72.60	1.00	...	...
Health variables						
Self-reported general health						
Excellent, very good or good (R)	69.04 ‡‡	67.58	70.47	1.00	...	...
Fair or poor	58.73	54.63	62.71	0.76 *	0.60	0.96
Self-reported mental health						
Excellent, very good or good (R)	69.70 ‡‡	68.17	71.19	1.00	...	...
Fair or poor	59.44	56.04	62.75	0.96	0.78	1.19
Perceived life stress						
At most a bit stressful (R)	69.75 ‡‡	68.13	71.33	1.00	...	...
Very stressful	63.09	60.44	65.66	0.99	0.84	1.16
Satisfaction with life						
Very satisfied or satisfied (R)	69.95 ‡‡	68.42	71.43	1.00	...	...
Neither satisfied nor dissatisfied	61.19	56.29	65.88	0.83	0.64	1.06
Dissatisfied or very dissatisfied	56.06	51.09	60.91	0.82	0.63	1.08
Number of chronic conditions						
None (R)	67.03	65.02	68.97	1.00	...	...
One	68.58	65.81	71.23	1.11	0.92	1.34
Two or more	68.30	65.72	70.77	1.32 **	1.09	1.61
Disability						
Yes	64.99	60.94	68.84	1.00	0.78	1.29
No (R)	68.11	66.63	69.56	1.00	...	...
Interaction with the health care system during the year before the interview						
Health care provider consultation frequency						
One to four times (R)	67.56	66.08	69.01	1.00	...	...
Five or more times	68.50	64.99	71.80	1.53 ***	1.24	1.88
Number of difficulties to get appointment						
None (R)	81.91 ‡‡	80.24	83.46	1.00	...	...
One	60.86	57.86	63.78	0.58 ***	0.48	0.70
Two or more	45.03	42.21	47.88	0.38 ***	0.30	0.46
Number of perceived reasons for discrimination						
None (R)	70.50 ‡‡	69.08	71.88	1.00	...	...
One or more	38.87	34.38	43.56	0.40 ***	0.32	0.52

... not applicable

* significantly different from reference category ($p < 0.05$)
** significantly different from reference category ($p < 0.01$)
*** significantly different from reference category ($p < 0.001$)
† significant differences between the categories of the variable ($p < 0.05$)
‡‡ significant differences between the categories of the variable ($p < 0.001$)

Notes: R is the reference category for the logistic regression model. AOR stands for adjusted odds ratio. HP stands for health care professional. Indigenous people include First Nations people living off-reserve, Métis and Inuit. Groups could not be presented separately because of the sample size.

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

Table 2
Rating the last non-urgent primary health care visit as excellent or very good by selected characteristics, household population aged 18 to 64 who had a non-urgent primary health care visit in the year before the interview, Canada excluding the territories, 2024 (N=16,565,771) (continued)

	(A) Cross-tabulations of the percentage of people who reported this rating			(B) Logistic regression model for the probability of reporting this rating		
		95% confidence interval			95% confidence interval	
Characteristics	percent	from	to	AOR	from	to
Wait time before the last non-urgent primary health care visit in the year before the interview						
Wait time						
0 to 3 days (R)	71.19 ‡‡	69.04	73.26	1.00	...	...
4 to 29 days	67.50	65.62	69.33	1.22 *	1.03	1.45
One month or more	56.42	51.86	60.87	1.32 *	1.00	1.73
Satisfaction with wait time						
Very satisfied or satisfied (R)	81.54 ‡‡	80.00	82.99	1.00	...	...
Neither satisfied nor dissatisfied	53.95	50.97	56.91	0.34 ***	0.28	0.41
Dissatisfied or very dissatisfied	43.90	40.69	47.16	0.33 ***	0.26	0.40
Life affected by wait time						
Yes (R)	57.10 ‡‡	55.14	59.04	0.67 ***	0.57	0.78
No	81.27	79.59	82.84	1.00	...	...
Last non-urgent primary health care visit in the year before the interview						
Purpose of the visit						
Routine (R)	71.05 ‡‡	69.19	72.85	1.00	...	...
Non-routine	64.71	62.66	66.71	1.04	0.90	1.20
Type of visit						
In person (R)	68.08	66.54	69.59	1.00	...	...
Virtual	66.18	63.22	69.03	0.99	0.83	1.17
Type of access						
Has regular HP, met regular HP (R)	71.41 ‡‡	69.8	72.98	1.00	...	...
Has regular HP, met other HP	63.75	59.85	67.48	0.78 *	0.63	0.97
No regular HP	53.48	49.7	57.22	0.62 *	0.50	0.76

... not applicable

* significantly different from reference category ($p < 0.05$)
** significantly different from reference category ($p < 0.01$)
*** significantly different from reference category ($p < 0.001$)
† significant differences between the categories of the variable ($p < 0.05$)
‡‡ significant differences between the categories of the variable ($p < 0.001$)

Notes: R is the reference category for the logistic regression model. AOR stands for adjusted odds ratio. HP stands for health care professional. Indigenous people include First Nations people living off-reserve, Métis and Inuit. Groups could not be presented separately because of the sample size.

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

Table 3
Rating the last non-urgent primary health care visit as excellent or very good by selected characteristics, household population aged 65 and older who had a non-urgent primary health care visit in the year before the interview, Canada excluding the territories, 2024 (N=5,429,520)

	(A) Cross-tabulations of the percentage of people who reported this rating			(B) Logistic regression model for the probability of reporting this rating		
		95% confidence interval			95% confidence interval	
Characteristics	percent	from	to	AOR	from	to
Full sample	78.54	76.80	80.18	...	...	...
Sociodemographic variables						
Gender						
Men+	79.50	76.94	81.84	1.09	0.88	1.35
Women+ (R)	77.71	75.47	79.79	1.00	...	...
Age group						
65 to 84 years (R)	78.63	76.80	80.34	1.00	...	...
85 years and older	77.52	71.55	82.54	0.86	0.57	1.30
Education						
Less than high school	76.03	71.16	80.31	0.73	0.51	1.03
High school	76.77	73.51	79.73	0.75 *	0.58	0.96
Postsecondary (R)	79.91	77.75	81.92	1.00	...	...
Income quintile						
Quintile 1 (lowest)	73.74 †	69.98	77.19	1.05	0.72	1.53
Quintile 2	80.19	77.20	82.89	1.08	0.75	1.55
Quintile 3	80.07	76.15	83.48	1.15	0.78	1.70
Quintile 4	80.28	76.10	83.88	1.19	0.81	1.74
Quintile 5 (highest) (R)	79.96	75.63	83.68	1.00	...	...
Geography						
Urban (R)	78.80	76.80	80.67	1.00	...	...
Rural	77.44	73.87	80.65	0.79	0.61	1.03
Immigrant status						
Non-immigrant (R)	80.86 ‡‡	79.05	82.55	1.00	...	...
Immigrant or non-permanent resident	72.41	68.60	75.93	0.86	0.63	1.18
Population group						
Indigenous	79.18 ‡‡	66.80	87.78	1.11	0.56	2.18
Non-Indigenous, racialized	68.54	62.99	73.60	0.80	0.55	1.17
Non-Indigenous, non-racialized (R)	80.30	78.58	81.91	1.00	...	...
Health variables						
Self-reported general health						
Excellent, very good or good (R)	81.92 ‡‡	80.14	83.58	1.00	...	...
Fair or poor	66.60	62.42	70.54	0.62 ***	0.46	0.84
Self-reported mental health						
Excellent, very good or good (R)	80.27 ‡‡	78.52	81.92	1.00	...	...
Fair or poor	62.17	55.61	68.32	0.76	0.53	1.11
Perceived life stress						
At most a bit stressful (R)	80.15 ‡‡	78.37	81.81	1.00	...	...
Very stressful	67.29	61.54	72.55	0.98	0.68	1.41
Satisfaction with life						
Very satisfied or satisfied (R)	80.29 ‡‡	78.53	81.94	1.00	...	...
Neither satisfied nor dissatisfied	75.55	70.00	80.36	1.18	0.80	1.74
Dissatisfied or very dissatisfied	60.45	51.48	68.77	0.78	0.48	1.29
Number of chronic conditions						
None (R)	81.03	77.00	84.49	1.00	...	...
One	79.52	76.30	82.40	0.94	0.67	1.31
Two or more	77.08	74.75	79.26	1.00	0.74	1.35
Disability						
Yes	75.51	71.47	79.15	1.40 *	1.05	1.87
No (R)	79.37	77.51	81.11	1.00	...	...

... not applicable

* significantly different from reference category ($p < 0.05$)
*** significantly different from reference category ($p < 0.001$)
† significant differences between the categories of the variable ($p < 0.05$)
‡‡ significant differences between the categories of the variable ($p < 0.001$)

Notes: R is the reference category for the logistic regression model. AOR stands for adjusted odds ratio. HP stands for health care professional. Indigenous people include First Nations people living off-reserve, Métis and Inuit. Groups could not be presented separately because of the sample size.

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

Table 3
Rating the last non-urgent primary health care visit as excellent or very good by selected characteristics, household population aged 65 and older who had a non-urgent primary health care visit in the year before the interview, Canada excluding the territories, 2024 (N=5,429,520) (continued)

	(A) Cross-tabulations of the percentage of people who reported this rating			(B) Logistic regression model for the probability of reporting this rating		
		95% confidence interval			95% confidence interval	
Characteristics	percent	from	to	AOR	from	to
Interaction with the health care system during the year before the interview						
Health care provider consultation frequency						
One to four times (R)	78.89	76.98	80.69	1.00	...	...
Five or more times	77.03	73.10	80.55	1.33 *	1.02	1.74
Number of difficulties to get appointment						
None (R)	86.72 ‡‡	85.04	88.23	1.00	...	...
One	64.15	59.51	68.53	0.54 *	0.40	0.72
Two or more	52.53	46.79	58.20	0.45 *	0.32	0.63
Number of perceived reasons for discrimination						
None (R)	80.13 ‡‡	78.43	81.73	1.00	...	...
One or more	43.15	33.56	53.28	0.39 *	0.25	0.62
Wait time before the last non-urgent primary health care visit in the year before the interview						
Wait time						
0 to 3 days (R)	82.42 ‡‡	80.06	84.56	1.00	...	...
4 to 29 days	77.04	74.54	79.35	1.12	0.87	1.45
One month or more	69.22	63.01	74.81	1.39	0.96	2.02
Satisfaction with wait time						
Very satisfied or satisfied (R)	88.06 ‡‡	86.46	89.49	1.00	...	...
Neither satisfied nor dissatisfied	62.84	58.07	67.38	0.34 *	0.25	0.45
Dissatisfied or very dissatisfied	48.80	43.22	54.40	0.28 *	0.20	0.39
Life affected by wait time						
Yes (R)	65.91 ‡‡	62.93	68.76	0.54 *	0.42	0.69
No	88.30	86.62	89.79	1.00	...	...
Last non-urgent primary health care visit in the year before the interview						
Purpose of the visit						
Routine (R)	81.00	78.83	82.99	1.00	...	...
Non-routine	74.96	72.17	77.56	0.88	0.70	1.12
Type of visit						
In person (R)	79.66	77.70	81.48	1.00	...	...
Virtual	73.56	69.67	77.11	0.74 *	0.58	0.95
Type of access						
Has regular HP, met regular HP (R)	80.35 ‡‡	78.55	82.04	1.00	...	...
Has regular HP, met other HP	78.49	73.27	82.93	1.08	0.77	1.53
No regular HP	59.44	52.12	66.37	0.56 ***	0.39	0.80

... not applicable

* significantly different from reference category ($p < 0.05$)
*** significantly different from reference category ($p < 0.001$)
† significant differences between the categories of the variable ($p < 0.05$)
‡‡ significant differences between the categories of the variable ($p < 0.001$)

Notes: R is the reference category for the logistic regression model. AOR stands for adjusted odds ratio. HP stands for health care professional. Indigenous people include First Nations people living off-reserve, Métis and Inuit. Groups could not be presented separately because of the sample size.

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

For all respondents, having fair or poor self-reported general health (AOR=0.76 [CI: 0.60, 0.96] for those aged 18 to 64; AOR=0.62 [CI: 0.46, 0.84] for those aged 65 and older) was associated with a lower probability of rating the last non-urgent visit as excellent or very good. For respondents aged 18 to 64, having two or more chronic conditions was associated with a higher probability of rating the visit as excellent or very good (AOR=1.32 [CI: 1.09, 1.61]). For respondents aged 65 and older, having a disability was associated with a higher probability of this outcome (AOR=1.40 [CI: 1.05, 1.87]).

Interaction with the health care system and wait time

For all respondents, having had at least one difficulty getting an appointment or having perceived at least one sign of discrimination was associated with a lower probability of rating the last non-urgent visit as excellent or very good. Conversely, having had at least five visits during the year was associated with a higher probability of the outcome (AOR=1.53 [CI: 1.24, 1.88] for those aged 18 to 64; AOR=1.33 [CI: 1.02, 1.74] for those aged 65 and older). Not having a regular HP (AOR=0.62 [CI: 0.50, 0.76] for those aged 18 to 64; AOR=0.56 [CI: 0.39, 0.80] for those aged 65 and older) was associated with a lower probability of rating the last non-urgent visit as excellent or very good. Moreover, for the group aged 18 to 64, consulting an HP other than one's own regular HP during the visit was associated with a lower probability of the outcome, while a virtual visit was associated with a lower probability of the outcome for those aged 65 and older.

Being dissatisfied or very dissatisfied about the wait time (AOR=0.33 for those aged 18 to 64; AOR=0.28 for those aged 65 and older), being neither satisfied nor dissatisfied about the wait time (AOR=0.34 for both age groups), and having had their life affected by the wait time (AOR=0.67 for those aged 18 to 64; AOR=0.54 for those aged 65 and older) were associated with a lower probability of rating the last non-urgent visit as excellent or very good.

By contrast, a longer wait time was associated with a higher probability of rating the visit as excellent or very good, a result that appears to contradict the cross-tabulation results. This is explained by satisfaction with wait time acting as a suppressor variable. When wait time was entered into the model on its own, without satisfaction with wait time, its AORs were below 1 in both age groups and for both categories: for those aged 18 to 64, the AOR was 0.84 for 4 to 29 days and 0.52 for one month or more, and for those aged 65 and older, it was 0.72 and 0.48, respectively. Once satisfaction with wait time was added, all AORs of wait time rose above 1: 1.41 and 1.45 for those aged 18 to 64, and 1.17 and 1.36 for those aged 65 and older. This shift reflects how multivariate models work: each variable's effect is estimated while holding all others constant, so that adding a correlated variable like satisfaction with wait time can reverse the apparent direction of another variable's effect.

Positive attitudes of the health care professional

The percentage of respondents who strongly agreed, somewhat agreed, or neither agreed nor disagreed with the eight statements related to their HP's attitude varied from 92.0% to 97.4% (Table 4). Among those respondents, the percentage who rated their visit as excellent or very good was high in general. It was higher for those aged 65 and older, compared with those aged 18 to 64. In both groups, its highest value was observed for the second statement (the professional "spent enough time with you"), 73.3% for those aged 18 to 64 and 81.8% for those aged 65 and older. Its lowest value was observed for the first statement (the professional "treated you with courtesy and respect"), 69.3% for those aged 18 to 64 and 79.6% for those aged 65 and older. Conversely, 6.9% of those aged 18 to 64 and 12.6% of those aged 65 and older who disagreed with the fifth statement (the professional "listened carefully to you") rated their last visit as excellent or very good.

Table 4
Attitudes of the health care professional, household population aged 18 and older who had a non-urgent primary health care visit in the year before the interview, Canada excluding the territories, 2024

	Percentage of population			Percentage of people who rated their last non-urgent primary health care visit as excellent or very good								
				Ages 18 to 64 (N=16,565,771)				Ages 65 and older (N= 5,429,520)				
		95% confidence interval				95% confidence interval				95% confidence interval		
Attitudes of the health care professional	percent	from	to	percent		from	to	percent		from	to	
1. Professional treated patient with courtesy and respect												
Strongly agree, somewhat agree, or neither agree nor disagree	97.40	97.00	97.90	69.30	‡‡	67.92	70.64	79.59	‡‡	77.89	81.18	
Somewhat disagree or strongly disagree	2.60	2.10	3.00	12.72		8.47	18.66	26.11		15.14	41.17	
2. Professional spent enough time with patient												
Strongly agree, somewhat agree, or neither agree nor disagree	92.00	91.30	92.60	73.28	‡‡	71.89	74.63	81.85	‡‡	80.19	83.39	
Somewhat disagree or strongly disagree	8.00	7.40	8.70	10.92		8.45	14.00	17.65		12.48	24.36	
3. Professional explained things in a way that was easy to understand												
Strongly agree, somewhat agree, or neither agree nor disagree	96.50	96.00	96.90	69.91	‡‡	68.50	71.28	80.28	‡‡	78.59	81.86	
Somewhat disagree or strongly disagree	3.50	3.10	4.00	10.03		6.83	14.50	20.28		13.00	30.21	
4. Professional involved patient in care and treatment decisions												
Strongly agree, somewhat agree, or neither agree nor disagree	95.20	94.70	95.70	70.96	‡‡	69.56	72.32	80.83	‡‡	79.17	82.39	
Somewhat disagree or strongly disagree	4.80	4.30	5.30	9.10		6.57	12.48	18.20		11.77	27.06	
5. Professional listened carefully to patient												
Strongly agree, somewhat agree, or neither agree nor disagree	94.80	94.20	95.30	71.38	‡‡	69.96	72.76	81.27	‡‡	79.62	82.82	
Somewhat disagree or strongly disagree	5.20	4.70	5.80	6.93		4.72	10.06	12.55		7.64	19.95	
6. Professional gave patient an opportunity to ask questions or raise concerns												
Strongly agree, somewhat agree, or neither agree nor disagree	94.90	94.40	95.50	71.21	‡‡	69.83	72.55	80.99	‡‡	79.35	82.54	
Somewhat disagree or strongly disagree	5.10	4.50	5.60	8.43		6.03	11.66	16.73		10.62	25.36	
7. Professional took into consideration patient's needs and personal situation												
Strongly agree, somewhat agree, or neither agree nor disagree	94.70	94.10	95.20	71.38	‡‡	69.98	72.75	81.19	‡‡	79.53	82.75	
Somewhat disagree or strongly disagree	5.30	4.80	5.90	8.33		5.72	11.97	13.89		8.63	21.59	
8. Professional had all medical information they needed about patient												
Strongly agree, somewhat agree, or neither agree nor disagree	94.30	93.70	94.80	71.09	‡‡	69.68	72.46	80.24	‡‡	78.53	81.84	
Somewhat disagree or strongly disagree	5.70	5.20	6.30	19.25		15.42	23.77	28.12		19.60	38.57	

‡‡ significant differences between the categories of the variable ($p < 0.001$)

Note: Indigenous people include First Nations people living off-reserve, Métis and Inuit. Groups could not be presented separately because of the sample size.

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

Discussion

This study shows that a patient's assessment of their last non-urgent primary care medical visit as excellent or very good was essentially related to their interaction with the health care system, much more than their sociodemographic characteristics or their health. More precisely, difficulties, perceived discrimination, wait time, and attitudes of the HP, which were identified as enabling factors according to Andersen's Behavioral Model of Health Services Use, were associated with the outcome.

Difficulties getting an appointment and perceived discrimination (in any circumstance during the year) were associated with the assessment of the visit, a finding already established in previous studies.[8,31] Being satisfied or very satisfied with the wait time and not perceiving one's life as being affected by it were associated with assessing the visit as excellent or very good, while the wait time itself either was not significant or had a non-intuitive effect. This confirms a finding already observed: the length of the wait time by itself is not as important for respondents as its actual impact on their lives.[32,33]

The eight statements related to the HP's attitudes were highly associated with assessing the visit as excellent or very good, confirming the importance of a patient-centred health care framework.34 This is particularly the case for the HP spending enough time with the patient (statement 2) and listening carefully to them (statement 5) (see Table 4). Other instances of HP attitudes were also observed in recent international work on patients' evaluation of health care. In Europe, health care processes were considered positive if information flow was personal and functional, corresponding to statement 8 of this survey (the professional "had all the medical information they needed about the patient").[35] In Norway,

patients assessed quality positively when they felt they were taken care of—this corresponds to statements 5 through 7 ("the professional "listened carefully to the patient:, "gave the patient an opportunity to ask questions or raise concerns", and "took into consideration the patient's needs and personal situation").[36]

Although the four self-reported measures of health were associated with assessing the visit as excellent or very good in the cross-tabulations for both age groups, only self-reported general health was significant in the models (for both groups). For those aged 18 to 64, the number of chronic conditions emerged as a significant factor;[37] among those aged 65 and older, disability emerged as well, a result that was previously observed in Canada[38] and the United States.[39]

The type of access was associated with assessing the visit as excellent or very good, as not having a regular HP at all was significant for both age groups. People who had a regular HP whom they met for their last visit were more disposed to rate this visit as excellent or very good, possibly reflecting the role of continuity of care.[40,41] For those aged 65 and older, in-person consultations as opposed to virtual visits were significant for assessing the visit as excellent or very good.[42,43]

Strengths and limitations

This study used a large Canadian sample with detailed questions about patients' experiences with health care to provide a current national picture of satisfaction with primary health care. The questionnaire may be considered adequately validated because it was built from other previously validated surveys.[29]

The survey's low response rate may influence the interpretability of results. All survey data were self-reported, and this could lead to desirability bias[44] or reference bias.[45] A list of chronic conditions was provided to the respondents, and the responses were not medically validated. Data do not include long-term care for seniors and retirement homes, a limitation that could restrict the generalizability of results for those aged 65 and older. Data do not include the territories, and this could restrict generalizability for Indigenous people. Data are cross-sectional, preventing any causal inference. No data on language were analyzed. Analyses excluded 7,109 individuals (representing 7.8 million people in Canada) who had not had a non-urgent visit during the year before the interview. This group comprised individuals who may or may not have had a scheduled appointment after the interview—it was not possible to analyze them further.

Conclusion

Based on a nationally representative survey on health care experiences and perceptions, this study shows that self-reported general health, satisfaction with wait time, and the impact of wait time, the number of visits during the year, difficulties getting an appointment, perceived discrimination, and access to one's own regular HP all contribute to the predictive model in which the last non-urgent medical visit is rated as excellent or very good. The eight statements describing attitudes of the HP are highly associated with the outcome, as each one represents a specific aspect of the evaluation of health care quality. This study illustrates the influence of patients' experiences and perceptions in the evaluation of their medical visit. Future research could focus on evaluating the validity of these results for children or for isolated (remote or institutionalized) populations.

Appendix

Appendix Table 1
Chronic conditions assessed in the survey

Options	Chronic conditions
1	Asthma
2	Chronic lung condition
3	Chronic heart disease
4	Diabetes
5	Chronic kidney disease
6	Liver disease
7	High blood pressure
8	Chronic blood disorder
9	Weakened immune system
10	Chronic neurological disorder
11	Effects of a stroke
12	Alzheimer's disease or other dementia
13	Cancer
14	Arthritis
15	Eye disease
16	Urinary incontinence
17	Bowel disorder
18	Mood disorder
19	Anxiety disorder
20	Post-traumatic stress disorder

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

Appendix Table 2
Difficulties getting an appointment

Options	Difficulties
1	Appointment cancelled or deferred by health care provider
2	Difficulty getting an appointment
3	Waited too long between booking appointment and visit
4	Did not get adequate information or advice
5	Overall health deteriorated
6	Condition got worse
7	Lack of First Nations, Métis or Inuit traditional medicines, healing or wellness practices
8	Lack of availability of culturally appropriate health services
9	Service not available at time required
10	Service not available in the area
11	Service not available in preferred mode (e.g., in-person, virtually)
12	Difficulties related to virtual care technology
13	Other

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

Appendix Table 3
Perceived reasons for discrimination

Options	Perceived reasons
1	Indigenous identity
2	Race, ethnicity or culture
3	Gender
4	Age
5	Weight
6	Religion
7	Language
8	Sexual orientation
9	A physical disability
10	Something else related to physical appearance
11	Socioeconomic status
12	A mental health condition
13	Lifestyle
14	Beliefs
15	Other

Source: Statistics Canada, 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care.

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