Tuesday, November 12, 2013 8:30 AM  Room: Les Saisons

HH48 Effects of Financial Incentive Changes on Family Physician Participation in Centralized Waiting Lists for Family Physicians

Mylaine Breton, PhD; Astrid Brousselle, PhD; Danièle Roberge, PhD; Antoine Boivin, PhD; Lynda Rey, PhD(c)

Context: Access to a family physician is a major concern in Canada. To address the need of the population without a family physician, some provinces have implemented centralized waiting lists for family physicians. In Québec, 95 centralized waiting lists (guichets d’accès aux clientele orphelines –GACO) have been implemented across the province. They were established in 2008 and financial incentives were introduced in November 2001. Since this change, family physician have received $100 for non-vulnerable patients and $200 for vulnerable patients (increased from of $100). Objective: To analyze the impact a change in financial incentives has on physician participation in Quebec GACOs. Design: Longitudinal quantitative analysis (2010-2013) of administrative and clinical databases. All patients referred through GACOs to a family physician are registered in these databases (N = 479 015). Analysis: Data from April 1, 2012 to March 31, 2013 were analyzed using the usual statistical comparison of proportions (x2) and repeated linear regression with SPSS®20 software to compare before/after the change in incentive formula. Results The financial incentive change has accomplished the objective of increasing the volume of patients connected to a family physician. The volume of patients referred via GACO has more than quadrupled. However, the other goal to prioritize vulnerable patients has not been reached. In fact, we observed that the proportion of non-vulnerable patients referred (70%) increased while the proportion of vulnerable patients (30%) referred has decreased. Conclusion The new incentive bypassed the initial goal of GACOs to connect vulnerable patients without family physicians and the results show that it even has aberrant effects on physician participation. For example, we observed that the majority of referred patients were self-referred by physicians. Moreover, even if the amount of the bonus received is doubled to prioritize
vulnerable patients, physicians seem to favour healthier and non-vulnerable patients to the detriment of those most needy and vulnerable. The GACOs’ intervention plan with the goal of encouraging physician participation is therefore questioned.

Wednesday, November 13, 2013 9:15 AM  Room: Governor General I

CR41 Explaining Time Elapsed Prior to Cancer Diagnosis

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Context: 22% of newly diagnosed cancers are in advanced stages and current pathways leading to diagnostic still generate delays. Objectives: To assess the relative influences of personal factors, the utilization of primary care services and the cancer site in explaining the time elapsed between first symptoms and cancer diagnosis. Design: Descriptive analysis Patients: 20 in-depth qualitative interviews with patients diagnosed with breast, lung or colorectal cancer. Patients were identified based on their responses to a survey on their primary care experience and their pathway in the healthcare system in the period preceding diagnosis (n=377). Patients were selected if the time between their first symptoms and their diagnosis was particularly short or, conversely, particularly long (extreme cases), in order to better identify explanatory factors. Results: Pre-diagnosis trajectories and elapsed time differed according to cancer sites. The time was much shorter (weeks) for the majority of patients with lung cancer, who consulted directly for an acute condition they did not associate with cancer. For colorectal cancer, patients experienced symptoms, sometimes during years, but consulted a primary care facility only when an acute condition occurred. For breast cancer, personal attitude played a role in initiating contact but care organization greatly influenced timing: step-wise discontinuous diagnostic testing introduced significant delays as compared to all-in-one-day investigation. For all cancer sites, shorter times were observed when patients were proactive in seeking care; having good connections within the system and financial capacity for private testing accelerated the investigation process. Conclusion: Clearly, early and coordinated access to investigation and diagnostic resources shortened the time elapsed between symptoms and diagnosis. However, in contrast to Canada’s positive reputation for its universal health care system, cancer diagnostic procedures are still easier to access for proactive patients with greater financial means and connections, aggravating inequities in cancer outcomes.

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