Accessing Immediate Treatment for Less-Urgent Health Problems

Conditions within emergency departments in the United States were recently described as *care . . . at the breaking point* as the demand for services exceeds the capacity to deliver.[1] This description is equally applicable to emergency departments in Canada. Recent reports highlight the difficulties that emergency departments are experiencing in their attempt to respond to the needs of those seeking services.[2,3] Increasingly, people who visit an emergency department face over-crowded conditions, long wait times, and may feel the need to justify the appropriateness of their visit. In a 2005 publication titled *Understanding emergency department wait times*, the Canadian Institute for Health Information (CIHI) reported more than half (57%) of patients treated in participating hospitals were triaged with less-urgent or non-urgent conditions.[4] It has also been noted that Canadians use emergency departments more than people in other countries.[5] A key recommendation stemming from the CIHI report was the need to understand how Canadians use emergency departments.

In a previous study,[6] we investigated the healthcare behaviors of people with less-urgent health problems who sought care at an emergency department. Using data from 1,973 New Brunswickers from five communities in two health regions, we attempted to predict their use of self-treatments, willingness to wait for treatment, and difficulty accessing immediate treatment for minor health problems by applying Andersen's theoretical model of healthcare services utilization.[7-10] Despite the popularity of Andersen's model and its frequency of use, we were surprised by its limited predictive capability given the number of predictor variables investigated. Upon reflection, we decided two key concepts may not have been adequately operationalized. First, although study findings offered some evidence to suggest people's beliefs about healthcare affect how they respond to health problems, the items used to measure health beliefs were not specific to the treatment of less-urgent health problems. In addition, we may not have adequately addressed the impact of contextual factors on healthcare utilization. We plan to address these limitations in this study.

Objective 1. *Identify aspects of care that people believe are important for the treatment of less-urgent health problems.* An instrument to measure people's beliefs about important attributes of the care for less-urgent health problems will be developed and tested. Items will be derived from a review of relevant literature as well as information collected in our previous study. A pilot study will be conducted to accumulate preliminary evidence of the instrument's reliability and validity. Understanding what people believe are the important aspects of care is an essential pre-requisite for designing appropriate and responsive healthcare services as well as for measuring healthcare quality. Such knowledge may also assist in the development of initiatives aimed at optimizing the use of available services.

Objective 2. *Examine extent that contextual factors affect people's views about the immediate treatment of less-urgent health problems.* Data from Statistics Canada's Health Services Access Survey (HSAS) will be analyzed to gain a better understanding of the effect of contextual determinants on healthcare utilization. Based on data from the 2003 HSAS[11], 35% of Canadians reported that they or a family member needed immediate care for a minor health problem in the past year. Of those who required this service, 24% reported access problems. An examination will be conducted to determine if contextual differences are evident based on where people live (health region).

Objective 3. *Further test the capabilities of Andersen's model to explain use of healthcare services for the immediate treatment of less-urgent health problems.* The instrument resulting from Objective 1 and the insights gained from Objective 2 will be incorporated into a pre-existing survey based on Andersen's model. Data will be collected from people who access services for the immediate treatment of a less-urgent health problem, in urban and rural communities. Participants will be recruited from facilities offering immediate care services - emergency departments, after-hours clinics, and community health centers. Structural equation modeling techniques will be used to examine how people's healthcare beliefs are shaped by individual and contextual-level factors and how these subsequently affect their utilization of services. Understanding how people use current services will help inform future healthcare initiatives.