UNMET HEALTH CARE NEEDS: A REFLECTION OF THE ACCESSIBILITY OF PRIMARY CARE SERVICES?

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In this thematic pamphlet, we present some results of a study entitled **Accessibilité et continuité des services de santé - Une étude sur la première ligne au Québec**[1], conducted in 2005 among more than 9000 people in Montréal and Montérégie. Our goal is to provide information concerning unmet health care needs and to analyse the initial implications.

The concept of unmet needs refers to the difference between health services deemed necessary to treat a particular health problem and services actually received[2]. A person who perceived the need to receive medical services—whether information from a health professional or a therapeutic procedure—but who has not obtained these services has unmet health care needs. To a certain extent, this reflects the lack of access to health services.

The hypotheses raised in this document will be the subject of more thorough analyses, the results of which will be published at a later date. The first section gives an overall description of the phenomenon of unmet needs: its scope, the profile of individuals reporting having unmet needs, the nature of health problems for which unmet needs are reported, and the outcome for persons who are not obtaining services. We then examine the factors associated with experiencing unmet needs, and we conclude with a discussion on aspects related to health services organization.

1. UNMET NEEDS: A GROWING ISSUE?

The number of people reporting unmet needs has increased over the last ten years. According to Statistics Canada, reports of unmet needs have risen across the country from 4% in 1994-1995 to 6% in 1998-1999 and to 13% in 2000-2001. In this study, 18% of individuals reported experiencing unmet health needs in the six months preceding the survey.

18% of individuals reported experiencing unmet needs in the past six months

The data presented here stem from a survey of 9206 adults (4789 in Montréal and 4417 in Montérégie) living in the community. The survey is part of a larger study whose aim is to better understand the organization models of primary care services and their influence on accessibility and continuity of care. For more information about the project, visit: http://www.santepub-mtl.qc.ca/ESPSS/production.html

The reference period in our study—the past six months—differs from that of most other studies, which usually define the reference period as the past 12 months (see Table 1, page 3). The target population also varies slightly: the minimum age required to participate in our study was 18, compared with 12 for Statistics Canada's survey. While some figures on unmet health needs are available, a clear definition of this term is much more difficult to find.

Many studies adopt a definition based on access[4], measuring difficulty of access due to service costs[5-7], or being insured or uninsured[8]. In the United States, financial barriers to care are preponderant[9], a situation that is much less common in Canada[10,11] (see Table 1, page 3).

The following map (Map 1) presents the proportion of unmet needs identified in our survey, by CSSS territory.

The percentage of individuals reporting unmet needs is similar in Montréal (18.4%) and in Montérégie (17.3%). There are, however, discrepancies between CSSS territories within the two regions. Rates of unmet needs in Montréal fluctuate between 13% and 24%; there is less variation in Montérégie, where rates are between 11% and 19%. In Montréal, the CSSS territories with above average rates of unmet needs are Jeanne-Mance, Ahunstic and Montréal-Nord, Cœur-de-l'île, Sud-Ouest-Verdun, Bordeaux-Cartierville–Saint-Laurent, Lucille-Teasdale and la Montagne. In Montérégie, these territories are Vaudreuil-Soulanges, Jardins-Roussillon, Champlain, Haute-Yamaska and Richelieu-Yamaska (see Map 1). Proportions of unmet needs that are greater or equal to 24% (in black on the map) as well as those less than 12% (in white) differ statistically from the unmet needs average for all territories.

Map 1: Proportion of individuals aged 18 and over who reported having unmet needs in the past six months, by CSSS territory, Montréal and Montérégie, 2005

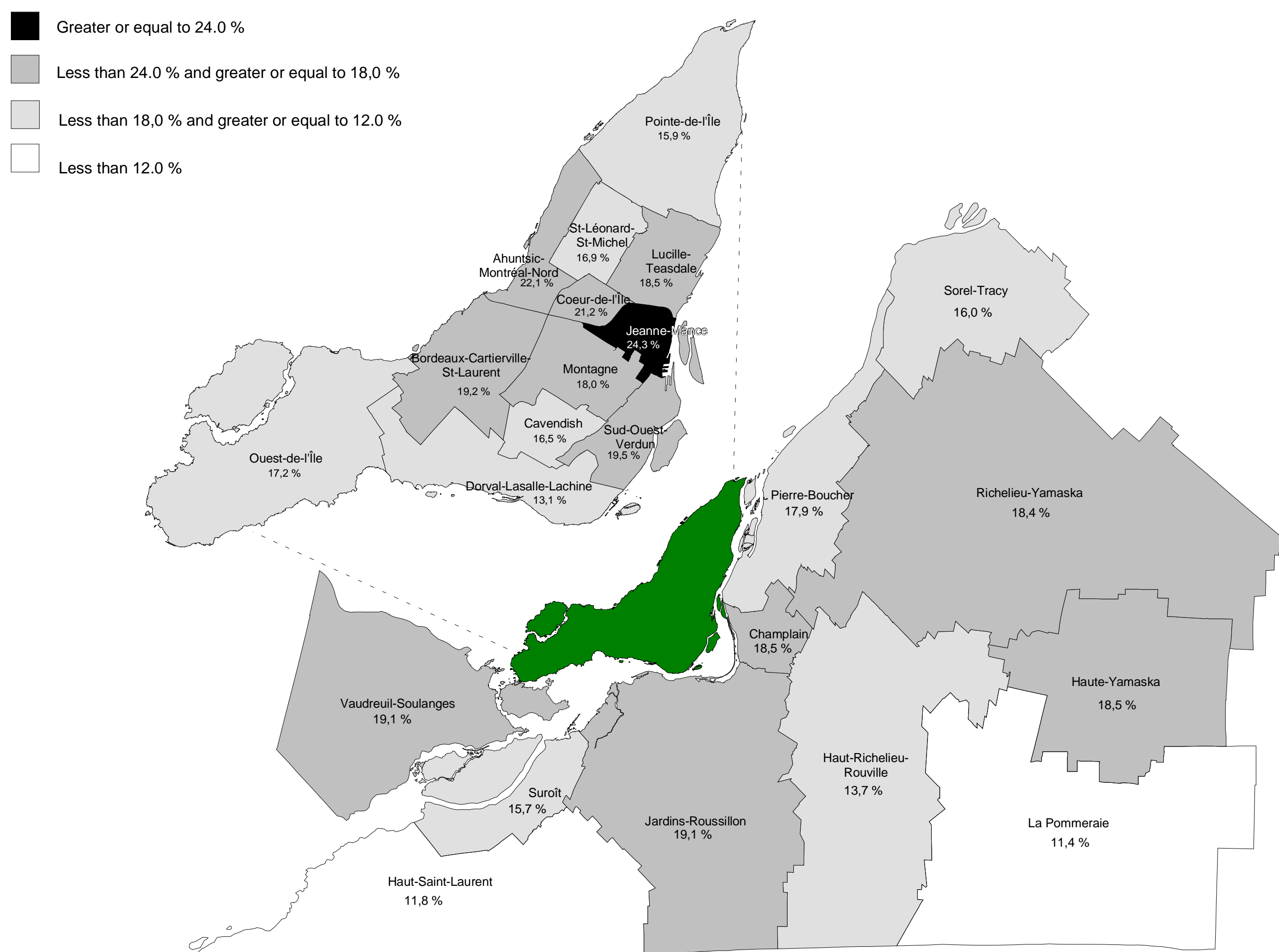


Table 1: Unmet needs in recent studies

Source	Reference period	Target population and year of survey	Proportion
Levesque J-F, Pineault R. et al. (2007)[12]. L'expérience de soins de la population - Portrait des variations intra-régionales à Montréal et en Montérégie	Past 6 months	18 years and over, 2 health and social services regions, Canada, 2005	18%
Pagan J and Pauly M (2006)[8]. Community-level uninsurance and the unmet medical needs of insured and uninsured adults	Past 12 months	18-64 years, United States, 2000-2001	Insured: 7% Uninsured: 18%
Shi L and Stevens GD (2005)[9]. Vulnerability and unmet health care needs: The influence of multiple risk factors	Past 12 months	18 years and over, United States, 2000	Between 2% and 20%, depending on the number of risk factors
Wu Z, Penning MJ and Schimmele CM (2005)[13]. Immigrant status and unmet health care needs	Past 12 months	18 years and over, Canada, 2000-2001	11.6% for immigrants and 13.6% for non-immigrants
Diamant AL, Hays RD et al. (2004)[5]. Delays and unmet need for health care among adult primary care patients in a restructured urban public health system	Past 12 months	Patients 18 years and over who had used primary care services, United States, 1999	25%
Sanmartin C, Houle C et al. (2002)[2]. Besoins non satisfaits de soins de santé : évolution	Past 12 months	12 years and over, Canada, 1994-2001	4.2% in 1994-95, 5.1% in 1996-97, 6.3% in 1998-99, 12.5% in 2000-01
Donelan K, Blendon RJ et al. (1999)[11]. The cost of health system change: Public discontent in 5 nations	Past 12 months	18 years and over, 5 countries, 1998	Canada: 10% Australia: 8% Great Britain: 10% New-Zealand: 12% United States: 14%

A survey of the literature on unmet health care needs indicates that the proportion of unmet needs in our survey is relatively high compared with other studies. However, American studies have reported prevalences that go even beyond our results, which shows that unmet needs can be influenced by health care coverage, a factor that should not be an issue in countries with universal coverage health systems. Our study reveals unmet need percentages that are higher than in recent Canadian studies [11,14]; this finding is consistent with the trend towards a rise in reported unmet needs over the last few years. We should also note that recall periods and regions studied also differed. Our study chose a shorter period; as a result, it is less prone to memory biases and leaves less time for health needs to be met. It is also possible that the proportion of unmet needs is higher in Québec than in the other Canadian provinces.

Who are the people reporting unmet health care needs?

While the population as a whole seems to be affected, certain characteristics set the group reporting unmet needs apart from the total population. Table 2 (page 6) indicates that young adults, recent immigrants, individuals with high levels of education, workers and students as well as people who report being in poorer health are more likely to experience unmet needs.

Unmet needs for a variety problems

Almost half (48%) of individuals who reported an unmet need were seeking to consult for a health problem they did not consider urgent. However, 20% had a health problem they thought urgent. Twenty-four per cent of cases wanted to see a physician for a routine examination, and 7% to get test results or have forms filled out.

To assess the nature of the problems for these unmet needs, it is important to focus on people who wanted to see a physician for health problems uniquely; consequently, routine exams, test results or prescription renewals are excluded.

Figure 1 presents perceptions of anticipated consequences of not having consulted. In all, 62% of individuals who wanted to consult for health problems were feeling moderate or a lot of pain. Over half of individuals who had reported unmet needs (53%) said the problem affected their activities (moderately or a lot). In 52% of cases, the problem was associated (moderately or a lot) with a fear of complications if left untreated, while 40% perceived it as threatening to their health (moderately or a lot).

Moreover, people's use of various health services over the past two years is also linked to reporting unmet needs. Fewer individuals who did not avail themselves of health services or made limited use of primary care services reported unmet needs (15% and 17% respectively) than people who went to emergency departments (24%) or used higher levels of services (18%) (Figure 2).

Figure 1: Nature of the problem behind an unmet need, Montréal and Montérégie, 2005

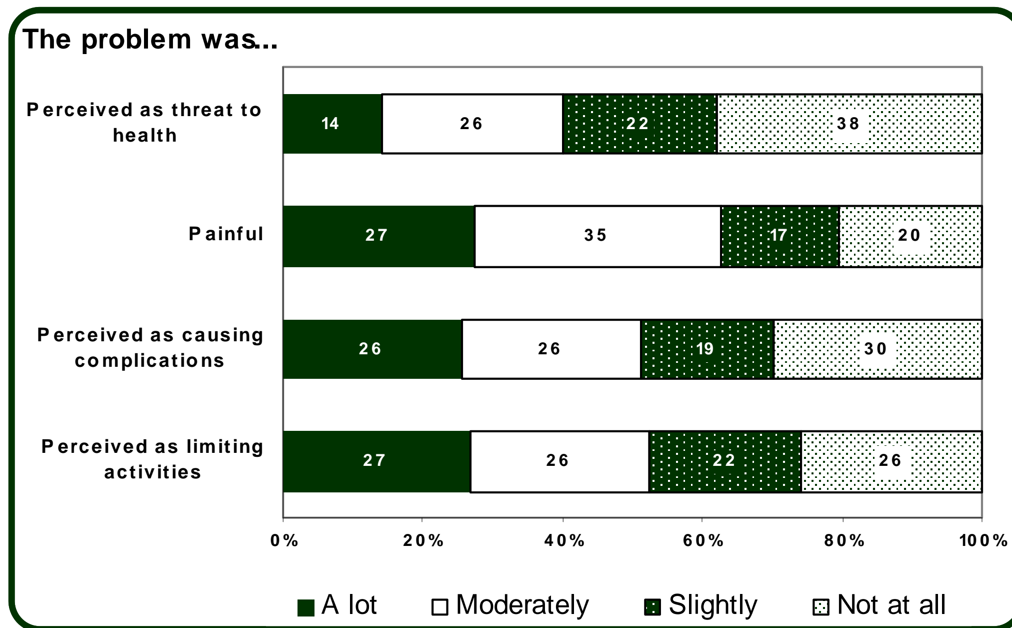
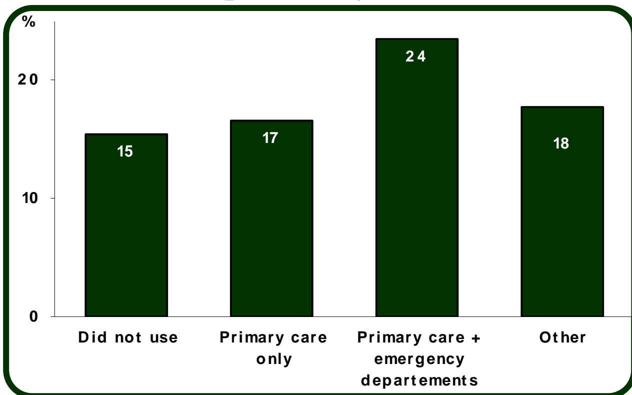


Figure 2: Proportion of individuals who reported unmet needs, by use of health services in the past two years



Significant consequences for users

The consequences for someone who does not have access to services can range from feeling worried to deterioration of the health problem. There is little information in the scientific literature concerning the consequences of unmet needs. Existing information mostly concerns the consequences for specific problems, such as lack of personal assistance with daily activities for older adults. The consequences most often analysed are reduced autonomy or premature death[16].

In our study, more than 45% of people who reported unmet needs were very or moderately worried or very or moderately bothered by pain, and almost 40% had difficulty with daily activities. These results deserve particular attention since in 42% of cases the problem had not always been resolved at the time of our survey and 17% of people felt their health had greatly or moderately deteriorated. Our results show that a sizeable proportion of individuals who reported unmet needs experienced significant consequences.

Figure 3 illustrates the main consequences of unmet needs noted in our study.

Figure 3: Consequences of unmet needs, Montréal and Montérégie, 2005

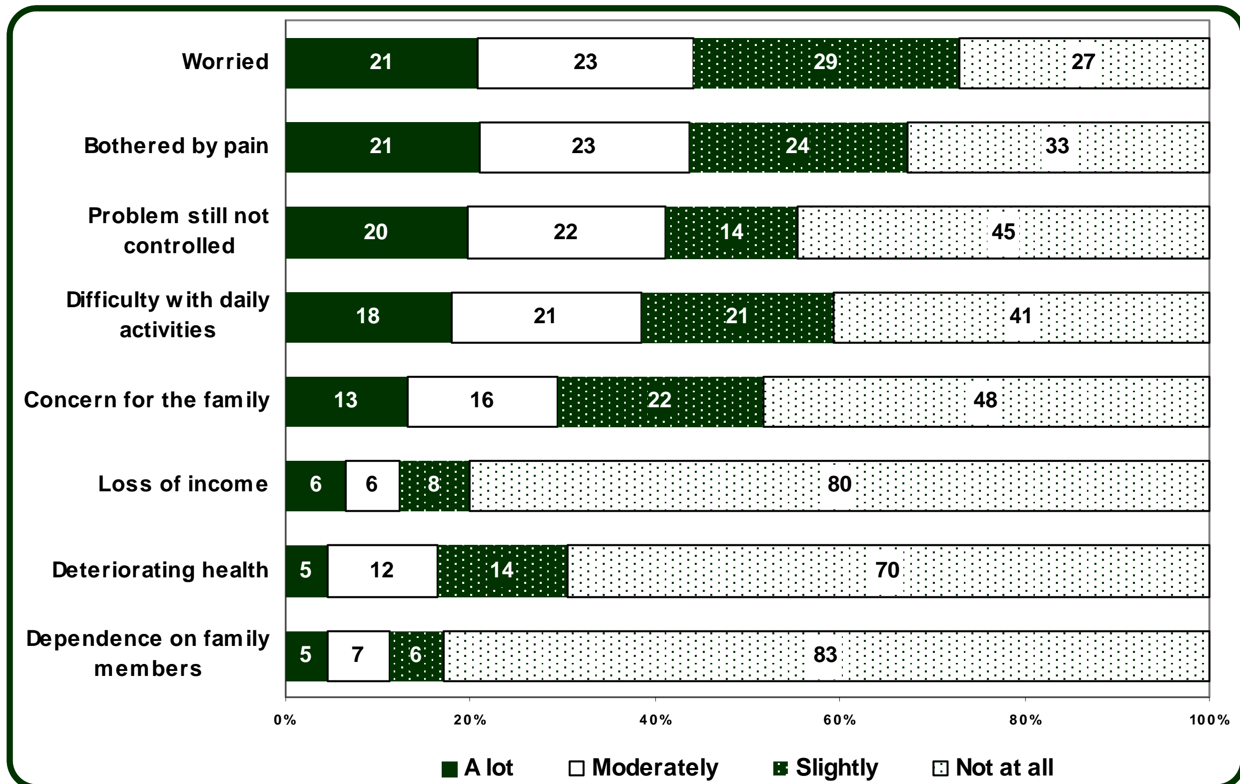


Table 2: Distribution of the population who reported unmet needs (%) [95% confidence intervals], by some characteristics

	Population reporting unmet needs		Total population	
Sex:				
Man	46.8	[44.0; 49.7]	48.5	[47.3; 49.8]
Woman	53.2	[50.3; 56.0]	51.5	[50.2; 52.7]
Region:				
Montréal	60.4	[57.8; 62.9]	58.9	[58.3; 59.5]
Montérégie	39.6	[37.1; 42.2]	41.1	[40.5; 41.7]
Age group:				
18/44 years	65.5	[62.7; 68.2]	49.0	[47.8; 50.3]
45/64 years	29.6	[27.1; 32.3]	33.5	[32.3; 34.7]
65 years +	4.9	[3.7; 6.4]	17.5	[16.5; 18.6]
Origin and duration since established in Canada:				
Born in Canada	77.8	[75.3; 80.0]	80.5	[79.5; 81.4]
Immigrant <5 years	5.6	[4.5; 7.0]	3.5	[3.1; 4.0]
Immigrant 5 to 10 years	3.6	[2.7; 4.7]	2.3	[2.0; 2.7]
Immigrant >10 years	13.0	[11.1; 15.2]	13.7	[12.9; 14.6]
Language spoken at home:				
French	76.0	[73.6; 78.4]	72.8	[71.8; 73.8]
English	14.2	[12.3; 16.3]	17.9	[17.0; 18.9]
Other language	9.8	[8.2; 11.6]	9.3	[8.6; 10.0]
Household income:				
<$15 000	14.7	[12.6; 16.8]	12.8	[12.0; 13.7]
$15 000 to $34 999	27.1	[24.7; 29.6]	30.2	[29.1; 31.4]
$35 000 to $74 999	35.3	[32.6; 38.2]	35.2	[33.9; 36.4]
>$75 000	22.8	[20.4; 25.5]	21.8	[20.7; 22.9]
Level of education:				
Primary school or less	9.8	[8.3; 11.6]	15.6	[14.8; 16.6]
Secondary/Trade school	29.1	[26.6; 31.7]	32.6	[31.5; 33.7]
CEGEP/ Diploma<Undergraduate	27.9	[25.4; 30.5]	24.3	[23.2; 25.3]
Undergraduate University	33.2	[30.6; 35.9]	27.5	[26.5; 28.6]
Occupation:				
Employed	72.2	[69.6; 74.6]	62.1	[60.8; 63.3]
Student	12.6	[10.8; 14.6]	9.1	[8.4; 9.9]
Looking for work/Welfare	4.1	[3.1; 5.3]	3.9	[3.5; 4.4]
Inactive: retired, volunteer	11.2	[9.5; 13.0]	25.0	[23.9; 26.0]
Perceived health status:				
Excellent	15.8	[13.9; 18.0]	20.5	[19.5; 21.5]
Very good	30.0	[27.5; 32.7]	34.8	[33.6; 36.0]
Good	31.1	[28.5; 33.8]	28.4	[27.3; 29.5]
Fair	19.1	[17; 21.3]	13.6	[12.7; 14.5]
Poor	4.0	[3.0; 5.3]	2.8	[2.4; 3.2]

2. FACTORS ASSOCIATED WITH REPORTING UNMET NEEDS

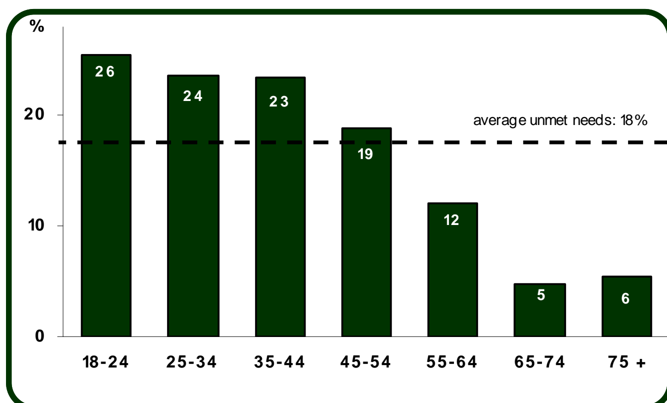
A number of demographic and socioeconomic factors as well as factors linked to respondents' health and their history of health services utilization can be associated with non-use of services despite a perceived need for health care. In this section, we describe some of the factors identified through descriptive statistics and multiple regression.

Demographic factors

According to the literature, women, younger people, individuals with higher levels of education and immigrants report more unmet health care needs [2,4,5,7-9,13,17].

In our study, 19% of women reported unmet needs in the past six months compared with 17% of men. Also, it is clear that reports of unmet needs tend to decrease with age (Figure 4).

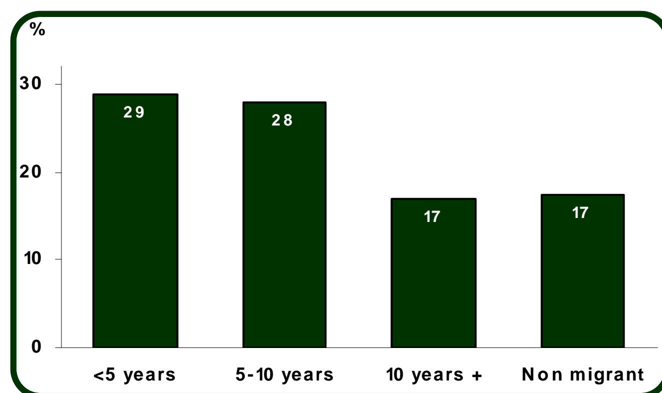
Figure 4: Proportion of individuals who reported unmet needs, by age



Various factors should be taken into consideration with regards to the relationship between age and unmet needs. The fact that income, state of health and occupation vary with age indicates that one should be cautious when interpreting such a relationship. Older individuals have increasingly more support from the health system as their need for services increases. In general, very few of them do not have a family physician. Expectations regarding the health system can also vary by age, and specific barriers for certain age groups—such as acceptability of services or availability of complementary services—might not be captured within the simple concept of unmet needs as articulated in our study.

As for country of birth, Sanmartin and Ross[4] state that non-immigrants report more unmet needs than immigrants. Other studies, however, have found the opposite, especially concerning recent immigrants[5,7]. For Wu et al.[13], the difference is not in the proportions of unmet needs but rather in the reasons for them. In our study, immigrants who came to Canada less than 5 years ago have more unmet needs than individuals born here (Figure 5). This might seem paradoxical since new immigrants tend to be in good health, a factor inversely correlated to unmet needs. The higher reported rate of unmet needs can be explained in part by barriers to the health system. Indeed, Wu et al. [13] maintain that new immigrants can be confronted with language problems, have different perceptions of health and illness, and have poor knowledge of the system and of their right to health care.

Figure 5: Proportion of individuals reporting unmet needs, by origin and time since arrival in Canada



Moreover, it is interesting to note that the difference gradually decreases with duration of residence. Immigrants who arrived more than 10 years ago reported unmet needs similar in proportion to people born in Canada.

However, this trend could be a reflection of both duration of residence of immigrants and of the age effect.

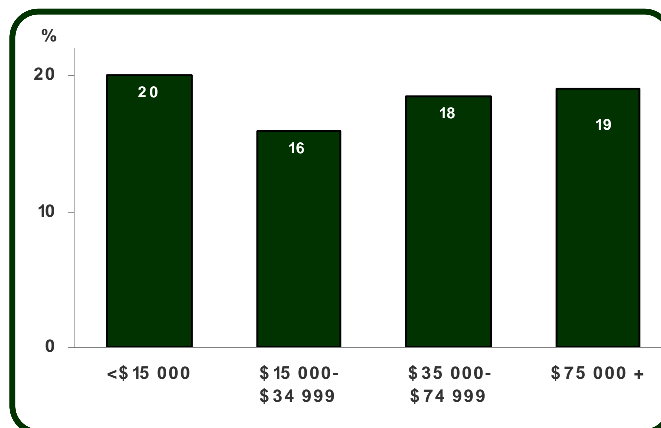
Finally, the proportion of unmet needs seems to be lower among individuals for whom the main language spoken at home is English (Table 3, page 9). The association between language spoken at home and experiencing unmet needs might be influenced by territory of residence. Additional analyses show that the proportion of unmet needs tends to be lower in areas with greater numbers of Anglophone households. However, the fact remains that cultural factors could also explain this association since Anglophones tend to report fewer unmet needs in all territories expect those with low proportions of Anglophone households. Conversely, the proportion of reported unmet needs is much higher among Francophones living in territories where there is a high concentration of Anglophone households.

Socioeconomic factors

In countries with universal health coverage, which implies equity of access, income is not associated with reports of unmet needs[4]. Yet, our study reveals a higher proportion of unmet needs among individuals who perceive themselves as poor or very poor (Table 3, page 9).

When correlated with income, the proportion of unmet needs among individuals with low and high incomes is higher (Figure 6). The relationship persists when income is corrected for family size (data not included). These findings are not contradictory. They can be understood by the fact that some categories of individuals, such as students and retirees, do not perceive themselves as poor even though their incomes are relatively low. Still, other studies have demonstrated a positive relationship between income and occurrence of unmet needs[8, 9].

Figure 6: Proportion of individuals who reported unmet needs, by household income



The rate of reported unmet needs among people who had attended university or who had graduated from college is double that of people who had at most finished primary school (Figure 7). Various studies have already shown that level of education is significantly correlated with occurrence of unmet needs[4,7,8,17].

Figure 7: Proportion of individuals who reported unmet needs, by level of education

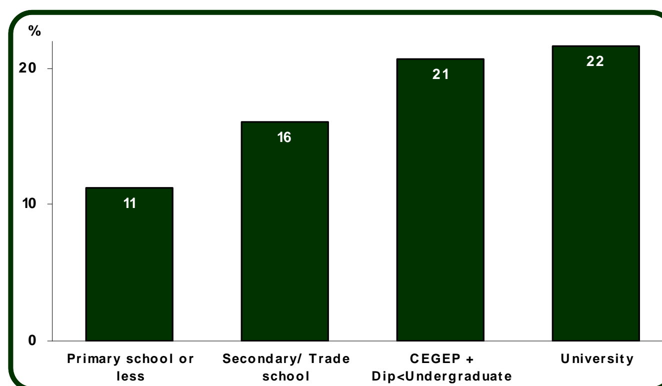


Table 3: Factors associated with reporting unmet needs, population aged 18 and over, Montréal and Montérégie, 2005

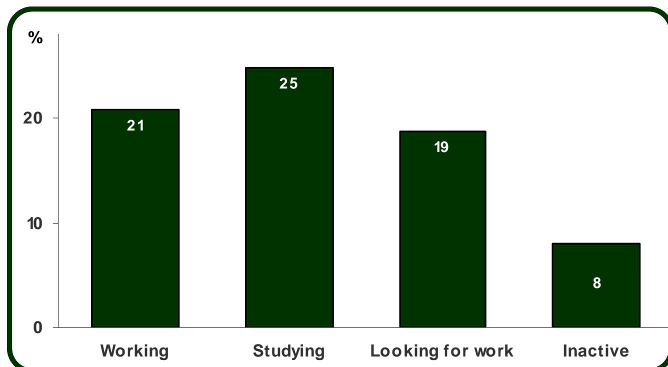
Proportion of respondents who reported …		… unmet needs in the 6 months preceding the survey (%)	Statistical significance*
Sex:	Man	17	*
	Woman	19	
Region:	Montréal	18	Excluded
	Montérégie	17	
Age group:	18-44 years	24	*
	45-64 years	16	
	65 years +	5	
Origin and duration since established in Canada:			
	Born in Canada	17	Excluded
	Immigrant <5 years	29	
	Immigrant 5 to 10 years	28	
	Immigrant >10 years	17	
Language spoken at home:	French	19	*
	English	14	
	Other	19	
Household income:	<$15 000	20	Excluded
	$15 000 to $34 999	16	
	$35 000 to $74 999	18	
	>$75 000	19	
Perceived poverty:	Well off	16	*
	Sufficient income	17	
	Poor	23	
	Very poor	30	
Level of education:	Primary school or less	11	*
	Secondary/Trade school	16	
	CEGEP/Diploma<Undergraduate	21	
	University	22	
Occupation:	Employed	21	*
	Student	25	
	Looking for work/Welfare	19	
	Inactive: retired, volunteer	8	
Perceived health status:	Excellent	14	*
	Very good	16	
	Good	20	
	Fair	25	
	Poor	26	
Regular source of care (2 years):	No source	16	*
	Clinic or office	18	
	CLSC or Family Medicine Unit	21	
	Emergency	28	
	Other type of source	16	
Morbidities and risk factors (RF)‡:	No health problem	16	*
	Risk factor only	12	
	Moderate morbidity	22	
	Severe morbidity	22	
	Severe co-morbidity	21	
Having a family doctor:	Yes	15	*
	No	26	

* Statistically significant variable based on logistic regression models

‡ Risk factors: high blood pressure, diabetes, cholesterol
Moderate morbidity: blood circulation, skin problems, backache, rheumatism
Severe morbidity: heart problems, respiratory problems, stroke
Severe co-morbidity: accumulation of moderate and severe morbidities

As for employment status, people who are not on the job market (looking for work or retired) report fewer unmet needs than individuals who have full-time occupations (job or studies) (Figure 8). However, this is quite likely due to an age effect, since older age and professional occupation are usually interrelated.

Figure 8: Proportion of individuals who reported unmet needs, by employment status

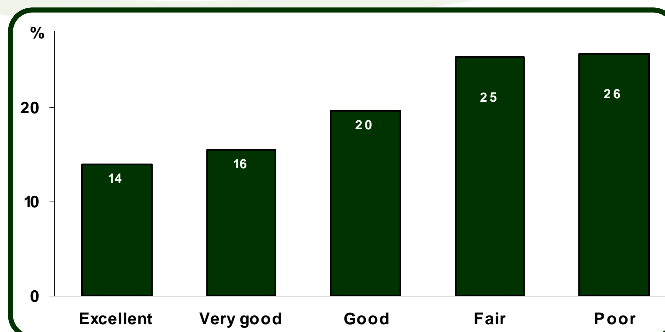


Our analyses identified that the proportion of unmet needs was higher among women, young people, recent immigrants and people who perceive themselves as poor or very poor. Individuals with low levels of education, people who are inactive and those who primarily speak English at home tend to report fewer unmet health care needs.

Factors linked to health status

A person's health status is frequently identified as a determinant of unmet needs. People who perceive themselves to be in poorer health and those with chronic conditions report more unmet needs[5,7,8,17]. In our study, healthier individuals are less likely to report unmet health care needs than people who consider themselves to be in poor health (Figure 9).

Figure 9: Proportion of individuals who reported unmet needs, by perceived health status

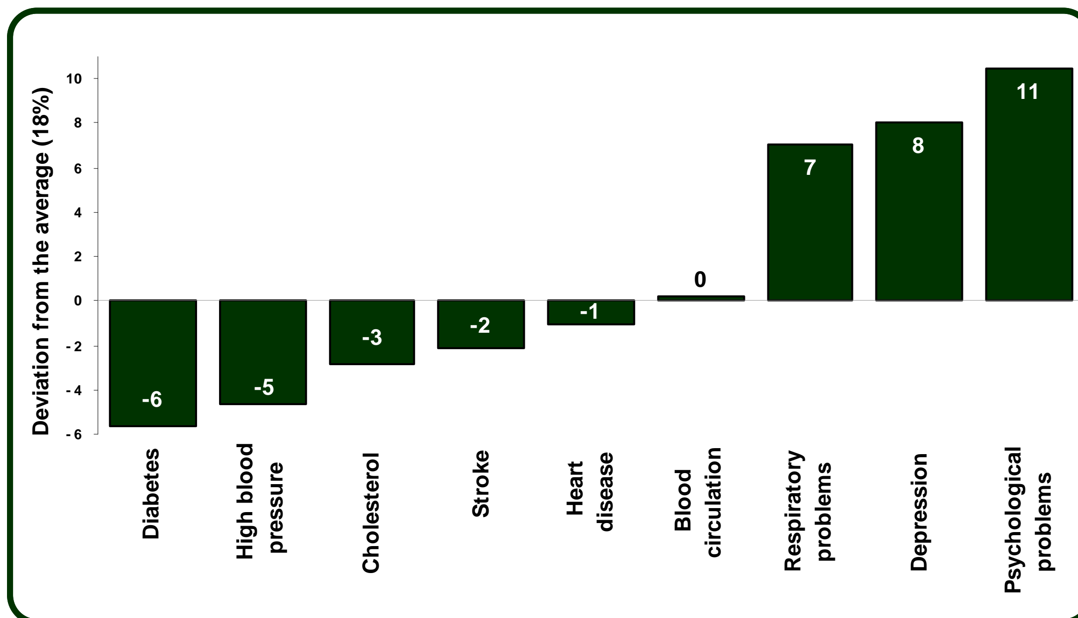


At first glance, this may seem to be in contradiction with the relationship between age and reported unmet needs described previously. Generally, the older people get, the poorer their health. Therefore, the older the individuals, the more unmet needs they should have. But in fact they report fewer unmet needs. This illustrates the complex relationship that exists among age, morbidity and reporting of unmet needs. Various factors associated with perception of health care needs, having regular sources of care and people's expectations should probably be considered. Nonetheless, in our study, perceived health status and age are independently associated with reports of unmet needs, when all other factors are taken into account.

Moreover, what emerges from our study is that some diseases such as diabetes, high blood pressure and hypercholesterolemia, are associated with lower rates of reported unmet needs, unlike other diseases, such as respiratory or psychological disorders (Figure 10).

It is interesting to note that there are fewer reports of unmet needs among people with diseases that require contact with health professionals to ascertain a diagnosis. Indeed, figures for people who reported having diabetes or high blood pressure are up to 6 points lower than the overall average (12% vs. 18%) (Figure 10). They even report fewer unmet needs

Figure 10: Gap between the average percentage (18%) and the percentage for individuals aged 18 and over who report unmet needs, by type of morbidity of which they have been aware for the past two years

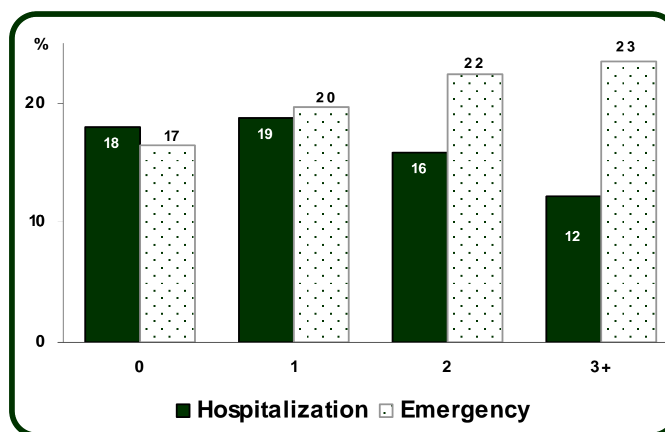


than people who have no health problems (16%, Table 3, page 9). We can therefore assume that it is not the effects of a disease itself but the fact of being closely followed by a health professional that reduces the probability of these people reporting unmet needs.

Conversely, health problems for which rates of reported unmet needs are higher than average correspond with problems for which access to the health system can be difficult. Figures for people who have reported mental health problems in the past are 8 to 11 points higher than the study average (Figure 10).

We can assume that there is an overall relationship between morbidity and reported unmet needs. All things being equal, unmet needs reporting increases with severity of the disease (multivariate regression data not included). This relationship suggests that people who are sick, and therefore who have greater need for health services than people in better health, are more likely to have unmet needs than people with fewer needs.

Figure 11: Proportion of individuals who reported unmet needs, by number of hospitalizations and use of emergency in the past two years



However, in relation to health services utilization (Figure 11), our study shows an association between having been hospitalized several times in the past two years and lower rate of reported unmet needs. This association could be a sign of more widespread patient management, which would attenuate the link between

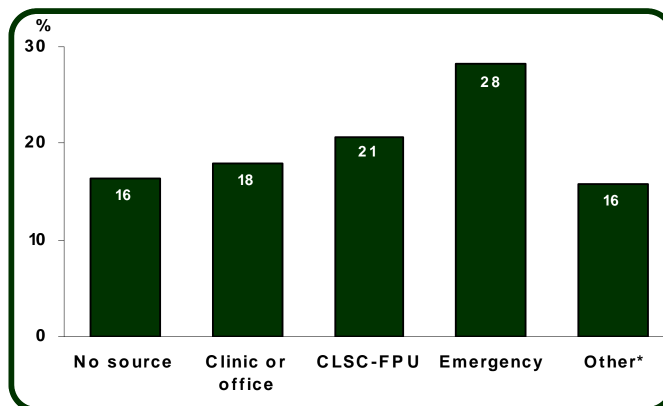
unmet needs and morbidity identified earlier. However, this does not hold true when we observe the effect of repeated visits to emergency, which appears to be associated with a higher prevalence of unmet needs. This finding evokes the traditional perception of emergency departments as a source of care that ensures less overall patient management.

Factors related to the health system that are associated with unmet needs

Studies such as those by Shi and Stevens[9] or Sanmartin and Ross[4] have demonstrated a link between having a regular source of care, especially a family physician, and having unmet health care needs. Indeed the literature suggests that people who do not have a regular source of care and those who do not have a family physician report more unmet needs. What clearly emerges from our study is that not having a family physician is one of the factors most strongly associated with having unmet needs: 26% compared with 15% for people who have a family doctor (Table 3, page 9). Not having a family physician very likely makes it more difficult to access health care services. However, having a family physician appears to be a protective factor against the risk of reporting unmet needs.

In this regard, regular source of care seems to play a very significant role. Individuals who reported having no source of care constitute a younger, distinct clientele that has little need for care. Indeed, these individuals report few health care needs (16%, Figure 12). People who have a doctor's office or clinic to go to as a regular source of care also report fewer health care needs. In all, 18% of people who go to a private office report having unmet needs compared with 21% of those who go to a CLSC-FPU and 28% who go to emergency departments. However, in multiple statistical models, the difference between people who use emergency departments and those who choose other sources of care is not statistically significant, when controlling for other factors (data not included). Finally, 16% of individuals who identified other types of regular sources of care (specialists, senior citizens homes, medical visits in another region) reported unmet needs. The latter probably have particular consultation profiles and specific contexts, compared with the general ambulatory population. Their lower rates of reported unmet needs could, in fact, indicate that they benefit from closer medical follow-up that is more specific to their health problems.

Figure 12: Proportion of individuals who reported unmet needs, by regular source of care in the past two years



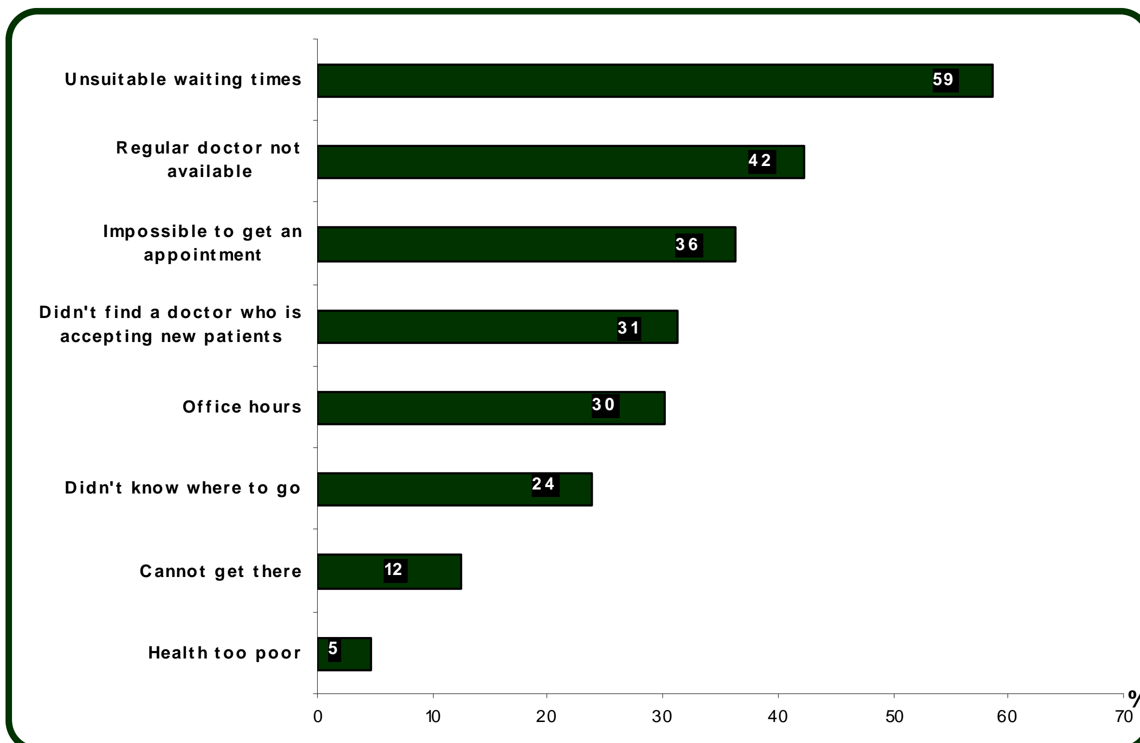
FPU = Family practice unit
**Other source: specialist, senior citizens home, outside the two regions included in the study.*

People who typically go to a clinic are certainly followed more regularly than individuals who go to emergency departments, usually for current, more pressing needs. This finding is again associated with having or not having a family physician. Almost 80% of people who go to a medical office report having a family doctor; this figure is over 68% for those who go to a CLSC and 31% for people who go to emergency (see the upcoming thematic pamphlet on family physicians).

Figure 13 provides an overview of the reasons behind unmet health care needs. Among the reasons given we note a significant proportion of individuals reporting factors linked to accessibility of services: waiting times too long to get an appointment (60% of cases); the impossibility of seeing one's regular physician (42% of cases); and the impossibility of making an appointment (36% of cases). Close to a third of individuals who reported unmet needs were also confronted with the impossibility of seeing a physician, since none would accept new patients. According to Sanmartin et al.[4], the number of individuals who cannot consult because of long wait times increased significantly from 1998 to

2001. Our results suggest that having a regular family physician, through client enrolment and the populational responsibility of sources of care should be encouraged in Québec. While some factors are linked to temporal accessibility of services, others highlight the difficulty of establishing a link with a family physician. The latter is strongly associated with a lower rate of unmet needs reporting. Consequently, there is a real barrier to access. Yet such reasons are modifiable factors that are related to primary care services organization.

Figure 13: Reasons given for reporting an unmet need



DISCUSSION

The goal of our study was to identify factors associated with unmet needs reporting in the past six months. More specifically, our aim was to verify whether unmet needs was a reflection of accessibility to primary health care services.

Our study results draw attention to the high proportions of reported unmet needs for health problems that are often serious and have grave consequences for individuals. This phenomenon seems to be growing and could reflect problems in primary care services organization. In fact, various factors relating to the health system and to care organization contribute significantly to unmet needs reporting by study participants.

Problems of affiliation with a regular source of primary care are especially associated with these unmet needs. Not having a family physician and having a regular source of care in emergency departments are associated with higher unmet needs reporting when other factors are taken into consideration. Therefore, health care organizations that are accessible to people are crucial to responding to the needs of individuals.

Individual characteristics are associated with unmet needs. Women, young adults, recent immigrants, people who work, people who speak a language other than English at home, and those who perceive themselves as poor tend to report more unmet needs. To gain a better understanding of this relationship, future analyses will enable us to assess whether organizations affiliated with these population groups are different from other health care organizations.

Moreover, it is important to note that there is a subjective and personal aspect involved in measuring unmet needs: an individual's perception of need. Perception of health and of need for care can both be influenced by people's expectations, independent of health status and actual need for services. In addition, cultural factors or factors related to differences in perception of health status among various groups were only partially considered here.

The fact that unmet needs reporting is associated with poorer health status substantiates the need to improve the health care system to ensure better patient management.

Finally, our results suggest that improving access to care, notably by encouraging affiliation with family physicians, is an avenue to explore if we want to reduce unmet needs.

The latter points suggest that solutions do not only lie in greater accessibility, which could even be accomplished by improved access to walk-in clinics. Better organization of primary medical care, by establishing models that encourage patient management and client enrolment, is one avenue to explore to curtail the rise in unmet needs in the population.

METHODOLOGY

This thematic pamphlet falls within the project entitled "Accessibilité et continuité des services de santé - Une étude sur la 1re ligne au Québec" (http://www.greas.ca or http://www.santepub-mtl.qc.ca/ESPSS/production.html).

The data presented in the pamphlet stem from a telephone survey conducted from February to June 2005 among a sample of the population aged 18 and over living in the community in the health and social services regions of Montréal and Montérégie. To participate, respondents had to be able to speak French or English. The response rate (AIRMS method) was 64.3% overall, 63.0% in Montréal and 65.9% in Montérégie. The total sample included 9206 respondents (4789 in Montréal and 4417 in Montérégie).

The questionnaire documents health services utilization in the two years preceding the survey, the characteristics, utilization, appreciation and results of services obtained from the regular source of care, as well as participants' care experiences for the main health problem, and unmet health care needs in the preceding six months.

Data are weighted to correct for distribution of age, sex and size of household, and to take into account the complex sampling design of the survey (stratified non-proportional sampling by CSSS and random selection of one individual per household). In our study, we measured the concept of unmet needs using the following question: *"In the past six months, did you feel the need to see a physician without actually doing it, that is, without seeing one?"*

In this pamphlet we present descriptive statistics. Chi-square tests ($p<0.005$) and 95% confidence intervals were performed to evaluate statistically significant differences. Logistic regression models were developed to identify factors associated with unmet needs reporting while controlling for potential confounders.

We essentially relied on results of the descriptive analysis; however, to verify certain trends observed, we occasionally used more detailed multiple regression analysis.

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IN SUMMARY

*** Prevalence of unmet needs appears to have grown over the past decade, and attained 18% in our study.**

***Health problems associated with unmet needs were perceived as urgent in one out of five people; this causes a large percentage of people who report unmet needs to feel worried and experience pain, and limits their activities.**

***Experiencing unmet needs affects the population as a whole but is more common among young adults, recent immigrants, people who work or study, individuals with higher levels of education and people who report being in poor health.**

*** Unmet needs rates are clearly higher among individuals who have no family doctor and people who go to the emergency as their usual source of primary care.**

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Unmet health care needs: A reflection of the accessibility of primary care services?

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