Access to primary care:
Advanced … or smart?

Access is back. Recent pronouncements by the prime minister and several UK health ministers have once again moved access to UK primary care services' centre stage, replacing choice, voice, and practice-based commissioning of services. The spectre of extended opening hours for GP services accompanies the politicians' commentary on access targets, and on the contribution of walk-in centres, NHS Direct, A&E departments, and primary care out-of-hours services to the increasingly complex patchwork of front-line NHS provision.

But this explosion in provision, accompanied by substantial investment in NHS service delivery, has not resulted in the end-user benefits that were anticipated. Significant sections of the population feel disenfranchised from primary care, as reported by the Secretary of State for Health who has warned that the results of the forthcoming GP–Patient Survey of 5 million NHS patients, and costing £11 million, may make 'uncomfortable reading for some doctors' on account of reported difficulties 'for a significant minority of patients' in accessing GP services.[1]

In these public statements, the spectre of political expediency and the courting of political popularity loom large. The recently announced review of NHS care led by Professor Ara Darzi has, as a central focus, the delivery of 'more accessible and more convenient care integrated across primary and secondary providers, reflecting best value for money and offering services in the most appropriate settings for patients'.[2] But such aspirations are not new. Building on proposals outlined in the NHS Plan,[3] Department of Health initiatives in 2002 encouraged practices to meet recently defined targets for the accessibility of GP care included the wholesale roll-out of 'Advanced Access'.[4] This approach to managing appointment systems was developed in the US and claimed to offer substantial benefits to service users in respect of reductions in waiting time for appointments, improved satisfaction with appointment arrangements, and reduced non-attendance rates. The scheme was widely and rapidly implemented. Shortly after roll-out two-thirds of UK practices claimed to operate Advanced Access arrangements, and by 2003, the UK Department of Health were claiming that 90% of patients were able to see a GP within 48 hours, or a health professional within 25 hours.[5] Four years and 40 million patients later, a series of high quality studies reported in this Journal provide, for the first time, robust evidence regarding the place and potential for Advanced Access in UK primary care.[6,7]

Led by Professor Chris Salisbury, these reports document a comprehensive series of studies whose findings will inform the access debate. The studies used mixed and innovative methods and a before-and-after study design to explore access to and continuity of care, practice capacity and workload, the attainment of NHS targets for access, and patient priorities and experience of care in 48 UK practices. Half of the practices were offering access arrangements which were broadly in line with the main principles of Advanced Access, as espoused and promoted by the National Primary Care Development Team. Most primary care professionals will find the results recognisable and relevant to their daily practice.

Despite its beguiling offer of benefit, the evidence suggests that Advanced Access appears to be something of a damp squib in UK settings. Using a simulated patient approach, 80% of appointment requests made by the research team were met with an offer of an appointment with a doctor within 48 hours. Advanced Access practices offered no advantage over control practices, but the proportion meeting the 48-hour NHS access target fell to only 65% in all practices when the full range of NHS access criteria were applied to the research data. Of interest and importance, and supporting the validity of the research approach, was the close approximation of results from the simulated patient study when compared with the reports of 12 825 patients surveyed in those practices following their consultation with a GP or nurse practitioner.

Based on a 5-day snapshot survey, all practices were observed to have a substantial increase in workload in the period following the roll-out of Advanced Access. This amounted to an average increase in control practices of around 12%, and to an average increase of 25% in Advanced Access practices — the latter equating to an additional 125 patients seen every week in an average sized 6000 patient practice.[8] The data presented suggest that Advanced Access practices offer a diverse economy of appointment provision, with a substantial proportion of this additional workload being met in ways other than by surgery-based consultations with a doctor. Furthermore, control practices appeared to operate with greater occupancy of the appointment system compared with Advanced Access practices, and, in line with expectations, there was evidence that Advanced Access practices closely matched the number of appointments offered to the number of patients seen.

While the UK government has hitherto largely focused its efforts on the speed of access, as embodied in the 24- and 48-hour access targets, these studies identify that patients' priorities may differ from those of the government. For all patients, being seen on the day of choice was considered of major importance. This attribute was prioritised above speed of access for all of the groups of patients studied. Speed of access was, however, an important attribute, but so were other aspects of access — the ability to choose the specific doctor, or the type of health professional consulted, and the ability to book appointments in advance. These findings echo the results of a sophisticated study from north-east England[9] in which speed of access was judged of 'limited importance' to patients, being outweighed by choice of GP, or convenience of the appointment, although it is known that for short-term problems, patients may be

willing to sacrifice personal continuity to be seen quickly.[10] A recent international study highlighted the major importance attributed to personal continuity of care as a core value of general practice/family medicine by doctors from three countries.[11]

Where do these studies leave the access debate? There have been previous calls for re-focusing the access debate away from the speed of access to care.[12] The Salisbury data provide a vitally important evidence base to inform UK primary care service provision.[6,7] Given the generally high levels of access to primary care in the UK, it is surprising that the UK government would adopt, and so extensively promote, a system of care derived from a health economy with low levels of primary care provision, high healthcare costs, poor satisfaction with service provision, and with a substantial proportion of the population with limited access to health care,[13] in the absence of substantial and robust evidence to support such a programme in the context of UK health care. A further focus of the Darzi review is likely to be welcomed by many doctors — informing the fashioning of services 'based less on central direction and more on patient control, choice, and local accountability, and which ensures services are responsive to patients and local communities'.[2]

In a separate report on London's health care,[14] Darzi recently recommended the establishment of polyclinics providing a level of health care between general hospitals and GP practice. These clinics are intended to become the main stop for health and wellbeing, and crucially, to provide improved access to health care. As with Advanced Access, evidence from the real world will be vital. The proposed polyclinics appear to share many characteristics with health maintenance organisations in the US. There seems a real danger that, once again, the UK will buy into a US model of health care that is untested for adoption in UK settings where an extensive network of general practices already provides high levels of access to care. A recent comparison of health maintenance organisations with community health clinics[15] reported that the former offered more immediate access, but at the expense of poorer ongoing care, coordination, comprehensiveness of services, and poorer community orientation.

If patient satisfaction reflects the gap between patient expectation and experience, systems of care delivered locally need to take account of the needs and expectations of local patients if high levels of satisfaction with access arrangements are to be achieved. Whether or not access needs to be 'Advanced' may be debated, but it certainly needs to be SMART — streamlined in delivery, monitored closely, adaptable to local need, responsive to patients' needs and expectations, and timely in its provision.

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Chronic musculoskeletal pain

Managing painful musculoskeletal disorders is a major part of general practice. Estimates for the proportion of the population consulting annually for musculoskeletal disorders, derived from general practice consultation databases, range from 6.6 to 20.7%.[1] Fortunately, many patients improve independent of any treatments we may advise. However, a minority develop chronic pain and disability which has a substantial health and social impact. Predicting which patients are more likely to have a poor outcome from their musculoskeletal pain may help us to make better use of resources. The pain that presents most commonly for treatment — and which is perceived to have the highest economic cost — is low back pain.