

Access to general practice in England:

time for a policy rethink

Improving access to general practice is one of the current priorities of healthcare policy in England and offering patients timely access is central to this agenda. A £50 million 'Challenge Fund' to support pilot initiatives offering GP appointments earlier and later in the day was set up in 2013 and a further £400 million has now been pledged to expand this programme. British Prime Minister David Cameron has promised that patients will be able to see a GP 7 days a week from 8 am to 8 pm and his Health Secretary Jeremy Hunt has outlined plans to recruit an additional 5000 GPs to make this possible.^{1,2} The Government believes that this policy will reduce admissions to accident and emergency (A&E) services.³ However, its approach is not based on any detailed evidence that there is a strong link between access to general practice and recourse to A&E.⁴ It also involves privileging a particular dimension of access to general practice over others. This article explores how policy came to be dominated by concerns about speed and convenience, and calls for a wider debate that incorporates other aspects of access.

A BROADER DEFINITION OF ACCESS

Access to general practice can be described as having three main components:⁵

- physical access: that is, the availability of GPs, distance and transport, design of premises, the availability of home visits;
- timely access: that is, the availability of appointments and the satisfaction of patients with opening hours; the provision of out-of-hours care and waiting times; and
- choice: that is, the choice of practice and choice of professional (GP, named GP, sex of GP, practice nurse, or other health professional).

If this definition is borne in mind, it would be logical to conclude that policy aimed at improving access would involve addressing these different dimensions of care simultaneously and evaluating the merits of initiatives that privilege one over the other. It would also be logical to think that the policy-making process would have involved an attempt to determine the relative benefits of investing in access to general practice ahead of other aspects of health care. In fact, the current policy context when

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it comes to access to general practice is the product of long-term shifts in healthcare policies and professional practices.

HOW WE GOT TO WHERE WE ARE

Two developments are particularly relevant. The first was the retreat of GPs from a personal model of primary care built around continuous access to a doctor, which was dominant up to the 1960s. The second was the development by successive governments since the 1970s of policies inspired by management techniques that were aimed at addressing perceived patient needs and making doctors more accountable to their patients.

At the time the NHS was established in 1948, there were concerns around what would in contemporary terms be described as access centred primarily around the unequal distribution of GPs. Access defined as timeliness was often straightforward for patients: they could get to see a GP by making a request for a home visit or if they presented at a surgery and were prepared to wait. In a study conducted in 1964, 84% of patients thought they would be able to contact their GP if they needed to on a Sunday afternoon or in the middle of the night.⁶ However, giving patients this level of access to individual doctors came at a price and GPs were at times placed under considerable pressure; or at least were perceived and perceived themselves to be under pressure from patient demands.⁷⁻⁹ British GPs started to move away from a model involving individual GPs providing around-the-clock care and allowing patients to turn up and wait to be seen. The result was that, by the early 1970s, patients were expressing dissatisfaction about appointment systems and experiencing difficulties in gaining access to doctors.¹⁰⁻¹² Access as timeliness and as a problem that was seen as putting pressure on A&E departments became a significant issue at this point in time.

In parallel, from the late 1970s, the Thatcher and Major Governments sought to engage with the perspective of patients when it came to the delivery of health care. The NHS Management Enquiry Report underscored the importance of ascertaining:

*'... how well the service is being delivered at a local level by obtaining the experience and perceptions of patients and the community...'*¹³

This philosophy, inspired by a business ethos geared towards engaging with customers and their needs, led to the establishment of targets, initially in hospitals. The new model gradually filtered through to general practice and the first set of standards for primary care was issued in 1993. This formalised the appearance of a consumer-focused approach in general practice, which continued under the Blair and Brown premierships. The 2000 NHS Plan set out the aim to ensure that by 2004 patients would be able to obtain a GP appointment within 48 hours. Access-as-timeliness provided a useful tool to measure patient satisfaction. Individual patients are unlikely to be able to comment on issues such as national disparities. It would also be much less straightforward to measure changes in the quality of continuity of care, that is, the evolution over time of established relationships with GPs. Whether or not an appointment can be obtained within a specific timeframe is easy enough to ascertain.

WHAT A DIFFERENT APPROACH MIGHT LOOK LIKE

The increased focus on timeliness has been accompanied by an erosion of the profile afforded to other dimensions of access. Without being prescriptive when it comes to outlining solutions, which would necessarily need to take local circumstances into account, it is possible to point to a number

of questions that deserve greater attention. In general terms, if investing in access is to be a priority, gaining a more detailed understanding of how it relates to mortality, A&E attendance, hospital admissions, and long-term health would seem essential in order to ensure that public funds are being spent in the most efficient way. The relationship between A&E and primary care would in particular benefit from closer scrutiny and further research. Concerns around patient use of A&E services date back at least to the 1970s when it was suggested that embracing patients' choice and providing primary care services in A&E departments could represent a way forward.¹¹ It is also noteworthy that the majority of GP surgeries used to provide access in a way that is not dissimilar to how A&E works today, with patients able to 'sit and wait' for an appointment. It would be useful to know more about how this system works in practices that have retained it and the impact that working in this way might have on A&E attendance in nearby hospitals.

Attempting to find ways of evaluating experiences of general practice that explore shifts over time and factor in the evolution of the relationship between doctors and patients also has the potential to provide valuable insights into the nature of some of the issues policy-makers face when it comes to managing access. It would be worth reflecting, for instance, on the existence of a more personal connection between doctor and patient in the early years of the NHS. To what extent might it be possible to replicate this, for instance, through dedicated local teams (not necessarily entirely composed of doctors) that would provide home visits if necessary and take responsibility for care and signposting on a 24-hours-a-day, 7-days-a-week basis? Continuity of care is an important dimension of general practice that has been shown to have positive effects on patient outcomes.¹⁴ It is hard to see how the current emphasis on timeliness will help in this respect.

The way in which choice around access is exercised also warrants closer scrutiny: successive governments have, for instance, offered different means of accessing the NHS (for example, through the establishment of walk-in centres or the NHS 111 service) but a patient wanting to see a doctor rather than a nurse, or their preferred doctor rather than another practitioner, might not be able to make such a choice.

TO CONCLUDE

It is important to ensure that the priority currently given to speed and convenience

does not lead to a neglect of equality. The disparities in the distribution of GPs still need to be addressed. Quicker access and the ability to consult a GP early in the morning or in the evening will not dismantle the barriers that people with disabilities face when attempting to access primary care. Finally, policymakers should recognise that, in the view of the majority of healthcare workers, demand for general practice is elastic and that measures to improve supply can have an effect on demand.¹⁵ The demand for services therefore needs to be managed as does the supply of doctors available to provide treatment. This is particularly relevant as recruitment to general practice is once again proving problematic.

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