# Discrepancies in the availability of open access services: comparison between the Northern and Oxford regions

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*SUMMARY. General practitioners have long been aware of variations in the range of open access services available to them.*

*This study compares the availability of 22 open access services in the Northern and Oxford regions and examines possible reasons for variations. From data collected from general practitioners and community managers two striking patterns emerge. First, there is a difference between the regions with wider availability in the Oxford region. Secondly, there are differences in the range of services available between health authorities, sometimes neighbouring, within the same region, although this is less marked in Oxford.*

*These discrepancies probably reflect the situation nationally and it would appear questionable whether there is any policy coordination at regional or national level to ensure an equitable distribution of open access services.*

## Introduction

GENERAL practitioners have long been aware of variations in the availability of open access investigations and paramedical services.[1,2] It is generally acknowledged that facilities available in one health authority may be unavailable in a neighbouring one and that a long established service is apt to disappear suddenly. Invariably such service withdrawals affect general practitioners rather than hospital doctors, and many feel that there is inadequate consultation. With the current emphasis on community management it is disconcerting to many general practitioners that their needs may not be understood and little attempt is made to ascertain what services they require.

This study, conducted by the practice organization committee of the Northern faculty of the Royal College of General Practitioners, compares the availability of open access services to general practitioners in the Northern and Oxford regions and examines possible reasons for the differences.

## Method

Data collection from general practitioners was done in three stages. A minimum of three general practitioner respondents were located in each health authority. The Royal College of General Practitioners' faculty board secretaries were asked to provide names of general practitioners representing every health authority in their respective areas, except in Cumbria where the vocational training course organizers were approached. The general practitioners were asked to complete a questionnaire indicating the availability of a list of services. A pilot study was conducted in 1985 and full data collection was done in December 1986, with a further confirmatory questionnaire in February the general practitioners were contacted by telephone, and where disagreement still existed the majority response was accepted.

Similar questionnaires were sent with explanatory letters to community managers in each health authority. They were also invited to indicate reasons for any non-availability of services.

Some services such as isotope scans were excluded from 1987. In situations where conflicting or no replies were received analysis because of uniform unavailability or major confusion about their availability. The results relating to 22 services were analysed.



## Results

Table 1 shows a comparison of the two patient populations together with the finances allocated to the Oxford and Northern regions. The Northern region had a higher annual revenue per head of population in 1985/86.

**Table 1.** Patient populations and annual budgets for the two regions.

| | Oxford region | Northern region |
|---|---|---|
| Number of health authorities | 8 | 16 |
| Population (millions) | 2.41 | 3.09 |
| Revenue budget (£ millions) | 357.9 | 558.4 |
| Revenue budget per head of population (£) | 149 | 181 |

Source: *The hospitals and health services year book 1985–86.* Chaplin NW (ed). London: Institute of Health Services Management, 1986.

### *Responses from general practitioners*

Table 2 compares the availability of open access services in all the health authorities in the two regions, based on the responses from 69 general practitioners. As expected, the study confirmed the uniform availability of routine haematology, biochemistry and bacteriology together with plain X rays, barium meals and cholecystography. Speech therapy, chiropody and dietetic services were also available to all. However, the results show the Northern region lagging well behind in the availability of 11 of the 22 services in Table 2 with differences most marked with regard to intravenous pyelography, barium enemas, obstetric and diagnostic ultrasound (for example, for gallstones), gastroscopy, physiotherapy and occupational therapy. Only open access to community psychiatric nursing was available in more authorities in the north.

In one health authority barium enema is available providing the referring practitioner performs a sigmoidoscopy first.

Open access mammography was reported to be available in only a third of the health authorities in each region.

The data also showed marked variations in open access services between health authorities, sometimes neighbouring, in the same region, although this was less marked in the Oxford region.

### *Responses from community managers*

Thirteen out of a possible 24 community managers replied (nine out of 16 from the Northern region and four out of eight from Oxford), giving a response rate of 54%. There was a close correlation between their responses and those from the general practitioners regarding the availability of services.

**Table 2.** Availability of open access services in health authorities in the two regions, based on responses from 69 general practitioners.

| Open access service | Number (%) of authorities offering service: Oxford region ($n=8$) | Northern region ($n=16$) |
|---|---|---|
| Routine haematology | 8 *(100)* | 16 *(100)* |
| Biochemistry | 8 *(100)* | 16 *(100)* |
| Bacteriology | 8 *(100)* | 16 *(100)* |
| Plain X-rays | 8 *(100)* | 16 *(100)* |
| Barium meals | 8 *(100)* | 16 *(100)* |
| Speech therapy | 8 *(100)* | 16 *(100)* |
| Chiropody | 8 *(100)* | 16 *(100)* |
| Dietetics | 8 *(100)* | 16 *(100)* |
| Cholecystography | 8 *(100)* | 16 *(100)* |
| Audiography | 8 *(100)* | 14 *(88)* |
| Physiotherapy | 8 *(100)* | 12 *(75)* |
| Occupational therapy | 8 *(100)* | 7 *(44)* |
| Obstetric ultrasound | 8 *(100)* | 6 *(38)* |
| Psychology | 7 *(88)* | 14 *(88)* |
| Non-obstetric ultrasound | 7 *(88)* | 8 *(50)* |
| Intravenous pyelography | 7 *(88)* | 8 *(50)* |
| Barium enemas | 7 *(88)* | 7 *(44)* |
| Community psychiatry nursing | 6 *(75)* | 15 *(94)* |
| Hearing aids | 6 *(75)* | 2 *(13)* |
| Medical appliances | 5 *(63)* | 5 *(31)* |
| Gastroscopy | 5 *(63)* | 2 *(13)* |
| Mammography | 3 *(38)* | 5 *(31)* |

$n$ = total number of health authorities.

Reasons for unavailability of services assessed from community managers' responses included 'insufficient machine and operator time' (non-obstetric ultrasound), 'limited capacity', 'recruitment and staffing difficulties' (occupational therapy), 'pressure of work' (physiotherapy), as well as 'only undertaken by consultant referral to limit demand' (intravenous pyelography). Lack of equipment was generally cited for non availability of mammography, although one manager stated that 'the consultants believed it was important for them to see the patient first'. This was also the case for hearing aid services in four health authorities. In one area in the North where the general practitioners were denied access to obstetric ultrasound scans it was officially reported that this was available 'by personal contact with the radiologist, but that there was no demand for the service'.

## Discussion

The method enabled a complete picture of all the health authorities in the two regions to be built up. We accept that there may still be omissions in the data but we believe the overall picture to be accurate. There appears to be no absolutely certain way of establishing what services general practitioners have access to. The relatively poor response rate from health authority managers may be a reflection of the difficulty they have in obtaining this information.

The findings illustrate clearly, however, a paucity of open access services in the North compared with Oxford. The fact that there is substantially greater financial allocation on health per head of population in the Northern region makes it harder at first sight to understand this difference. Replies from the Oxford region indicated a relatively good level of liaison between general practitioners and consultants, as well as a greater proportion of community hospitals, sometimes with charity funded equipment.

The existence of variations between neighbouring health authorities suggests a lack of coordination at regional level. Experience would indicate that services are offered or withdrawn by consultants at a local level. This variation would seem to reflect a less than equitable service provision to patients within some health authorities, for example, for those having to queue for a rheumatological appointment before being referred for physiotherapy[3] or appliances,[4] or for those made to attend a specialist obstetric appointment before having an ultrasound scan. At the same time early anomalies in the data indicated that general practitioners were not always aware of the range of services available to them.

Provision of services for the community receives a lower priority than for hospitals. Traditionally investigations and services are handed down to general practitioners after becoming established for hospital use and some consultants fear that general practitioners are apt to 'misuse' services. However, inappropriate use is notoriously hard to prove, partly because of the inherent value of 'negative' results from some investigations, and because doctors are consulted by a highly selected patient population.

Cost-effect analyses of open access services need to reflect lost patient working time, inappropriate and inadequate management from a lack of readily available facilities, 'wasted' general practitioner time, resources for outpatient appointments and consequential effects on waiting lists. The belief that increased provision of open access diagnostic services is not associated with eventual diminution of total hospital workload is challenged by several studies.[5-8]

In conclusion, we believe that the variations shown here between the Northern and Oxford regions exist nationally. These discrepancies exist in the range of open access services offered both within and between regions and do not necessarily relate to financial allocation. It is questionable whether there is any coordination at national or regional level. It seems unreasonable that despite many years' discussion there is not a more equitable distribution of services.

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