Questionnaire survey of users of NHS walk-in centres: observational study

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SUMMARY

Background: *NHS walk-in centres have recently been established throughout England to improve access to primary health care.*

Aim: *To determine the characteristics and experiences of people consulting NHS walk-in centres compared with general practice.*

Design of study: *Observational study using questionnaires.*

Setting: *Thirty-eight walk-in centres and 34 neighbouring general practices.*

Method: *People attending randomly selected survey sessions at walk-in centres or neighbouring general practices on a 'same-day' basis were given a self-administered questionnaire. This collected data about socio-demographic characteristics, reasons for consulting, attitudes to continuity, satisfaction, enablement, referrals, and intentions.*

Results: *Walk-in centre visitors were more likely to be owner-occupiers (55% versus 49%;* P*<0.001), to have further education (25% versus 19%;* P *= 0.006), and to be white (88% versus 84%;* P*<0.001) than general practice visitors. Main reasons for attending a walk-in centre were speed of access and convenience. Walk-in centre visitors were more likely to attend on the first day of illness (28% versus 10%;* P*<0.001), less likely to expect a prescription (38% versus 70%,* P*<0.001), and placed less importance on continuity of care (adjusted odds ratio = 0.58; 95% CI = 0.50 to 0.68) than general practice visitors. People were more satisfied with walk-in centres (adjusted mean difference = 6.6%; 95% CI = 5.0% to 8.2%). Enablement scores were slightly higher in general practice (adjusted mean difference = 0.40; 95 % CI = 0.11 to 0.6). Following the consultation 13% of walk-in centre visitors were referred to general practice, but 32% intended to make an appointment.*

Conclusion: *NHS walk-in centres improve access to care, but not necessarily for those people with greatest health needs. People predominantly attend with problems of recent onset as an alternative to existing health providers, and are very satisfied with the care received. These benefits need to be considered in relation to the cost, and in comparison with other ways of improving access to health care.*

Keywords: *Walk-in centres; general practices; health services accessibility; questionnaires; patient satisfaction.*

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Introduction

THE principal aim of NHS walk-in centres is to improve access to primary health care. These nurse-led centres provide advice and treatment for minor illnesses and also direct people to the most appropriate health care provider for their needs.[1] Given this role, the subjective experience and satisfaction of their users is arguably the most important outcome measure by which walk-in centres may be judged.

Walk-in centres are a new organisational model within the NHS (Box 1). It is important to consider the socio-demographic characteristics of the users of walk-in centres, why people contact them rather than alternative health providers, their expectations, their experiences, and their satisfaction with care received. This survey was designed to address these issues.

For comparative purposes, the survey was also conducted among people who attended general practices close to a walk-in centre on a 'same-day' basis; that is, by attending without an appointment booked before the day of their consultation. For this group of people, attending a nearby walk-in centre would be a realistic alternative source of care.

Method

The study was approved by South-West Multi Centre Research Ethics Committee.

Setting

The survey was conducted at all walk-in centres which were open by March 2001. The general practice nearest to each walk-in centre was approached to act as a control site; if this practice declined we approached the next nearest practice and so on.

Participants

Consecutive visitors to walk-in centres or general practices attending during randomly selected half-day sessions were invited to participate. In general practices, the survey was only conducted among patients attending on a 'same-day' basis. Parents or carers completed the questionnaire on behalf of people unable to do so themselves. Unaccompanied children aged under 16 years were excluded.

Development of questionnaire

The questionnaire was divided into two sections. The first was designed to be completed before the consultation and included questions about socio-demographic characteristics, convenience of location and opening hours, reasons for consulting, expectations, recent use of health services, and attitudes to continuity of care. The second section, completed after the consultation, included questions about waiting times, satisfaction, treatment, referrals, 'enablement',[2] and

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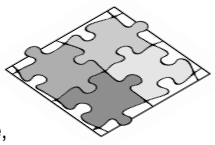

What do we know?

NHS walk-in centres are a new initiative to improve access to primary health care, by providing a convenient nurse-led service. Experience of walk-in centres in North America (where centres are staffed by doctors) suggests that they are popular with patients, particularly attracting young adults of relatively high socioeconomic status.

What does this paper add?

Visitors to walk-in centres in the UK were younger, better educated and more affluent than those attending general practice and mainly attended walk-in centres for reasons of convenience. People were very satisfied with the care they received from walk-in centre nurses. Most walk-in centre visitors stated they would otherwise have attended a general practice or emergency department, but only 39% still intended to do so following their walk-in centre consultation.

- Announced in April 1999
- Forty centres opened in 30 towns in England by 2001
- Sited in convenient locations, mainly in large towns
- Walk-in access, without the need for an appointment
- Wide opening hours (normally 7.00 am to 10.00 pm every day)
- Consultations mainly provided by nurses, using clinical assessment software
- Provide information and treatment for minor conditions

Box 1. Background to NHS walk-in centres.

intentions. Some questions were only applicable to the walk-in centre version of the questionnaire. Questions were used or adapted from existing validated questionnaires where possible.[2,3-5]

Six questions about satisfaction were each designed to substitute for one of the longer multi-item scales used in an earlier validated questionnaire.[5] Each of these questions comprised a five-point scale from 'not at all satisfied' to 'very satisfied'. Pilot studies showed that each question correlated with the relevant longer scale, that the brief questions achieved higher response rates than the long versions, and that the six questions could be combined to form a single satisfaction scale with good internal reliability.

The entire questionnaire was piloted over a one-week period at a walk-in centre and a general practice, before being slightly modified and re-piloted.

Sampling

Half-day sessions were randomly sampled at each walk-in centre or general practice site. For each site, a sampling fraction was calculated, based on the number of patients seen in a typical week, in order to sample sufficient sessions to invite about 100 patients. Wherever possible, the study was run in the walk-in centre and the neighbouring practice in the same week, to minimise seasonal effects.

Commentary

GPs have mixed views on the new open access services that are being introduced into primary care in the UK. These services include NHS Direct (a national telephone triage and advice service) and local walk-in centres. But do they improve access to necessary care, or do they duplicate services and fragment care? With respect to walk-in centres, Salisbury *et al* have begun to provide answers. The findings indicate that walk-in centres for many patients are an additional, rather than alternative, service. In contrast with same-day users of general practices, users of walk-in centres tended to be younger people from more affluent backgrounds, with minor illnesses for which they did not expect a prescription. Convenience was a key factor in their decision to attend a walk-in centre. For some patients, walk-in centres may offer an alternative to consulting a GP or accident and emergency department, but the impact on consulting rates in general practice is unclear.

We need to know why less affluent patients make less use of walk-in centres. One explanation is that they prefer certain characteristics of general practice; another is that walk-in centres in some way deter and therefore disadvantage them. If the latter proves to be the case, the NHS will have to confront the fact that it has introduced a new service that disadvantages the already disadvantaged.

The findings related to patient satisfaction should be regarded with some caution. The level of satisfaction after use of a service will be determined by prior expectations. A patient attending a GP will have different expectations from a patient attending a nurse in a walk-in centre. It is therefore possible for patients to express greater satisfaction with nurse consultations, but still express a preference for seeing a GP. The findings tell us that the patients attending walk-in centres and general practices were generally satisfied with the care they received, but do not indicate which service they would have preferred. Nevertheless, it is clear that certain patients with certain conditions will prefer convenience to the advice of a GP. A key question now faces the managers of walk-in centres: if they can make their services equally relevant to the disadvantaged as to the affluent, then there is a case for the continued development of walk-in centres; if they cannot, then the NHS must decide whether to charge the affluent users for such services, and direct the resulting resources to those in greatest need.

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Administration of questionnaire

People attending a survey session were given the questionnaire on arrival and their age and sex were recorded. They were asked to put the completed questionnaires in a box at the reception. Questionnaires were marked with an identifying number, but were otherwise anonymous. Non-responders were sent one reminder questionnaire by post.

Power of study

Prior power calculations were based on 36 walk-in centres and 36 practices each inviting 100 people, and a 70% response rate. In the absence of significant clustering effects, this would provide 80% power in a comparison of proportions to detect differences between all walk-in centres, compared with all practices of at least 4% at a 5% significance level.

Analysis

For each question, descriptive statistics were calculated for all walk-in centres and for all practices combined. Comparisons between walk-in centres and practices were made using linear models that adjusted for the effects of age, sex, and ethnicity among patient groups, as these factors have been shown to be potent determinants of patient satisfaction in similar contexts.[5] Scale scores for satisfaction were calculated so that 'very satisfied' on all six questions scored 100%, 'neutral' scored 0%, and 'not at all satisfied' on all items scored 100%.

As appropriate, multivariable linear models were estimated using ordinary, logistic or ordinal logistic regression. Estimation of models, and of 95% confidence intervals, was undertaken using design-weighted survey estimators in statistical software Stata version 7. Analyses took full account of the stratification of the sampling frame and the clustering of patients within walk-in centres and general practices, and were weighted to take account of the differential sampling fractions used in each site.

Results

The survey was conducted between October 2000 and April 2001 in 38 walk-in centres and 34 general practices. At two of the sites it was not possible to recruit a local general practice, and two practices subsequently withdrew from the study. In 15 out of 34 areas, the general practice closest to the walk-in centre ran the survey; the median number of practices approached was two.

The overall response rate was 82% (6229/7633) with a slightly higher response at walk-in centres than general practices (85%, [3856/4555] versus 77%, [2373/3078]). Responders did not differ significantly from non-responders in terms of age or sex.

Socio-demographic characteristics

The population attending walk-in centres had different age characteristics from that attending general practices, including a higher proportion of men aged 17 to 45 years ($P<0.001$) and women aged 17 to 35 years ($P = 0.013$). Walk-in centre visitors were more likely to be white, to be owner-occupiers and to have education beyond the age of 18 years (Table 1). Four-fifths (80%, [2990/3803]) lived locally, with 13% (548/3803) being in the area for work, shopping or leisure. The vast majority (96%, [3653/3825]) were registered with a general practitioner (GP), 79% (2994/3825) being registered locally.

Convenience

Convenience of location and opening hours were scored on a five-point scale, from 'very poor' to 'excellent'. Users of walk-in centres found them more convenient in terms of location ($P<0.001$) and opening hours ($P<0.001$) than those attending general practices (adjusted logistic regression analysis).

Reasons for attending walk-in centre or general practice

Table 2 shows the main reasons why responders chose to attend a walk-in centre or general practice rather than another NHS provider. The most important reasons for walk-in centre users were speed of access, convenience of location or wider opening hours. People attending general practice frequently did not think about going anywhere else, but other important reasons for attending included a preference for seeing a known health professional and wanting to see a doctor rather than a nurse. Preference for seeing a known professional increased with age, and people aged 17 to 25 years were less likely to express a wish to see a doctor rather than a nurse.

Table 3 shows that most walk-in centre visitors stated that they would have attended a GP (46%) or accident and emergency department (26%) if the walk-in centre had not been available. Only 10% would have managed the problem themselves.

Expectations and recent use of health services

People attending a walk-in centre were much less likely to expect a prescription or medication than those attending a general practice (38%, [1423/3746] versus 70%, [1591/2286], $P<0.001$). Compared with general practice patients, walk-in centre visitors were more likely to attend on the first day of their illness (28%, [1030/3745] versus 10%, [235/2299]) and overall they had their problems for a shorter time ($P<0.001$). Although some walk-in centre users had consulted a doctor or nurse about the same problem within the previous four weeks, this was true of an even higher proportion of general practice patients (18%, [673/3758] versus 26.5%, [580/2266], $P<0.001$).

Attitudes to continuity

Attitudes to continuity of care were assessed by asking respondents how important it was to see the same doctor or nurse. People consulting in walk-in centres placed less priority on continuity of care than those consulting in general practice (adjusted odds ratio for preferring to see same doctor or nurse = 0.58; 95% CI = 0.50 to 0.68) (Table 7). Attitudes to continuity were also related to demographic factors, with younger people, males, and people of white ethnicity placing less importance on seeing the same doctor or nurse.

Consultation

Most visitors to walk-in centres (87%, [2866/3242]) consulted nurses, whereas almost all consultations in general practice (93.4%, [1917/2037]) were with a doctor. Waiting times were shorter in walk-in centres ($P<0.001$), with fewer people waiting more than 20 minutes (29%, [1012/3479] versus 38%, [795/2107]).

Satisfaction

Preliminary analysis confirmed that the six attitudinal questions had high internal consistency ($\alpha = 0.82$). Because responses were skewed towards satisfaction, and responses of 'fairly satisfied' in health care surveys usually imply a need for improvement,[6] responses were dichotomised into 'very satisfied' and other responses (Table 4). The mean overall satisfaction score was higher among walk-in centre

Table 1. Characteristics of visitors to walk-in centres and 'same-day' patients in general practices. Figures are numbers (weighted %).[a]

	Walk-in centre or general practice				Significance of walk-in centre versus general practice
	Walk-in centre		Practice		
	n	%	*n*	%	
Median age (years)	29		32		$P = 0.011$
Male visitors	1763/3856	46.6	975/2373	41.9	$P = 0.002$[b]
Education beyond the age of 18 years	847/3314	24.7	382/1993	18.9	Odds ratio (OR) = 1.30 (95% CI = 1.08 to 1.57) $P = 0.006$[c]
Owner-occupiers	2096/3806	54.9	1253/2335	49.2	OR = 1.44 (95% = 1.27 to 1.66) $P<0.001$[c]
White ethnicity	3324/3816	87.7	1994/2348	84.4	OR = 1.41 (95% CI = 1.18 to 1.69) $P<0.001$[d]

[a]Weighted in relation to sampling fraction; [b]Mann–Whitney test; [c]adjusted for age, sex and ethnicity; [d]adjusted for age and sex. Denominators vary because of missing responses.

Table 2. Main reasons for consulting in a walk-in centre or as a 'same-day' patient in general practice. Figures are numbers (weighted %).[a]

Main reasons[c]	Walk-in centre or general practice				Significance[b]
	Walk-in centre (*n* = 3777)		Practice (*n* = 2299)		(*P*-values)
	n	%	*n*	%	
Quicker appointment than GP	2272	59.7		-	
Convenient opening hours	1252	32.6	260	11.9	<0.001
Convenient location	1154	29.8	673	29.1	0.83
Shorter wait than casualty	1062	29.1	387	16.4	<0.001
Didn't want to bother doctor	672	17.5	-	-	
Wanted to see nurse rather than doctor	371	9.5	-	-	
Sent by casualty, minor injuries unit, GP or walk-in centre	316	9.2	44	1.8	<0.001
More confidence in advice/treatment	306	8.1	491	21.4	<0.001
Not registered with GP	188	5.0		-	
Better range of services	183	4.9	158	6.5	0.04
Didn't think about going anywhere else	218	5.9	862	39.0	<0.001
Wanted to see a doctor or nurse that I knew	-	-	1031	44.9	
Wanted to see a doctor not a nurse	-	-	811	33.7	
Walk-in centre not suitable for my problem	-	-	481	19.6	
Wanted definite appointment time	-	-	428	16.8	
Other reason	426	11.0	205	8.6	<0.001

[a]Weighted in relation to sampling fraction; [b]adjusted for age, sex and ethnicity; [c]not all options were applicable in both walk-in centre and general practice settings.

visitors than general practice patients (85% versus 75%; adjusted mean difference = 6.6%; 95% CI = 5.0% to 8.2%) and was also independently related to age, ethnicity, education, and waiting times (Table 5). Further questions were asked which were likely to reflect satisfaction, and in each case walk-in centre users were more satisfied. There was a strong relationship between each of these questions and the satisfaction scale score (Table 4).

Enablement

The enablement questionnaire[2] was used as a measure of outcome. Scores could be calculated for only 56% (3506/6229) of responders due to a high level of missing responses. Mean enablement scores in general practice patients were slightly higher than for walk-in centre visitors (3.44 versus 3.06, mean difference = 0.40, 95% CI = 0.11 to 0.67, $P = 0.007$).

Treatment, referral, patient intentions

More people were given a prescription or medication in general practice than in walk-in centres (70%, [1512/2180] versus 21%, [709/3441], $P<0.001$). Following the consultation, 13% (2991/3441) of walk-in centre visitors were referred to a GP and 6% (3429/3441) to an accident and emergency department. When asked what they actually intended to do following the consultation, almost a third of walk-in centre

visitors (32%) intended to make an appointment in general practice and 7% to attend an accident and emergency department. However, a similar proportion of general practice patients also intended to re-consult (Table 6).

Discussion

Main findings

This survey describes the views of a large and representative sample of people attending NHS walk-in centres. The results show that walk-in centre users were of higher socioeconomic status than those attending as same-day patients in nearby general practices, and a greater proportion were young adults. The main reasons for attending a walk-in centre were speed of access and convenience. Most walk-in centre users lived locally and were already registered with a doctor. These findings are consistent with research from North America[7] and raise concerns that walk-in centres tend to improve access for groups with generally fewer health needs, thus reinforcing the 'inverse care law' and inequalities in health care resourcing.

Given that walk-in centres do not provide continuity of care, it is interesting that about half of those visiting the walk-in centres (compared with two-thirds of those consulting in general practice) stated that they preferred to see a doctor or nurse that they knew. In conjunction with the results in Table 2, this suggests that convenience of time or location was a higher priority than continuity for the problems they consulted about on this occasion.

Most people attending walk-in centres consulted very soon after their problem began, few had already consulted another health professional, most were given only advice and information, and few were referred to another health agency. Although a significant minority of those consulting in a walk-in centre intended to make an appointment with their doctor following the consultation, this was equally true for those attending initially in general practice. Most visitors to walk-in centres claimed that they would otherwise have attended a general practice or accident and emergency

Table 3. Alternatives if walk-in centre or general practice had not been available. Figures are numbers (weighted %).[a]

	Walk-in centre or general practice			
	Walk-in centre (*n* = 3785)		Practice (*n* = 2263)	
	n	%	*n*	%
Looked after problem myself	401	9.7	366	16.7
General practice	1767	46.3	-	-
Walk-in centre	-	-	473	18.9
Pharmacist	194	5.1	353	15.6
Dentist	7	0.2	5	0.2
Minor Injuries Unit	100	2.9	24	1.0
Casualty department	919	26.0	315	13.8
NHS Direct	82	2.0	121	5.8
Call GP out	148	3.7	306	13.5
Other	167	4.2	300	14.5

[a]Weighted in relation to sampling fraction.

Table 4. Satisfaction with walk-in centres and general practice. Figures are numbers (weighted %).[a]

Percentage of responders 'very satisfied' with each item	Walk-in centre or general practice				Significance[b]
	Walk-in centre		Practice		
	n	%	*n*	%	*P*-values
The attitude of the receptionist	3093/3615	85.0	1575/2200	70.6	<0.001
The time you had to wait before you saw a doctor or nurse	2202/3490	60.5	916/2088	43.6	<0.001
The attitude of the doctor or nurse	3098/3485	88.3	1639/2099	79.0	<0.001
The explanation the doctor or nurse gave you about your problem	2718/3384	79.9	1403/2044	69.3	<0.001
The treatment or advice you were given	2637/3420	76.9	1407/2056	68.9	<0.001
Overall, how satisfied were you with the service you received?	1399/3491	79.9	2812/2099	66.2	<0.001
Did you leave the doctor/nurse with unanswered questions? (Yes)	190/3253	6.0	173/2048	8.7	<0.001
Overall satisfaction of patients with/without unanswered questions, 57% versus 85%, mean difference = 28.7% (95% CI = 23.2% to 34.1%), P<0.001.[b]					
Would you recommend this walk-in centre/(surgery) to your family and friends?					
	(*n* = 3506)		(*n* = 2186)		
No/not sure	106	3.2	172	7.6	
Probably	675	19.5	732	32.9	
Definitely	2725	77.2	1282	54.5	<0.001
Overall satisfaction in those responding 'definitely recommend/other', 90% versus 64%, mean difference = 26.4% (95% CI = 24.3% to 28.5%), *P*<0.001.[b]					
Would you use this walk-in centre/(surgery) again?	(*n* = 3512)		(*n* = 2195)		
No/not sure	29	3.4	114	1.4	
Probably yes	677	19.4	328	14.7	
Definitely yes	2721	77.3	1838	83.8	<0.001
Overall satisfaction in those responding 'definitely use again/other', 88% versus 63%, mean difference = 25.5% (95% CI = 23.1% to 27.8%), *P*<0.001.[b]					

[a]weighted in relation to sampling fraction; [b]adjusted for age group, sex, and ethnicity; and [c]denominators vary because of missing responses.

Table 5. Determinants of satisfaction. Relationship between satisfaction and independent variables (linear regression analysis).

Variable	Coefficient	95% Confidence interval	Significance (*P*-values)
Walk-in centre versus general practice	6.61	4.98 to 8.23	<0.001
Sex (Female versus male)	–0.25	–1.69 to 1.19	0.735
Age (years); base <5 years			
5 to 16	3.91	–0.27 to 8.08	0.067
17 to 25	–2.45	–6.34 to 1.43	0.215
26 to 35	–0.26	–4.29 to 3.76	0.898
36 to 45	2.55	–1.51 to 6.61	0.218
46 to 55	4.61	–0.60 to 8.61	0.024
56 to 65	5.60	1.32 to 9.88	0.010
66 to 80	3.51	–1.12 to 8.13	0.137
Over 80	7.36	1.14 to 13.58	0.021
Ethnicity (white versus other)	6.59	3.56 to 9.61	<0.001
Education beyond age 18 years versus other	4.16	2.28 to 6.04	<0.001
Owner-occupier versus other	1.45	–0.19 to 3.09	0.083
Waiting time (ordered categorical variable)	–6.37	–6.87 to –5.89	<0.001
Constant	99.2	94.94 to 103.62	<0.01

Table 6. Intentions following consultation. Figures are numbers (weighted %).[a]

	Walk-in centre or general practice[b]			
	Walk-in centre (*n* = 3160)		Practice (*n* = 1915)	
	n	%	*n*	%
Make an appointment at GP surgery	1041	32.0	608	36.9
Visit casualty department 209	7.1	50	2.5	
Deal with the problem myself	1302	41.2	788	40.6
Other	608	19.7	389	20.1

[a]Weighted in relation to sampling fraction; [b]no significant difference between walk-in centre and practice in combined reconsultation rate at GP or casualty (*P*<0.956, adjusted for age, sex, and ethnicity).

Table 7. Importance of continuity. Figures are numbers (weighted %).[a]

	Walk-in centre or general practice[b]			
	Walk-in centre (*n* = 3772)		Practice (*n* = 2309)	
	n	%	*n*	%
How important is it to you to see the same doctor or nurse each time you seek health care?				
I always try to see the same doctor/nurse	1032	26.6	826	35.0
I usually prefer to see the same doctor/nurse	930	24.7	703	30.7
I don't really mind which doctor/nurse I see	1755	47.3	759	33.5
I prefer to see a doctor/nurse who I don't know	20	0.5	6	0.3
Other	35	0.9	15	0.7

[a]Weighted in relation to sampling fraction; [b]significance of difference between walk-in centre and practice, *P*<0.001, adjusted for age, sex and ethnicity. Adjusted odds ratio for preferring to see same doctor or nurse = 0.58; 95% CI = 0.50 to 0.68.

department and there is little evidence from this survey that walk-in centres are duplicating care already provided elsewhere.

Walk-in centre users appear very satisfied with all aspects of the care they received. Compared with general practice they predominately saw nurses rather than doctors, and had shorter waiting times and longer consultations. These are all factors which have been associated with satisfaction in other settings.[5,8,9]

Limitations

Although the findings from walk-in centres are representative, the results from general practices are not necessarily generalisable. Practice selection was not random but was based on proximity to a walk-in centre, and 'same-day' patients were recruited as an appropriate control group for walk-in centre visitors but are not representative of all patients consulting in general practice. Secondly, some of the questions in the survey were hypothetical. The responses are likely to underestimate the proportion of visitors who would have managed the problem themselves without consulting anyone, if the walk-in centre had not been available. A third limitation was the need to develop new questions about satisfaction because existing questionnaires were inappropriate or too long to be used alongside other questions in a survey conducted in waiting rooms. The high level of internal consistency, the strong relationship with other questions relating to satisfaction, and the anticipated relationships with age, ethnicity, and waiting times support the validity of the questions used. A fourth problem was assessment of outcomes other than satisfaction, which is problematic for services that mainly provide care for minor self-limiting illnesses. Although the enablement questionnaire[2] was designed for this purpose it did not perform well in this study. Many responders omitted the enablement questions or scored them as 'not applicable', so the result favouring general practice should be treated with caution. Finally, it was not possible to obtain meaningful data about the clinical reasons for consultations, which would have improved our understanding of why people chose one service or the other and allowed adjustment for casemix in our analyses. It is important to emphasise that this study is a description of the differences between people consulting two different services, rather than a direct comparison.

Conclusion

NHS walk-in centres appear to improve access to care for some groups of people, but not necessarily those with the greatest health needs. People predominantly attend with minor problems of recent onset as an alternative to existing health providers, and are very satisfied with the care they receive. These benefits need to be considered in relation to the cost of providing this service, and in comparison with other ways of improving access to health care and competing claims for resources.

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