Problems with a 'target' approach to access in primary care: a qualitative study

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SUMMARY

We report an analysis of the qualitative phase of a study of patients' and carers' views of primary care services, focusing on their experiences of access to face-to-face general practitioner (GP) consultations during the period when new access policies were being implemented. Practices interpreted the new policy in various ways; restricted interpretations, including restriction of access to telephone booking, could cause distress to patients. Patients and carers welcomed flexible interpretations of the policy that offered choice, such as a choice of GP, or of booking in advance.

Keywords: *access to health care; national health policy; patient choice.*

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Introduction

The new *NHS plan* for primary care in England[1] promises access to a healthcare professional within 24 hours and to a general practitioner (GP) within 48 hours, and practices are given financial incentives for achieving access targets. The plan includes provision for patients to see a GP of their choice, but this may involve patients waiting longer and carries no financial incentive for practices.[2] The emphasis on achieving access targets could therefore lead to reduced choice of whom to consult and hence diminish personal continuity.[3]

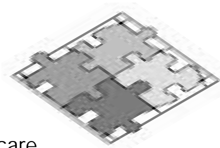
The National Primary Care Development Team (NPDT)[4] reports variation in the way that GP practices have interpreted the focus on access. They note that some practices have adopted an approach of 'restricted booking': limiting the availability of pre-booked appointments, or stopping them completely. The NPDT do not advocate this, pointing out the potential for frustration among patients who wish to book in advance. However, there is little information about the effects on patients of the various interpretations.

We have had a serendipitous opportunity to explore patients' and carers' experiences of the ways in which the policy was implemented, while conducting the qualitative phase of a larger research programme exploring patients' and carers' views and choices about continuity in primary care.

Method

The analysis was based on semi-structured interviews conducted in the East Midlands, one of two study centres. The topic guide focused on patients' and carers' experiences and priorities regarding aspects of primary health care provision, including personal continuity and quick access issues. Following approval from the Leicester Research Ethics Committee, 41 interviewees were recruited through 14 GP practices and 15 through other organisations, such as community centres, a charity, and providers of complementary or alternative services. All but one had used their GP practice at least once during the previous 12 months. Practices were selected so that we sampled from a wide range in terms of list size and GP numbers, organisation, deprivation level, and locality (inner city, urban, market/other town, rural). Purposive sampling of patients and carers (aged 13–85 years) ensured a range of demographic and socio-economic characteristics, caring responsibilities and self-reported health status over the previous 12 months ('very good', 'good', 'fair', 'poor', or 'very poor' health, whether they had suffered any limiting or non-limiting conditions, and if so whether these were long-term or short-term). Table 1 summarises interviewee characteristics. Participants were interviewed in 2002 and 2003 and

HOW THIS FITS IN



What do we know?

Current policy emphasises the importance of quick access to primary care.

What does this paper add?

Interviews with patients and carers during 2002 and 2003 revealed that new GP practice appointment systems, based on restricted interpretations of access policy, caused distress to some patients. Patients and carers welcomed flexible interpretations of the policy that were responsive to their needs and offered choice within the context of a single service. Specifically, it was important to be able to make appointments several days or more in advance, to have the opportunity to choose whom to consult, and to have easy telephone access to receptionists.

interviews were recorded and transcribed verbatim. Independent readings of transcripts, followed by discussion in the light of relevant literature, generated a thematic coding system that was revised through review of further transcripts. We report patients' and carers' experiences of access to face-to-face GP consultations in the context of the new access policies.

Results

Problems with 'restricted' appointment systems

Systems that did not allow for advanced booking meant less choice for patients about *when* to consult:

> *'I've noticed that they seem to change the system about making appointments at the local practice and it seems that they won't accept your call for an appointment unless you want to see them today, and you can only see them today if there's still available space. If not, then you have to ring up tomorrow in order to see them tomorrow, whereas I see no reason why you shouldn't have an appointment in a week's time.'* (Male, practice 6, 60–79 years, multiple long-term health problems, full-time carer for wife.)

Some patients did not want to consult on the same day, but preferred to book in advance in order to see a GP of their choice. Systems that did not allow for advanced booking made it difficult for patients to make choices about *whom* to consult:

> *'They have a new system that I must telephone to get a doctor's appointment for the same morning. Now I am not that sick that I want immediate attention, there should be a possibility for the individual to go to the same person … he should not be put into a situation where he has no choice.'* (Male, practice 14, 60–79 years, multiple long-term health problems.)

Other practices did offer a limited number of pre-bookable appointments, but there could be a long wait for these

Table 1. Characteristics of interviewees.

Characteristic	n[a]
Age group (years)	
11–17	4
18–29	8
30–59	22
60–79	19
≥80	3
Sex	
Male	21
Female	35
Ethnicity	
White	48
Non-white	8
Carer status	
Non-carer, non-disabled	25
Non-carer, disabled	8
Parent of child <10 years	13
Carer (for adult or child with health problem)	14
Location	
Inner city	11
City: urban/suburban	20
Market town	3
Other town/large village	11
Isolated rural	11
Employment	
Employed	21
Not employed/retired/student/homemaker	35
Occupation when employed	
Professional	12
Non-manual	16
Manual	13
Student	6
Qualifications	
Up to 'A' level	32
Post-'A' level	17
Living arrangements	
Lives alone	5
With family/others	48
Institution	2
Health status	
Chronic condition requiring ongoing management	31
Good health	24

[a]Numbers may not add up to 56 for every characteristic because of incomplete data. In case of carer status, categories are not mutually exclusive.

appointments. Patients with multiple, complex problems were distressed at having to choose between seeing a non-preferred GP quickly or waiting weeks to see their preferred GP:

> *' … it takes a couple of months to get an appointment to see* [own GP] *… the fact that I can't see him quickly doesn't seem at all fair. If I see any other doctor they don't really have time to read all the records so I've gotta explain myself, my injuries, and that's enough to put me off going there.'* (Male, non-practice-based recruitment, 30–59 years, depression following injury, unable to work.)

Some practices had introduced a policy of restricting the times at which patients could telephone to make same-day appointments. In two practices, patients described significant delays in getting through to receptionists on the

phone, due to phone lines being engaged during the booking period. While this would not appear in access figures for the practice, it clearly delayed patients' access beyond 48 hours:

> *'The way the practice operates is you must phone in on the day … the lines are off the hook … recently it took me a week and a half of phoning to get an appointment … it had to do with my birth control so it was getting more and more urgent … the only reason I got my appointment in the end was because my husband had a day off, and he phoned for 45 minutes and it took that long.'* (Female, practice 6, 18–29 years, long-term non-limiting problem, full-time work.)

Positive views of 'flexible' appointment systems

In contrast, other patients welcomed flexible appointment systems, incorporating same-day access, which also allowed them to choose personal continuity over quick access when appropriate:

> *'If I wanted to go today I could just go, and I might have to sit an hour or so, and I could just choose from one of three doctors, whichever one I wanted to see.'* (Female, practice 4, 30–59 years, long-term non-limiting problem, part-time work.)

> *'… in the evening times they run an appointment system and so if I wanted to make an appointment, say for next week, and I didn't want to wait in the morning, I would then book an appointment for next week ... I think it works well.'* (Female, practice 1, 30–59 years, parent of young children, full-time work.)

Discussion

Patients and carers experienced problems with 'restricted' interpretations of the access policy, whether restrictions applied to making pre-bookable appointments or to telephone access. They welcomed flexible implementation of access policies in which they had the option of booking an appointment with their preferred GP, even if this meant waiting more than 48 hours.

Qualitative interviewing was used to investigate the range of experiences rather than their frequency and we are not able to provide information about the statistical distribution of the problems experienced or of occasions when 24– to 48–hour access may be experienced positively. The latter issues will be addressed in our next, quantitative phase. We are also reliant on patients' reports of the difficulties they experienced and it is not feasible to validate these accounts using other sources of information.

However, previous work highlights the value of interviewing as a tool for generating ideas for services[5] and the current findings have implications for primary care trust (PCTs) and other primary care providers. First, it would be useful to recognise that access policies can and should be implemented so as to accommodate priorities other than quick access; the NPDT discuss this in their *Advanced Access* publication.[4]

Secondly, PCTs and practices should ensure that patients/carers are aware of any choices available to them when they request a consultation. Current guidance emphasises patient choice among primary care services.[6] Choice within a service may be equally important.

Thirdly, there is an issue of measurement: practices measure achievement of access targets in terms of how long a patient waits for a consultation after making a request. Any difficulty in requesting a consultation is a potential cause of delay which is not reflected in practice measures. It has been reported in a national survey that 'getting through on the phone' was a problem to 48% of patients in 2003,[7] so PCTs and practices may wish to monitor how far delays getting through on the telephone contribute to delays in consulting.

In conclusion, an overemphasis on '48–hour' access can interfere with providing access to appropriate care because it focuses attention on the means rather than the end, as recognised in the United States by Murray.[8] Access alone is not enough. It is important to consider who requires access, when, and to what.

References

1. Department of Health. *The NHS plan*. London: Department of Health, 2002. http://www.publications.doh.gov.uk/nhsplan/nhsplan.htm (accessed 1 Apr 2004).
2. NHS Executive, Department of Health. Achieving and sustaining improved access to primary care. London: Department of Health, 2002; http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareTrusts/PrimaryCareTrustsArticle/fs/en?CONTENT_ID=4016138&chk=gvOn07 (accessed 1 Apr 2004).
3. Freeman G, Shepperd S, Robinson I, *et al*. *Continuity of care: report of a scoping exercise for the SDO programme of NHS R&D.* London: NHS Executive, 2000.
4. National Primary Care Development Team. Advanced Access. http://www.npdt.org/Pre-Bookable.pdf (accessed 1 Apr 2004).
5. Mahoney C. Interviews with patients better than surveys for generating change. *BMJ* 2003; **326:** 618.
6. Department of Health. *Building on the best. Choice, responsiveness and equity in the NHS.* London: Department of Health, 2003. http://www.dh.gov.uk/assetRoot/04/07/52/93/04075293.pdf (accessed 5 Apr 2004).
7. Commission for Health Improvement. The National Patient Survey Programme: 2003 results. London: CHI, 2003; http://www.chi.nhs.uk/eng/surveys/nps2003/pct.shtml (accessed 1 Apr 2004).
8. Murray M, Bodenheimer T, Rittenhouse D, Grumbach K. Improving timely access to primary care: case studies of the advanced access model. *JAMA* 2003; **289(8):** 1042-1046.

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