Measuring access: lessons from across the Pond

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- **Context is different to US**
- **Many of the lessons are the same**
- **Six lessons we've learned in the UK (the hard way)**

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- **Powerful incentives / penalties / rigid targets will always have unforeseen effects**

- **Payers and policymakers always fail to invest in the “Department of Unintended Consequences”**

- **Solution: Think about the intended and unintended consequences in advance and measure them**

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Lesson 1. A target to reduce ER waiting times had the perverse effect of increasing hospital admissions

- **The NHS has had a target of a maximum ER waiting time (ER arrival to departure) of four hours.**
- **For some patients it's difficult to meet this target (elderly slightly confused, needs blood tests, X rays, results, diagnosis and additional home support all within four hours)**
- **Result: some patients got admitted who didn't really need to be. This showed up in a spike in short term admissions when the target came in associated with a reduction in in-hospital mortality.**

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Nuffield Trust. Trends in Emergency Admissions in England 2004-2009.
www.nuffieldtrust.org.uk/files/2017-01/trends-emergency-admissions-report-web-final.pdf

Lesson 2. Alternative forms of access may increase rather than reduce workload (don't always believe what you're told)

- Two commercial companies promoted a 'telephone first' scheme whereby patients contacting the practice for an appointment would first be phoned back by the doctor to see if the problem could be dealt with without a physician visit.
- Company data: "Dramatic reduction in physician workload, greatly increased patient satisfaction"
- Independent evaluation: Net 8% increase in FP workload (though wide variation), net negative patient evaluation (also wide variation)

Newbould et al BMJ 2017; 358: j4197

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Lesson 3. Alternative forms of access may widen disparities

- **‘GP at Hand’ is a new approach to access, heavily promoted by one commercial company in the UK (Babylon)**
- **All initial patient contacts are by smartphone. Only if the problem can’t be sorted out over the phone does the patient go (sometimes long distances) to a facility for a face to face consultation.**
- **Result: The service is popular with fit young people who have moved to register with the new service. Payment formulae (largely capitation) do not adequately reflect this – i.e. too much money for the commercial company to look after fit people and too little for conventional practices who are potentially left looking after the sick and the elderly.**

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Lesson 4. An incentive for primary care practices to provide rapid appointments actually made it harder for many patients to see the doctor

The Problem: Patients were having to wait days or weeks to make an appointment to see their primary care doctor

Incentivised indicator: Patients should be able to make an appointment to see a doctor within 48 hours

Measurement tool: National survey of primary care patients

Response by primary care practices: Over rigid application of 'Advanced Access' – offering unlimited appointments 'on the day' but limited ability to book ahead

Consequence: Patients were unable to book ahead and could only book on the day. The 'target' was met but many patients found it harder to make an appointment

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Question
Question
Question

Lesson 5. Beware inadequate sample size in surveys (even when n=5,000,000)

- From 2007-2009, GPs had an incentive payment based directly on the responses to two access questions in a national survey – getting and urgent appointment and being able to book ahead.
- The national survey sampled 5m patients per year, est. 2m responses. This aimed to provide approx. 500 responses per primary care practice
- The number of responses for some practices was much less, especially in areas with low response rates.
- VERY unpopular with physicians (“only the miserable patients respond” etc)
- Sampling error meant that practices could put significant effort into improving access and find their incentive payments reduced.

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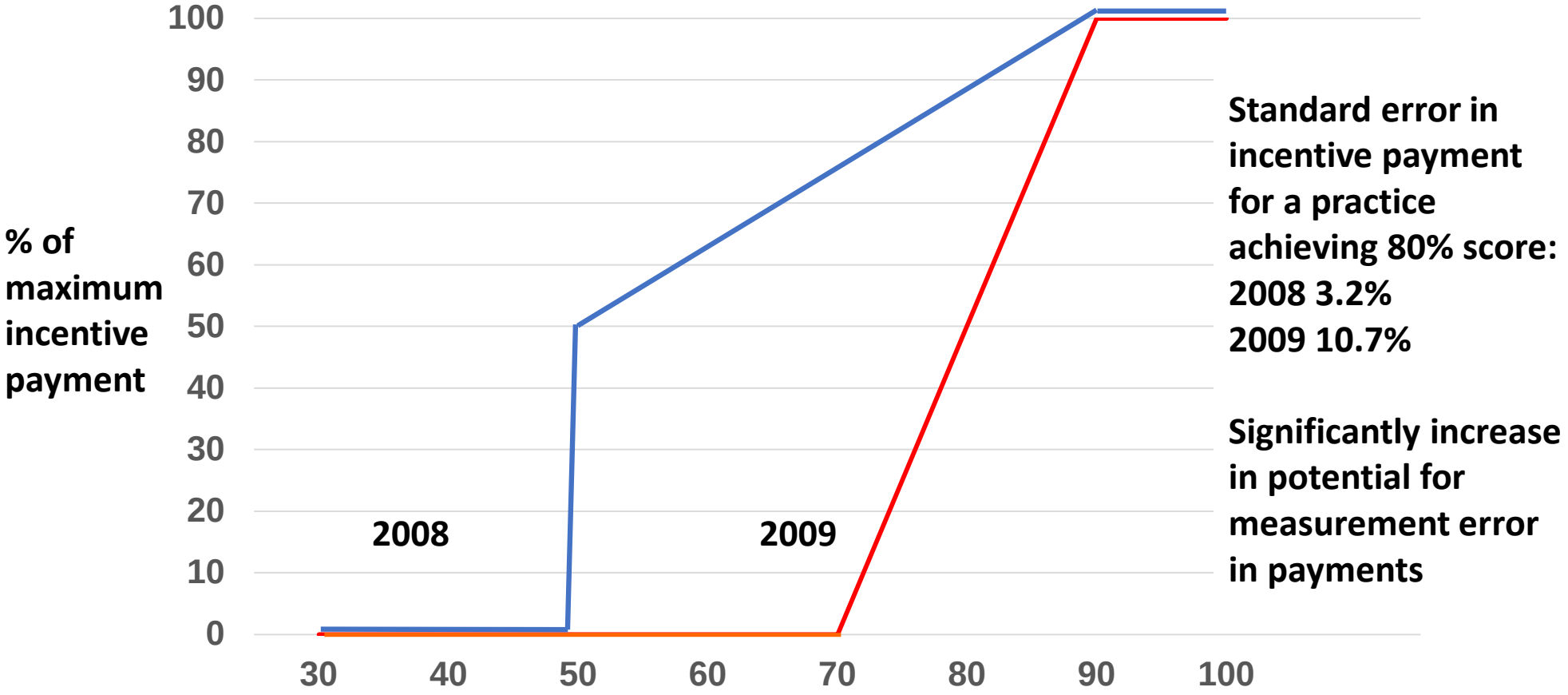
Changes in the payment formula increased the chance of practice payments being affected by random variation



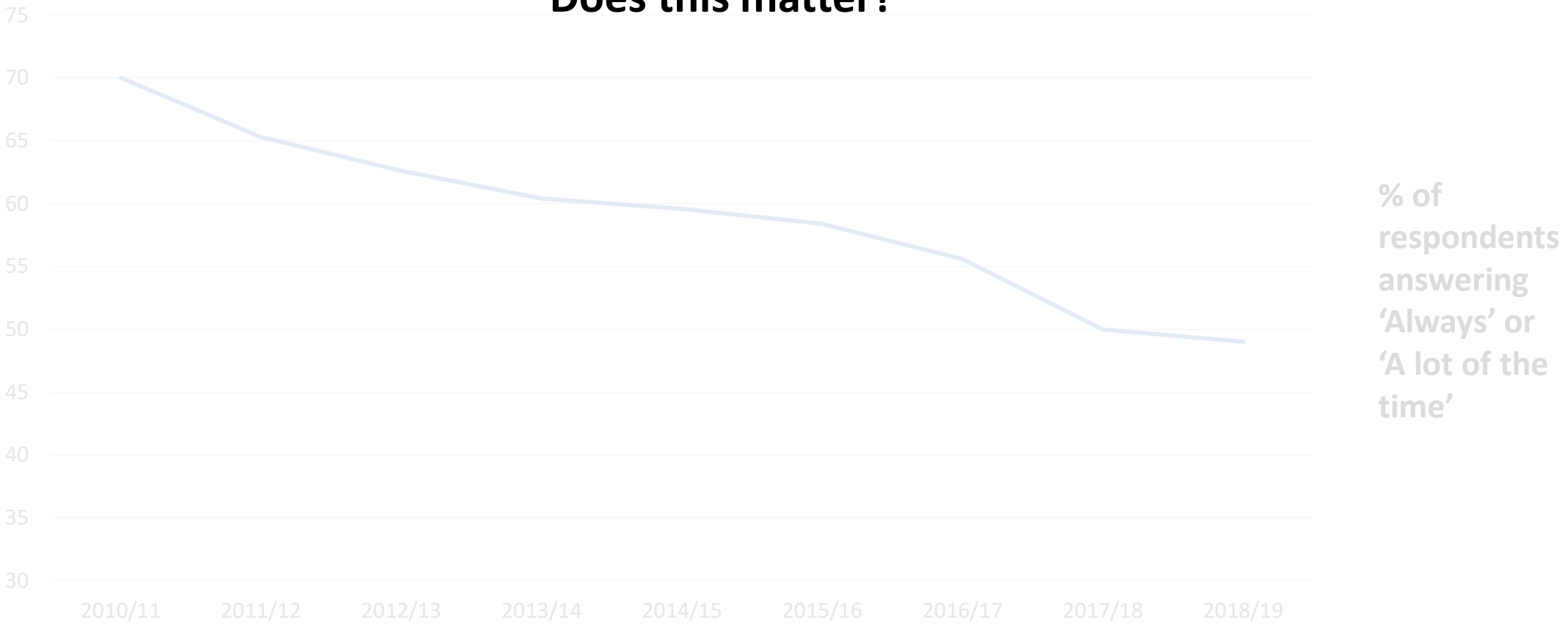
Score on patient survey question - able to see a doctor in the next two days that the doctor's surgery was open

Roland et al BMJ 2009; 339: b3851

Lesson 6. Constant focus on access has made continuity of care worse

For patients who say they prefer to see a particular GP, responses to ‘How often do you see or speak to the GP you prefer?’ (n=>1 million responses each year)

Does this matter?



Lesson 6. Constant focus on access has made continuity of care worse

Does this matter?

Yes - because better continuity of care is associated with:

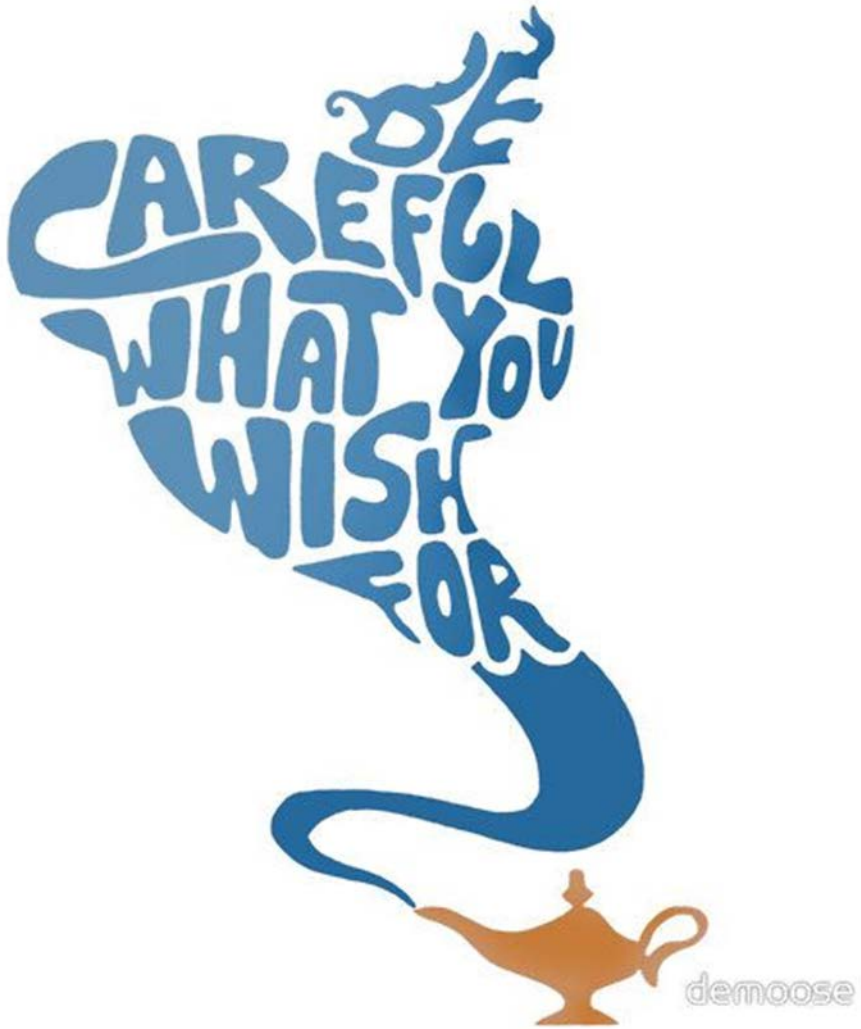
- **Improved patient satisfaction**
- **Improved physician job satisfaction**
- **Improved quality of care**
- **Increased adherence to prescribed medications**
- **Increased acceptance of offers of preventive care**
- **Reduced A&E attendance**
- **Fewer unscheduled hospital admissions**
- **Reduced mortality (even allowing for reverse causation)**
- **Reduced healthcare costs**

(references available on request)

Improving access is not straight forward. Nor is measuring it.

For all initiatives to improve access:

- **Think of the unintended consequences, e.g. increased disparities, reduced continuity of care, reduced access for planned care**
- **Beware supply induced demand**
- **When you've thought about all the intended and possible unintended consequences – keep measuring them!**



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