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)
• 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
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.

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
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.
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
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.
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

Standard error in incentive payment for a practice achieving 80% score:
2008 3.2%
2009 10.7%

Significantly increase in potential for measurement error in payments

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?

% of respondents answering ‘Always’ or ‘A lot of the time’
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 straightforward. 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!