

Access to Diagnostics in Primary Care and the Impact on a Primary Care Led Health Service

Abstract:

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Abstract

We undertook a postal survey of GPs to establish their current access to radiological and endoscopic tests. More than one fifth of GPs do not have direct access to abdominal (n=42, 21.4%) or pelvic (n=49, 24.6%) ultrasound in the public system. Where access is available public patients have an average 14 week waiting period. In stark contrast in the private system virtually all GPs have direct access (n=159, 99.2% and n=156, 98.8% respectively for abdominal and pelvic ultrasound) with an average wait of just over four days. Direct access to CT scan in the public system is available to the minority of GPs, e.g. n=31, 18.4% for chest scan, in the public system; even where available, there is an average 12 week wait for this. In comparison 151 (88.6%) GPs have access to CT chest scanning in the private sector with an average waiting time of 5.4 working days. Such limited access to diagnostics impacts on the delivery of a quality service.

Introduction

Patients present to general practice with a variety of undifferentiated symptoms. The general practitioner (GP) is a skilled diagnostician as symptoms and signs of serious and common conditions often overlap and there is a high prevalence of medically unexplained symptoms. As a result the diagnostic process in general practice is often a combination of shortcuts, loops and dead ends as it is a straight line going from presentation to diagnosis. It is not surprising therefore that the importance of appropriate access for GPs to diagnostics has been highlighted in a number of Irish Health Service Reports. The Irish primary care strategy provided the road map for a primary care led health service and it clearly states that Primary care teams will have direct access to appropriate hospital-based diagnostic services based on local protocols, which can support earlier intervention and better on-going care for individuals. The A and E 10 point plan promoted enhanced access to GP diagnostic services to support diagnosis, prevent GP referral to the emergency department and speed up treatment in the inpatient setting. The Tribal Secta Report clearly outlined the importance of access to diagnostics for GPs and highlighted how lack of access left them with no option other than hospital referral. In many instances the only option available to GPs when a patient needed an urgent scan or test given that waiting for out-patient appointments can be months was to send a patient to the emergency department or attempt to get the patient admitted to an in-patient bed, a scarce and entirely inappropriate resource.

The Acute Hospital Bed Review⁵ supported improved GP access to hospital and community diagnostics to reduce delays and avoid unnecessary admissions. The Comptroller and Auditor General commented on a community based diagnostic initiative developed by the HSE in 2007 to improve GP access to xray and ultrasound. The resulting HSE report found it led to reduction in waiting times, improved access for patients and that there was spare capacity within public and private facilities. Studies in Irish general practice reinforce the importance of these findings. In a recent report two thirds of GP respondents indicated that their fee paying patients had difficulty accessing diagnostic tests with this figure rising to 99% of GMS patients. The diagnosis of heart failure is severely hampered by lack of access to diagnostics with 54% of GPs unable to access Natriuretic Peptide testing and 99% unable to access echocardiography for their public patients. An audit of a pilot project of direct access to xray and ultrasound demonstrated less referrals to emergency departments and more appropriate referral to OPD. Positive patient satisfaction and professional satisfaction were also reported. Direct access to diagnostics in general practice appears to increase demand for testing but does not reduce appropriateness of testing or diagnostic yield with imaging requests by GPs and hospital specialists showing similar diagnostic yields. A London based group explored the effect on patient management of providing direct access to diagnostic imaging tests - 71% of patients referred for diagnostic imaging were managed in the primary care setting. An Irish study showed a high positive detection rate from direct access to dexascan with 30% found to have osteoporosis and 44% osteopaenia. There has been a rapid increase in the use of diagnostic imaging in recent years. These investigations may not always be necessary. Guidelines for appropriate referral are needed to highlight relevant information such as risks, limitations and interpretation. One of the principle barriers identified in Ireland and the UK in relation to early detection of cancer was the lack of direct access to diagnostics. The British Government intends to invest £450 million in the next four years to support GP direct access to diagnostics for patients with suspected cancer.

Early detection is likely to be cost effective but not cost saving leading to improved health outcomes and reduced treatment costs. Direct access results in reduced waiting times from presentation to testing and treatment. It has been shown that direct access to diagnostic tests allows GPs to manage a substantial number of patients who would otherwise have been referred to the hospital out-patient department (OPD) or specialist referral. A systematic review of the literature indicated that multiple interventions to modify test ordering rather than single interventions were more successful. In a Cochrane review of interventions to improve outpatient referrals from primary to secondary care, effective interventions included dissemination of guidelines with a structured referral form. Limited uptake of direct access by GPs can be an issue highlighting the need to engage GPs in the planning and implementation of new services. This paper reports on current GP access to radiological and endoscopic diagnostics in Irish general practice. Based on a survey of Irish GPs, it outlines current access for both public and private diagnostics and GP opinion on how this affects their ability to provide an effective service for patients. The international experience of GP access to diagnostics is explored, and proposed solutions to the problems identified are also included.

Methods

A postal survey of GPs on the Irish College of General Practitioners (ICGP) membership database was carried out. The questionnaire with one reminder was sent to a random sample of 500 GPs. The response rate was 58.4% and the respondent profile is consistent with that of the full membership population. The ICGP is the professional body for GPs in Ireland and in excess of 95% of all GPs in the country are members. Data analysis was carried out using PASW (Version 18) using univariate and bi-variate analysis as appropriate. Descriptive statistics are reported for most analyses. The waiting times for tests reported are based on working days and excludes outliers.

Results

Overall, 44.3% of respondents were female and the majority (67.1%) were more than 15 years in practice; 39.9% of respondents had a primary practice location in a town and 45.7% were less than 5 miles from the nearest hospital for acute admissions. These statistics are in line with the overall population demographics. There was a marked difference in access to diagnostics for patients in the public healthcare system (Table 1) versus those in the private system (Table 2). In the public system direct access was defined as access to tests by a GP without referring to another practitioner first, which the patient could then receive free of charge. There was a great deal of variability in the waiting times for access to diagnostics in the public system. Waiting times showed a wider distribution and a higher mean in all cases in respect of the public system when compared to the private system. The narrowest differential in the mean between public and private was noted for chest xray and xray for trauma. The comparatively low numbers with direct access in the public system for CT scans and MRIs are of note when comparing the summary statistics. Of the tests listed, the average waiting times in the private system was longest for gastroscopy and colonoscopy both in the region of 12 working days.

However, the comparable data for the public system was in the region of 12 weeks. In the public system 5% and 7.1% reported access within 15 working days for gastroscopy and colonoscopy respectively while in the private system access in this timeframe was reported by three-quarters of responding GPs. Among respondents 86% were of the opinion that

increased access to diagnostics would reduce their referrals to emergency departments and improve the quality of their referrals (Table 3). When questioned about OPD referrals, 90% felt that improved access would reduce their referrals to out-patient departments while 92% felt this would improve the quality of these referrals. Overall 87% believed that improved access to diagnostics would reduce unnecessary admissions.

Discussion

The importance of appropriate access for GPs to diagnostics has been highlighted in a number of Irish Government Reports. The international literature suggests that access to diagnostics has the potential to minimise delay in diagnosis, support management in primary care and reduce onward referrals to emergency and out-patient departments. The results of this survey of a representative sample of Irish GPs outlines current access to radiological and endoscopic diagnostics in general practice. Striking differences are demonstrated between access for public and private patients. In all services, the access to diagnostics for public patients is unacceptably long when compared to private patients. There is no doubt that as a result, GPs are forced to refer patients inappropriately to overcrowded emergency departments in order to access diagnostic tests. This can be an unnecessary traumatic experience, particularly for elderly patients, and places an extra costly burden on hospital services. Patient access should be on the basis of need not on the ability to pay. GPs are highly trained specialists who are currently constrained in their ability to deliver a quality service to their patients due to limited access to diagnostics. The vast majority of respondents in this study indicated that increased access to diagnostics would facilitate them to reduce the number of referrals to both emergency and out-patient departments, reduce unnecessary admissions and improve the quality of referrals overall.

It is time to empower GPs to provide the services they are trained to deliver in the interest of improved quality and safety for Irish patients. In a time of limited public expenditure, it is essential that all services are used appropriately. The provision of increased access for GPs to diagnostics will need to be flexible in terms of service provision. There will need to be analysis of the advantages of private versus public provision, community versus hospital based diagnostics and co-ordination across the primary and secondary care interface. The appropriateness of referrals would be enhanced by the development of joint GP-Hospital referral guidelines. The majority (92%) of Irish GPs have computerised medical records. The success of the electronic referral letters to cancer centres in Ireland illustrates the willingness of GPs to engage in structured referral processes based on national referral guidelines. In conclusion, GPs have limited access to diagnostics for public patients in stark contrast to their access for private patients. Irish GPs believe and international evidence concurs that increased access to diagnostics will lead to a reduction in diagnostic delay, reduce the number of referrals to both emergency and out-patient departments, reduce unnecessary admissions and improve the quality of referrals overall. This in turn will lead to more effective use of the hospital services and improve the quality of service for Irish patients.

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