What brings you here today?

Sophia Samuel

Doctor: As your headaches have become worse, the neurology registrar suggests magnetic resonance imaging (MRI) of the brain, and will see you in the outpatients clinic.

Patient: Oh no! I can't pay for an MRI. I can go to the emergency department; I'll wait, but I'll see the specialist tonight.

General practitioners (GPs) in Australia are confronted on a daily basis with a mixture of hope, uncertainty and frustration that patients display when faced with problems with access. Despite these issues being health-related problems, it is uncertain how clinicians should respond. For instance, GPs engage daily with the influence of cost on healthcare. Where treatment is affordable, perhaps because of bulkbilling, does access correspondingly improve?[1] Does private insurance unlock a resource sphere with lower demand and higher supply?[2]

Clinicians have a long history of innovative solutions to the problems posed by the unequal distribution and availability of doctors.[3,4] They also recognise that the burden of multiple diseases has an impact beyond the sum of its parts.[5] Factors such as opening hours, carer commitments and medication regime become explicit in every consultation. GPs commonly bundle many elements of care into a single visit, sometimes at the price of running late.[6] They also help integrate patients into a broader care network of other health professionals, community supports and online treatments.[7]

Apart from being available, services also need to be acceptable – to provide a 'good enough' intersection with the cultural and social factors that influence how and where a person seeks healthcare. One common illustration is using translators to overcome a language barrier. Many practices have adapted to the ubiquity of smartphones by providing online booking of appointments and reminder SMS messages. Aboriginal Community Controlled Health Services and street health clinics[8] are examples of primary health facilities that are explicitly shaped by the populations they serve.

However, there remain many access constraints beyond the individual GP's or clinic's control. As these contraints are not amenable to control, one argument is that there is little benefit in analysing or debating the attendant concepts. On the other hand, experiences in clinical practice suggest that an accurate diagnosis, even without a cure, can be powerful.[9] Consequently, it may be worthwhile for all clinicians to explore the conceptual frameworks that describe access to healthcare.[10] Such frameworks may provide a better language with which to describe influences that help or hinder patients. Naming is the start of discovery and can help identify relationships and affiliations.[9]

Patient demand and service type both propel the domains of access:[10] approachablity, availablity, affordablity, acceptablity, appropriateness. Various elements act as barriers or facilitators to each domain. As GPs tend to focus on individual care, these paired patient and service determinants can further inform the scope of history-taking and management strategies needed, especially in complex, multidisciplinary or chronic health presentations. It also illustrates how aspects of access are inter-related and will change with different episodes of care. This may then illuminate patient or clinic-specific initiatives that are evidence-driven, contextually relevant and sustainable.[11]

The health of a person is linked to their underlying social and environmental situation. Despite the limitations inherent in individualised medicine, a conceptual understanding of access is congruent with the aim of providing patient-centred care.

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References

1. Day SE, Alford K, Dunt D, Peacock S, Gurrin L, Voaklander D. Strengthening Medicare: Will increasing the bulk-billing rate and supply of general practitioners increase access to Medicare-funded general practitioner services and does rurality matter? Aust New Zealand Health Policy 2005;2:18
2. Harley K, Willis K, Gabe J, et al. Constructing health consumers: Private health insurance discourses in Australia and the United Kingdom. Health Soc Rev 2011;20(3):306–20.
3. Australian College of Rural and Remote Medicine. ACCRM telehealth provider directory. Available at www.ehealth.acrrm.org.au/provider-directory [Accessed 7 March 2018].
4. Royal Flying Doctor Service. What we do. Available at www.flyingdoctor.org.au/what-we-do/ [Accessed 7 March 2018]
5. Trevena L. Minimially disruptive medicine for patients with complex multimorbidity. Aust J Gen Pract 2018;47(4):175–79.
6. Knight AW, Lembke T. Ten tips for becoming a Time Lord. Aust J Gen Pract 2018;47(4):188–90.
7. Orman J, O'Dea B. e-Therapy in primary care mental health. Aust J Gen Pract 2018;47(4):168–72.
8. Arnold-Reed D, Troeung L, Brett T, et al. Increasing multimorbidity in an Australian street health service: A 10-year retrospective cohort study. Aust J Gen Pract 2018;47(4):181–87.
9. Stone L. Reframing chaos: A qualitative study of GPs managing patients with medically unexplained symptoms. Aust Fam Physican 2013;442:13, 501–02.
10. Levesque JF, Harris M, Russell G. Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. Int J Equity 2013;12:18.
11. Richard L, Furler J, Densley K, et al. Equity of access to primary healthcare for vulnerable populations: The IMPACT international online survey of innovations. Int J Equity Health 2016;15(1): 1–20.

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