Numerous studies, across multiple health systems, have demonstrated the value to child health of accessible and high-quality primary care.\textsuperscript{1–4} The past decade has witnessed an unprecedented pace of primary care reform, most not specific to children. Although the health policy contexts and mechanisms vary across jurisdictions, a common goal of reform efforts is access to timely care with a focus on both extending hours, and providing same or next day care for sick visits. According to the most recent international Commonwealth Fund study,\textsuperscript{5} there is wide variation reported by (adult) patients on both access measures. The United Kingdom ranked highest on after-hours care (69%), yet use of emergency departments (EDs) by children is higher than in the United States, which ranks eighth on this access metric (39%) and continues to have underinsurance problems. Many countries report high (and in some cases increasing) nonurgent ED visit rates by children,\textsuperscript{6–9} and in England additional concerns have been raised around increasing short-stay admissions.\textsuperscript{10} Whether these trends relate to ineffective primary care reform for children’s needs or factors outside of the primary care system is not well understood.

In this issue of Pediatrics, Cecil et al\textsuperscript{11} explore the relationship of access to general practitioners (GPs) and health care outcomes (ED visits, short- and longer-term hospital admissions) in a population-based sample of almost 10 million children (0–15 years) registered to all but 1% of GPs in England. The authors capitalize on the 2011 to 2012 cycle of the GP Patient Survey, linked to other practice characteristics and individual patient records in multiple health administrative data sets. Overall, primary care access is very high, with only 414 of 8035 practices characterized by <75% of patients reporting the ability to see/speak with their GP or nurse at last attempt. The authors report significant associations of modest magnitude between enrollment in the most (versus least) accessible practices and reduced ED visits (9% overall, 10% for after-hours visits). Associations of access and hospital admissions were not consistent. High primary care access was associated with reduced admissions for asthma, short stays for chronic conditions (21% and 8%, respectively), and a 4% lower risk of any longer-term (>2-day) admission. There was no association between primary care access and admissions for acute ambulatory care-sensitive conditions,\textsuperscript{12} diabetes complications, or overall short stays. Finally, an exploration of the proportion of patients older than 65 in the practice showed no association with ED visits but a modest 2% higher risk of unplanned admission.

The authors discuss a number of study limitations. Perhaps the most relevant is the potential for unmeasured confounding. Examination of the baseline characteristics of children by practice-level access reveals...
important differences that should be highlighted as an important study finding. Children in the lowest-versus highest-access practices are much more likely to be low income (56.8% vs 7.7% in the most deprived quintile, with a stepwise gradient across all quintiles) and urban. Disease burden, known to be higher in lower income (and in some cases urban) children, could account for higher ED use, and asthma and chronic disease admissions. Patterns of care-seeking also may vary by socioeconomic characteristics, and explain differences in ED use.13,14 Generalizability to other countries may be limited by the relatively high level of access and explain the attenuated findings relative to similar studies.1

Albeit these limitations, findings are relevant to the evolution of the National Health Service and clinical commissioning groups. The results point to the need to address demographic inequities in accessible primary care and the potential benefit in lowering ED visits and some hospital use. A recent systematic review15 of organizational interventions to reduce ED use points to evidence for other policy options, including cost-sharing, and against others, such as gatekeeping. The study findings also suggest that addressing high short-stay admission rates will require more root-cause analysis.

Primary care access alone will not be a panacea for all potentially avoidable hospital use. For the wider audience, this study sharpens the construct validity and provides benchmark data of a number of commonly used health system indicators. It underlines that universal coverage does not ensure universal access, and introduces hypotheses around potential competing dynamics of care of children and adults/elderly within primary care general practices.16 Finally, the study is an exemplar of the potential for population-based data to inform policy. The relative paucity of comparative child health system data and research capacity in the context of large natural experiments in health care delivery redesign disadvantages children. Efforts such as the UK Farr Institutes,17 the Pan-Canadian Real-world Health Data Network,18 and US attempts to integrate data across payers can improve access to relevant data. Building an international community of child health services researchers also will be important.

Abbreviations

ED: emergency department
GP: general practitioner

References


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Astrid Guttmann
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