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General practice and residential aged care: A qualitative study of barriers to access to care and the role of remuneration

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RESEARCH

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ABSTRACT

Background
More than 169,000 people live in residential aged care facilities (RACFs). As people age they use health services, particularly general practitioner (GP) services, more frequently but many GPs do not attend patients in RACFs.

Aims
To examine GPs' perceptions of barriers to providing care to patients in RACFs.

Methods
This study was conducted in June 2014 in the Bayside Medicare Local (BML) region in Victoria, Australia; all participants were drawn from this region. Two focus groups (FGs) were conducted. One was for GPs (n=5) that have a specific interest in practicing in RACFs, the other with RACF staff (n=8) representing public, private, and not-for-profit aged care providers. Results were presented to the Royal Australian College of General Practitioners (RACGP) National Standing Committee for General Practice Advocacy and Support for feedback and validation of the findings against national perspectives of the effect of remuneration on the provision of GP services in RACFs.

Results
Remuneration problems are a barrier to the provision of GP services to patients in RACFs. These problems can be grouped into: direct remuneration, opportunity cost, additional administrative burden, and unremunerated work. GPs' perceptions of the effects of these problems on willingness to practice in RACFs are described.

Conclusion
Innovative models of remuneration for GPs attending RACFs are needed to ameliorate the problems identified. Such models need to capture and pay for activities that are time consuming but often unremunerated.

Key Words
General practice, residential aged care, remuneration, access to care

What this study adds:

1. What is known about this subject?
Patients living in RACFs are frequently the frail aged with complex health needs, yet many GPs are unwilling to practice in RACFs. Remuneration can influence GP behaviour.

2. What new information is offered in this study?
This study identified remuneration barriers to providing medical care to patients in RACFs from the perspective of GPs that currently practice in this setting. These barriers can be grouped into the following broad categories: direct remuneration, opportunity cost, additional administrative burden, and clinically important but unremunerated clinical activities.

3. What are the implications for research, policy, or practice?

Encouraging GPs to attend patients in RACFs requires innovative models of GP remuneration. Such changes should adequately remunerate GPs by capturing activities that are time consuming but currently unremunerated. To achieve this aim in the Australian context may require new or modified items in the Medical Benefits Schedule, and GPs charging differently for services under the Medicare Benefits Schedule Items.

Background

Australia's population profile is ageing rapidly. The population aged 65 years and over is in excess of 3.2 million, and those aged 85 years and over (the very elderly) are in excess of 400,000.[1] As people age, their healthcare needs tend to become more complex.[2] The majority of healthcare services are provided through the primary healthcare system.[2] As people age they use health services, particularly primary health care provided by general practitioners (GPs), more frequently.[2] Access to comprehensive high quality health care can result in health gains that can lead to a relative decline in demand for aged care services.[3]

More than 169,000 people live in residential aged care facilities (RACFs). Forty-eight per cent of permanent RACF residents at June 2010 had medium or high needs for complex healthcare services.[4] RACFs provide long-term care to chronically ill, frail, disabled, or convalescent people, or cognitively impaired people. While this care involves regular basic nursing, RACFs are private residences not healthcare facilities. For people living in RACFs, timely access to GPs is a cornerstone of meeting their essential complex healthcare needs.[5]

This paper describes one component project of the Sub Acute Healthcare Linkages in Later Years (SALLY) project. The SALLY project was funded by the Australian federal government through the Department of Health and Ageing (now part of the Department of Social Services) under the Better Health Care Connections: Models for Short Term, More Intensive Health Care for Aged Care Recipients Program. The program's aim is to improve the quality of health care for aged care recipients. This paper reports on GPs perceptions of barriers to providing services to older people living in RACFs, and in particular examines the effect of remuneration on provision of GP services.

Aim

In this study we aim to examine the opinions of GPs on barriers to the provision of medical care to patients in RACFs and to describe the effect remuneration has on their practice.

Method

This study used primary data (focus groups: FGs) and secondary data from multiple aged care stakeholders including: GPs, RACF managers, and staff. A purposive sample of GPs participated in this study. Eligible participants were GPs who practised in the Bayside Medicare Local region in Victoria, Australia. All GPs in the region were eligible and invited to a FG. Separate region level FGs were facilitated by an experienced researcher, one for GPs (n=5) with a specific interest in practising in RACFs participated, each representing individual practices. The other FG involved RACF staff (n=8) representing public, private, and not-for-profit providers.

FGs were conducted using a simple request to participants to discuss barriers to the provision of medical care to patients in residential aged care facilities; beyond this participants were free to respond to the topic as they chose. FGs were conducted in June 2014 by a facilitator using the grounded theory approach. All FGs were audiotaped and transcribed verbatim. In addition, contemporaneous field notes were made.

FGs were analysed using a content analysis approach and thematic analysis included explicitly sought information and identification of emergent themes. Two research staff identified repetitive/salient themes, participant-emphasised themes as identified by group behaviour observational data, whether the question resulted in animated and/or extended discussion, whether most participants were interested in the question, and whether participants agreed or disagreed as a group.[6] Secondary data analysis used QSR Nvivo (version 10). Where differences were evident, these were resolved by consensus.

The study results were presented to the Royal Australian College of General Practitioners (RACGP) National Standing Committee for General Practice Advocacy and Support for consultative feedback and validation of the findings against national perspectives of the effect of remuneration on the provision of GP services in RACFs.

Setting

This study was conducted in the Victorian Department of Health Southern Region. The catchment is service rich, with approximately 700 GPs working in 170 general practices. The region has numerous allied health practitioners and medical specialists, and contains two large public hospital networks and multiple private hospitals.

The aged care provider in this study is a not-for-profit aged care provider. Human Research Ethics Committee approval for this study was granted by Monash University approval number CF13/2748: 2013001474.

Results

GP motivation

Amongst those GPs that provided care to patients in RACFs, their motivations had common themes: a desire to continue providing care to long-term patients, combined with a sense of professional obligation to practise medicine with vulnerable, frail elderly people.

"*I mean, I don't think people are doing aged care to make money, really. It's because of the ... the patient, that you know the patients and you were doing the care for them.*"

and

"I suppose, you know, geriatric medicine, to some extent's not very glamorous. It is one of the areas of need in the future… I did a fantastic six-month term at a geriatric hospital with a very, what's the word? Fantastic, I suppose, geriatrician and I think that perhaps, you know, [that] has encouraged me to do geriatric [medicine]... It's not an area that gets a lot of... public positivity."

Also evident was sense of obligation to adhere to expected professional norms.

"*... a lot of us have done it because that's the way we've been brought up. That's the way you do it [practise medicine].*"

Many GPs that do practise in RACFs felt a personal and professional sense of obligation to provide care for patients in this setting. Yet these motivations were not unalloyed. GPs cited a long list of reasons why providing care to patients in RACFs is sometimes difficult and unappealing, and these are consistent with the literature.[7–9] Those that relate specifically to aspects of remuneration are canvassed in detail in this paper. These can be grouped into the following broad categories: direct remuneration, opportunity cost, additional administrative burden, and unremunerated work.

Inadequate remuneration for the time and work involved and opportunity costs

With many GPs working to full appointment schedules, attending patients in RACFs during normal clinic hours was problematic. Relatively few patients could be seen at a RACF compared to the number of patients that could be seen in the same period at the clinic. Additionally, each clinic consultation can be charged at the full Medicare Benefits Schedule (MBS) schedule fee (possibly accompanied by an additional patient fee), and such consultations are not subject to the diminishing MBS fee schedule that applies for multiple RACF patient consultations, as shown in Table 1.

GPs said that providing services to patients in RACFs was often more time consuming and difficult than providing the equivalent care to older people who attended their clinic, primarily due to the complexity of their health needs.[10–11] Difficulties related to the broader logistical, organisational, and administrative aspects of providing care in RACFs compounded this problem. Participants reported that return travel time from the clinic to the RACF was unremunerated and was "lost time" as little other productive work could be performed in transit. These findings are consistent with other studies.[7,8,12,13]

"Right, if I say for example, if I got called to a facility because something happened and I go down there, it's $50 [remuneration for the site visit and consultation]. You know, like, after driving down there, seeing the patient, it's $50. So they'd [other GPs would] rather see five patients in the practice or four patients in the practice than driving there, going to the facility, coming back."

Medicare benefits schedule

Remuneration can influence GP behaviour.14–19 All GPs reported that they charged patients from RACFs the Medicare Benefits Schedule fee directly to Medicare, the Australian national health insurance system. This billing practice is known as "bulk billing" and involves no additional payment from the patient. The MBS classifies consultations into four Levels (A–D) and remunerates consultations according to complexity and duration, with Level A being straightforward (usually short) consultations, and Level D being complex consultations of more than 40 minutes duration. The most common consultation is Level B, a standard consultation of up to 20 minutes.

The (MBS) fee for a Level B consultation in a RACF is currently AUD $83.75. This reduces progressively with each additional consultation provided at the same site visit, decreasing to AUD $40.35 where seven or more patients are attended as shown in Table 1. This decreasing fee structure has been reported as providing a strong disincentive to providing care in RACFs.[8]

However, the GPs in this study said seeing multiple patients in select RACFs was their preferred way to practice as this minimised the opportunity cost of being away from the clinic. This practice also minimised logistical, organisational and administrative difficulties of providing care in RACFs as good working relationships could be established and maintained with a small number of facilities which improved communications and administrative processes, maximising efficiency. Interestingly none of the participants suggested others models of engagement and remuneration, successful trials of which have been reported elsewhere.[20]

"...there's certainly no money to be made in aged care and I think that is perhaps where, in the future, you're going to have to have multiple patients at the same facility to make it at all worthwhile to see your patients in aged care."

and

"So I go to sort of five and I have, you know, 20 or 30 in each facility. So, I tend to concentrate on that and it works okay."

GPs that provide significant levels of MBS eligible services in RACFs may access the General Practitioner Aged Care Access Incentive payment scheme.[21] However, this payment is made based on the number of consultations billed by individual GPs and cannot be amortised across GPs in group practice. The effect of this payment structure may create a financial incentive for those individual GPs that already attend RACFs, but this payment scheme also acts as a disincentive for those GPs who would sometimes attend RACFs, but whose frequency of attendance would not meet the required consultation threshold to be eligible for the payment. Consequently, GPs agreed that a pragmatic practice develops where only one or two GPs in a group practice attend patients in RACFs, rather than all GPs in the practice sharing this clinical activity.

"*Definitely remuneration is a major issue if you're going to continue the workforce going [to RACFs]".*

Possible benefits of this approach to the provision of care for patients in RACFs are greater continuity of care for the patient and maximising the income for the GP. However, the demands of practising medicine in RACFs, which are discussed below, must necessarily be borne by a relatively small number of practice GPs.

Out-of-hours demands

Consequent to the opportunity costs of RACF consultations during clinic hours, GPs often attend RACFs on their way to or from their clinic, requiring early morning or early evening consultations, thereby extending their working day for minimal additional remuneration. GPs also reported RACFs were the source of more calls for advice or attendance out-of-hours compared to patients living in private dwellings. These findings are consistent with other jurisdictions.[10–11]

Where only some GPs in a practice serviced patients in RACFs, providing continuity of service during periods of annual leave was problematic. Those GPs that did practice in RACFs had to cover the extra work, as their colleagues that did not usually attend RACFs were reluctant to do so, even for short periods. This compounded the out-of-hours workload for those GPs that were willing to attend patients in RACFs. In short, GPs reported that caring for patients in RACFs was more work, took more time, and demanded greater out-of-hours service, and that this extra workload was becoming burdensome over time.

Unremunerated work

GPs repeatedly remarked on the additional work that providing care to patients in RACFs necessarily entailed, but which is unremunerated: updating RACF clinical notes in addition to their medical records, consultation with RACF nursing staff, and discussions with family members where patients had appointed a designated decision maker for their health care.

Unremunerated contact with RACF staff and family occurred more frequently as patient needs changed due to significant changes in the patient's health status; for example, increased cognitive impairment, commencement of palliative care, or transitioning to end-of-life care. These clinically important tasks often occur subsequent to the consultation when the GP is no longer at the RACF, so are not remunerated.

Poor information transfer from hospital to RACFs was problematic. GPs reported spending a lot of time following up regarding medications, tests, and care plans when a patient returns from hospital.[10,11,22] Following up on

documentation and discharge information is not specifically funded through the MBS but is necessary for good patient care.

The issue of updating medication prescriptions was consistently noted to be particularly time consuming and was a cause of some resentment for GPs.[7,10,11]

"One of the bigger... biggest problems that I find is scripts and it's an absolute nightmare. As I said, I probably have 100+ residents [in total]. I spend three hours on a Sunday morning doing all these scripts for... for these… for the pharmacies. And it's an absolute nightmare and it's… a great hindrance to taking on new patients."

and

"Scripts are an issue because they take a lot of time and you don't get remunerated for it."

Discussion

Many GPs that practise in RACFs feel a personal and professional sense of obligation to provide care for patients in this setting. Yet providing care to patients in RACFs is sometimes difficult and unappealing. Inadequate remuneration is a barrier to GP practice in RACFs: specifically, direct remuneration, opportunity cost, additional administrative burden, and unremunerated work. These matters contribute to ambivalence amongst GPs about their willingness to practice in RACFs.

Recent changes to aged care policy (the *Living Longer, Living Better* reforms) have been substantial, but the aim for people to age in the community wherever possible remains foundational to the Australian aged care system.[23] Nevertheless, the demand for residential aged care is steadily increasing in relative and absolute terms.[23,24]

Those people that are accepted into a RACF in the future will have multiple, complex healthcare needs. Many will be very frail and have cognitive impairment or dementia. They will enter a RACF closer to the end of their life than is currently the case. The duration of residency will decrease and there is likely to be an earlier transition from curative medicine to medicine that provides good palliative and end-of-life care.[3,25] In the future, patients in RACFs will have poorer health status than at present[2,24] and the demand for GP care for people living in RACFs will also likely increase, placing even greater demands on the time and clinical expertise of GPs that practice in RACFs.

Some ambivalence was evident amongst GPs about providing care in RACFs. While a personal and professional obligation contributed to their willingness to care for patients in RACFs, they felt that they were knowingly complicit in contributing to their situation; their professional good will was being exploited, and this was evident in the inadequate remuneration they received. GPs frequently mentioned the amount of their time consumed with necessary but unremunerated activities as an unfair burden, and they felt that this was personally draining on them.

Remuneration can influence GP behaviour,[15,17,18] yet currently there are strong financial disincentives for GPs to provide care to patients in RACFs. Attending these patients is already unappealing to many GPs,[7,8,26] so inadequate remuneration is therefore likely to discourage GPs to begin providing care in this setting, and may encourage those GPs that do practise in RACFs to cease doing so.

In other related work RACF nursing staff wanted GPs to conduct more frequent comprehensive medical assessments for patients in RACFs. Given the increasing complexity of patients in RACFs, this raises the question of whether GPs are utilising the correct MBS items for patients in RACFs. Examples of potential items that may receive a higher fee are listed in Table 2. Out-of-hours consultations (MBS items 5010, 5028, 5049, 5067) also attract a higher fee.

With a large increase in the number of people who will be living in RACFs with greater health needs that at present, there is a strong case to be made that new models of GP remuneration for care of patients in RACFs is needed. This is most easily done with a change to the MBS for Items 20 and 35.

Conclusion

Strengths and limitations of this study

This study has limitations. The number of participants is small, drawing from one region in suburban Melbourne. However, the method of content confirmation using FGs of other aged care staff and confirmation of the findings with the RACGP National Standing Committee for General Practice Advocacy and Support strengthen the findings. In addition, the results are consistent with previous survey data, so the results are consistent with previous literature.

A strength is that this is the first qualitative study in Australia to describe the barriers to GP provision of care to people in RACFs, and what this means for GPs from their

perspective. It provides insights into the various factors that GPs feel is important in relation to remuneration in this context, including identifying onerous and discouraging unremunerated activities. It enriches and adds to previous quantitative studies that have described GP activity in RACFs.[27] This contribution is important in identifying those activities that can be remunerated according to what GPs feel is important to support them in practice.

Recommendations for change

The implications for general practice are: the provision of primary healthcare services to patients in RACFs is dependent on the goodwill of the minority of older GPs who practice in this setting, and is therefore unsustainable in the longer term. A minority of GPs practice in RACFs. There are strong financial disincentives for GPs to provide this service.

Remuneration problems are a barrier to the provision of GP services to patients in RACFs. To encourage GPs to attend patients in RACFs innovative models of GP remuneration are needed. The specific goals of such a remuneration model should be to encourage GPs that do practise in RACFs to continue to do so, and to encourage GPs that do not currently practice in RACFs to do so, particularly younger GPs.

To achieve this aim may require new or modified items in the MBS schedule. These items will need to adequately remunerate GPs by capturing activities that are time consuming, but currently are often unremunerated. This would ameliorate the related problems of opportunity cost to GPs dedicating practice time to RACF visits and associated unremunerated activity.

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PEER REVIEW

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CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

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ETHICS COMMITTEE APPROVAL

Monash University Human Research Ethics Committee Approval CF13/2748: 2013001474

Table 1: Medicare Benefits Schedule for general practitioner consultation at a residential aged care facility (current as at September 2014)

Attendance (Each Patient)		Medicare Benefits Schedule (100% fee)	After Hours Medicare Benefits Schedule (100% fee)
		Item 20	Item 5010
Level A	One	$63.65	$75.70
	Two	$40.30	$52.35
	Three	$32.50	$44.55
	Four	$28.60	$40.65
	Five	$26.30	$38.35
	Six	$24.75	$36.80
	Seven or more	$20.25	$32.30
		Item 35	Item 5028
Level B	One	$83.75	$95.70
	Two	$60.40	$72.35
	Three	$52.60	$64.55
	Four	$48.70	$60.65
	Five	$46.40	$58.35
	Six	$44.85	$56.80
	Seven or more	$40.35	$52.30
		Item 43	Item 5049
Level C	One	$118.40	$130.65
	Two	$95.05	$107.30
	Three	$87.25	$99.50
	Four	$83.35	$95.60
	Five	$81.05	$93.30
	Six	$79.50	$91.75
	Seven or more	$75.00	$87.25
		Item 51	Item 5067
Level D	One	$152.25	$164.45
	Two	$128.90	$141.10
	Three	$121.10	$133.30
	Four	$117.20	$129.40
	Five	$114.90	$127.10
	Six	$113.35	$125.55
	Seven or more	$108.85	$121.05

Table 2: Selected MBS Items for provision of service in RACFs (current as at September 2014)

Service Provided	Item number	100% Fee
Health Assessment (Brief <30 minutes) Item 701	701	$59.35
Health Assessment (Standard >30 <45 minutes) Item 703	703	$137.90
Health Assessment (Long >45 <60 minutes) Item 705	705	$190.30
Health Assessment (Prolonged >60 minutes) Item 707	707	$268.80
Preparation of General Practitioner Management Plan	721	$144.25
Review of General Practitioner Management Plan (to which a 721 applies)	732	$72.05
Coordinate Team Care Arrangement (2-year cycle)	723	$114.30
Coordinate review of Team Care Arrangement (to which a 723 applies)	732	$72.05
Multidisciplinary Care Plan contribute to review	729	$70.40
Multidisciplinary Care Plan (prepared another provider) contribute to review	731	$70.40
Case Conference organise and coordinate (15–20 minutes)	735	$70.65
Case Conference participate (15–20 minutes)	747	$51.90
Case Conference organise and coordinate (20–40 minutes)	739	$120.95
Case Conference participate (20–40 minutes)	750	$89.00
Case Conference organise and coordinate (>40 minutes)	743	$201.65
Case Conference participate (>40 minutes)	758	$148.20
Medication Management Review (Residential)	903	$106.00