Medical services provided by general practitioners in residential aged-care facilities in Australia

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ABSTRACT

- We conducted a literature review to assess the current status of general practitioner services in residential aged-care facilities (RACFs) in Australia and the impact of recent initiatives to enhance access by RACF residents to these services.
- Of 400 publications identified, 22 were selected as relevant to our study. We also analysed publicly available statistical data on GP services in RACFs.
- Recent initiatives to improve quality of care and facilitate access to GP services for RACF residents include the Aged Care GP Panels Initiative, the Enhanced Primary Care program, and an expanded role of palliative care.
- Despite these initiatives, many GPs still find RACF services unappealing due to a perceived poor level of remuneration for the effort involved.
- Further improvements in access to and quality of GP services to RACFs may require new models of care delivery and financing.

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The importance of aged care is growing substantially with the increase in the number of older people in our society. This trend will continue, with the number of people aged ⩾ 85 years projected to increase from 1.5% of the population in 2004 to 6%–8% by 2051.[1] Along with an increase in the number of elderly people in Australian society, there has been a steady increase in the number of people living in residential aged-care facilities (RACFs). At 30 June 2005, an estimated 7.3% of people aged ⩾ 70 years were living as permanent residents in RACFs.[2] Although nurses and personal care attendants provide 24-hour supportive care to residents of RACFs, general practitioners are the main providers of primary medical care. The current primary care medical model leaves the medical care of each resident to his or her independent GP, who, in many cases, will not have formal links with the RACF.[3] The purpose of our article is to review the current status of GP clinical activity in RACFs and the impact of current initiatives to enhance access by RACF residents to these services.

Sources

We searched the English-language literature indexed in MEDLINE, the Australasian Medical Index (AMI), the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Rural and Remote Health database (RURAL), AgeLine, and government and other reports of research projects in aged care conducted in Australia up to January 2007. Over 400 publications from peer-reviewed and non-peer-reviewed sources were identified using the terms "Australia", "general practice", "general practitioner", "GP", "primary health care", "nursing homes", "aged care" and "residential aged care". The publications were examined independently by two reviewers, and 22 were selected as being relevant to our study objectives.

Statistical data were obtained from publicly available sources including Medicare Australia, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.

Current level of GP services to RACFs

Data extracted from Medicare Benefits Schedule (MBS) statistics for the financial year 2005–06[4] indicate that the predominant service provided by GPs to residents of RACFs is a standard consultation. Standard, after-hours and public-holiday consultations together comprise 96.5% of all medical services provided in RACFs (Box 1). The remaining items comprise services related to Medicare rebates that have been progressively introduced by the Australian Government to facilitate better access to GP services as part of its Enhanced Primary Care (EPC) program.

Medicare data show that between 2000 and 2005 there was an increase in the provision of complex services to patients in RACFs. For example, complex consultations of Level D (items 51 and 96) increased by 67%. There has also been an 18% increase in the number of all services provided per GP since 2000.[5,6] In 2005–06, an average of 12.8 GP services were provided per occupied aged-care bed, amounting to an average cost to Medicare of $570 per occupied bed per year. This is substantially higher than the average of 4.5 non-specialist services per whole patient equivalent in 2005–06,[7] with expenditure of $239 per patient in 2005–06.[8]

Concern about levels of GP services to RACFs

There is a growing concern reflected in the literature that GP services to RACFs are inadequate to meet current needs. A 2004 survey of GP availability in RACFs found that 52% of RACFs sometimes had difficulty obtaining GP services for existing residents, and 56% sometimes had difficulty obtaining GP input for routine services such as writing and reviewing medication charts and prescriptions.[9]

Barriers to GP services in RACFs

We identified the following barriers to provision of GP services to RACFs:

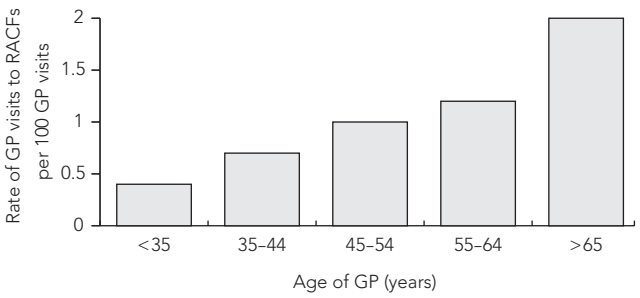
- Low levels of reimbursement. GPs perceive that the level of reimbursement for their services to RACFs is lower than for routine clinical work in their surgeries.[10,11]
- Time-consuming processes. Increased demands on GPs — with the paperwork required for RACF residents[12] and, quite often, unnecessary and time-consuming transposition of clinical data — make visits to RACFs time-consuming and leave GPs with little time for contact with the patients themselves.
- Younger GPs have much lower rates of providing services to RACFs than older GPs. RACFs are becoming increasingly reliant on an established cohort of older, predominantly male GPs who themselves may soon be reaching retirement age (Box 2).[6,13]

1 Medicare services provided by general practitioners to residents of RACFs in the financial year 2005–06[4]

Service provided by GP to residents of RACFs (MBS item numbers)	Number (%)* of services provided, 2005–06	Medicare benefit ($)
Standard consultations in RACFs (items 20, 35, 43, 51, 92, 93, 95, 96)	1 809 659 (92.4%)	73 971 254
After-hours, weekend and public-holiday consultations in RACFs (items 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267)	79 754 (4.1%)	4 149 688
Comprehensive Medical Assessment of a permanent resident in an RACF (item 712)	31 671 (1.6%)	5 777 798
Contribution to a care plan for a patient in an RACF (old item 730 or new item 731)	14 252 (0.7%)	601 548
Organisation and coordination, or participation in a case conference in an RACF (items 734, 736, 738, 775, 778, 779)	6 342 (0.3%)	619 457
Participation in a collaborative Residential Medication Management Review for a permanent resident in an RACF (item 903)	16 966 (0.9%)	1 516 579
Total	*1 958 644 (100%)*	*86 636 324*

MBS = Medicare Benefits Schedule. RACF = residential aged-care facility. * Proportion of total number of services provided in RACFs. ◆

2 General practitioner visits to residential aged-care facilities (RACFs), by age of GP*

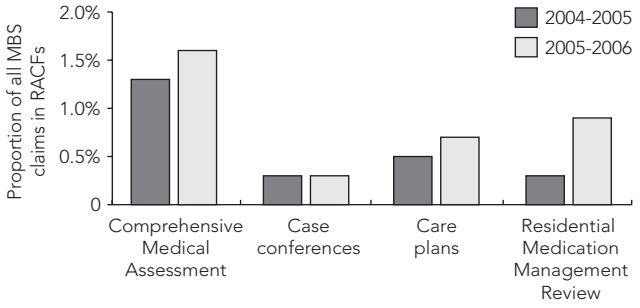


* Expressed as rate per 100 GP visits. Adapted from data from the Bettering the Evaluation and Care of Health study on general practice.[13] ◆

Initiatives to improve GP services to RACFs

In response to these challenges, a variety of incentives and programs have been initiated by the Australian Government and state health departments to facilitate GP activity in RACFs. These include the Aged Care GP Panels Initiative, the EPC program and expanded palliative care programs.

3 MBS claims relating to Enhanced Primary Care items in residential aged-care facilities (RACFs)*



MBS = Medicare Benefits Schedule. * Data from MBS statistics.[4] ◆

The Aged Care GP Panels Initiative

The Aged Care GP Panels Initiative seeks to increase the number of GP services for RACFs and to encourage younger GPs to work in the area of residential aged care.[14,15] The initiative was introduced in July 2004. A review after 12 months of operation showed that 58% of aged-care homes in Australia were participating in the initiative at 1 July 2005.[5] Progress during the first year of operation of the initiative was good, with the number of participating GPs increasing by 59% in the second half of the year compared with the first half. The number of aged-care services provided also increased by 5.4% over this period. In the 2007–08 federal budget, additional funding for the initiative was announced.[16]

The Enhanced Primary Care program

The EPC MBS program was introduced in November 1999. It provided new Medicare items to increase the financial incentives for greater GP involvement in RACF care: Comprehensive Medical Assessment (CMA), multidisciplinary case conferences, GP contribution to care plans, and Residential Medication Management Review. A 2003 evaluation of the uptake of EPC items relating to RACFs found that CMA items were the most commonly claimed.[17] GPs found care plans to be complex, involving a considerable amount of paperwork and time to review medical notes and test results. They also found organising case conferences to be very time-consuming and poorly remunerated for the effort involved,[17] despite the evidence that conferences can be effective.[18,19] There was a small increase in the number of EPC Medicare claims from 2004–05 to 2005–06, with the exception of the item relating to case conferences (Box 3). Further increases in the number of care plans could be expected with recent improved remuneration for the item relating to GP contribution to care plans.[16]

Palliative care programs

Recognising that a substantial proportion (over a third) of permanent residents will die within a year after admission to an RACF,[2] a range of innovative palliative care programs has been developed as part of the National Palliative Care Program. These include guidelines for a palliative approach designed for staff (including GPs) working in or with RACFs.[20,21] However, participation of GPs in advanced care planning in RACFs remains limited because

of a lack of financial incentives, the time required, and difficulty in advising patients about the treatment they may require in advance of need.[22]

Conclusion

With the ageing of the population and consequent increase in the number of people requiring care for multiple and complex conditions in RACFs, the role of GPs is prominent as a primary source of medical services. However, we have identified several ongoing barriers to the provision of GP services to RACFs. Initiatives to increase GP access — including improved reimbursement, participation in Aged Care GP Panels, and an enhanced role in palliative care — appear to be having an impact, but it is too early to determine whether they will be sufficient to meet the rapid projected growth in this sector. Additional research is needed to investigate the potential impact of innovative models of care and alternative funding methods.

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Competing interests

None identified.

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