

Variation between Divisions of General Practice in the uptake of health assessments, care plans and case conferences through the Enhanced Primary Care program

DAVID WILKINSON, HEATHER MCELROY, JUSTIN BEILBY,
KATHY MOTT, KAY PRICE, SUE MOREY, AND JOHN BEST

David Wilkinson is Professor, Pro-Vice Chancellor and Vice-President of the Division of Health Sciences, University of South Australia, Adelaide. Heather McElroy is a statistician and Justin Beilby is Professor of General Practice, Department of General Practice, University of Adelaide. Kathy Mott directs KM Consulting Services Pty Ltd. Kay Price is Senior Lecturer with the Centre for Research in Nursing and Health Care, Division of Health Sciences, University of South Australia. Sue Morey directs Morey Australia Pty Ltd and John Best directs Diagnosis Pty Ltd.

Abstract

We aimed to describe the variation in rates of uptake of the enhanced primary care (EPC) Medicare Benefits Schedule items for health assessments (HA), care plans (CP) and case conferences (CC), between Divisions of General Practice from November 1999 (when these items first became available) to October 2001. There was substantial variation in uptake of the various EPC services between Divisions of General Practice, ranging from very low to high. For HA the rate in the highest uptake Division was 496 per 1000 eligible population, and the lowest was zero. There are seven Divisions with high and six with very low uptake, with the rest ranging between 100 and 400/1000. Five Divisions had CP rates over 15/1000 total population; most Divisions had fewer than 10/1000, and many had less than 5/1000. A similar pattern is observed for CC. The levels of uptake for HA increased in the second year of the program for all but eight Divisions of General Practice, and the levels of uptake for CP increased in all but two Divisions. In the first two years of availability, uptake has been highly variable across Divisions of General Practice. Uptake has however increased substantially and consistently in the second year of the program.

The context

The Enhanced Primary Care (EPC) package was launched by the Federal Government in the 1999 budget. The aim of the EPC package is to improve the health and the quality of life of older Australians, of people with chronic conditions, and of those with multidisciplinary care needs (Commonwealth Department of Health and Aged Care, 1999). The EPC package comprises a range of initiatives including additional coordinated care trials, chronic disease self-management demonstration projects, establishment of Carelink, and the introduction of new EPC items on the Medicare Benefits Schedule (MBS).

The EPC MBS items allow general practitioners (GPs) to undertake or participate in activities that support the broad aims of the EPC package. Specifically these activities comprise health assessments for older people, care planning for patients with chronic, complex and on-going care needs, and multi-disciplinary case conferencing (Commonwealth Department of Health and Aged Care, 1999).

We have previously reported (Wilkinson et al, 2002) on trends in uptake of items for health assessment (HA), care plans (CP) and case conferences (CC). Here we describe variation in uptake between Divisions of General Practice, and from the first to the second year of availability.

Methods

Data source and EPC services, patient and practitioner details

The main methods are as reported in the first paper in this series. Additional methods relevant to this paper are included below.

Analyses

Crude rates of coverage were estimated as the number of people having a particular type of EPC service in the first or second year divided by the estimated number of people in the Division eligible for such a service, using 1996 ABS census data available through HealthWiz 5.0 (<http://www.prometheus.com.au/healthwiz/hwiz.htm>), and reported as rate per 1000 eligible population.

For non-Indigenous HA the eligible population was defined as the number of people aged 75 or more in each Division. However, the number of Indigenous people aged 55 or older in each Division was not available in HealthWiz. HealthWiz does however contain data on the number of people who identified themselves as Indigenous during the 1996 ABS census for each Division of General Practice, and the proportion of Indigenous people aged 55 or more by state and rurality. Therefore we estimated the number of Indigenous people aged 55 or older in each Division by multiplying these two numbers. For example, 4.75% of indigenous people living in Perth were aged 55 or older, so we estimated that of the 1881 indigenous people living in Perth Division of General Practice 89 would be 55 or older. The entire divisional population was used as the denominator for CP and CC as the number of people with chronic, complex and ongoing care needs is not known.

Indirect age and sex standardisation was used to compare rates of non-Indigenous HA and CP across Divisions, and reported as the ratio of observed to expected. This ratio is a measure of the relative quantity of EPC services in the index Division compared with the national average, accounting for the population profile of the Division. 1996 census data from Health Wiz was used as the basis for the standard population to estimate the age and sex profile of each Division (age groups 0-14, 15-34, 35-54, 55-74, 75+).

Results

There was substantial variation in uptake of the various EPC services between Divisions of General Practice, ranging from very low to high.

Health assessments

For HA (non-Indigenous), the rate in the highest uptake Division was 496 per 1000 eligible population over the 2-year study period, and the lowest was zero (Table 1 and Figure 1). Statistics are shown only for very high and very low Divisions in Tables 1 and 2. The complete set of results is available from the authors.

There were seven very high (rate around or over 400 per 1000) and six very low uptake Divisions (below 75 per 1000). The rate of HA for the remaining Divisions of General Practice ranged from about between 100 and 400 per 1000 eligible population. The standardised ratio in the busiest Divisions was close to two (Table 1).

A similar pattern was observed for HA (Indigenous). In 3 Divisions very high rates were observed (over 400 per 1000) and in 5 more, rates were 3-400 per 1000. However, in the remaining Divisions, rates were very low (Figure 2).

While in about 90 Divisions HA were more typically done in GPs' rooms, in about 30 Divisions, HA were more likely to be done at home (Figure 3).

Care plans

While five Divisions had CP rates over 15/1000 total population, most Divisions had fewer than 10/1000 and many had less than 5/1000 (Table 2 and Figure 4). The standardised ratio in the busiest Divisions was around 3 to 4.5, indicating marked variation in rates. It is also notable that the variation in CP rates was substantially greater than HA rates (standardised ratio close to two).

Case conferences

A pattern similar to that for CP was observed for CC (Figure 5). Nine Divisions had CC rates of between 0.3 and 1.4 per 1000 population, and most of the rest had rates below 0.2 per 1000. The standardised ratio for CC was 11 in the two busiest Divisions (data not shown).

Change in uptake rates in the second year

The levels of uptake for HA increased in the second year of the program for all but eight Divisions of General Practice (Figure 6), and the levels of uptake for CP increased in all but two Divisions (Figure 7) in the second year of availability.

Discussion

These data demonstrate high variability in the rate of uptake of the three groups of EPC services, HA, CP and CC, across Divisions of General Practice. In almost all Divisions, the rate of EPC services increased in the second year of their availability.

As shown in the first paper in this series, rates of HA were highest overall, followed by CP and then CC. In this paper we show that variability is greatest for CC (adjusted ratio 11), with CP variability next (adjusted ratio about 4), and HA showing least variability overall (adjusted ratio about 2).

Even in the highest HA Division, coverage did not quite reach half of the eligible population. However, that at least 3 of every 10 eligible people did receive this service in 27 Divisions of General Practice in the first two years of the program is encouraging and demonstrates that a new service can be established quite quickly. It will be important to determine why some Divisions of General Practice have achieved substantially higher coverage levels than did others, and this is being addressed in the qualitative component of our evaluation. Almost all Divisions had a higher rate of HA in the second year of the program than in the first, and this suggests that over time the capacity to provide the HA service is increasing in a fairly systematic way, and again this will be explored during our field work.

As the eligible population for HA is clearly defined, and can be easily counted, it may be important to consider what target coverage is desired. Might it be that all eligible people should have a HA within five years, for example? How often should repeat HA be done? While MBS criteria allow HA to be repeated annually, this may not be necessary for every elderly person. Perhaps a second assessment should be done on all eligible people within five years of the first HA, but more frequently if needs dictate. (This could be agreed by the patient, doctor and carer, if appropriate). We are unaware of any evidence about how frequently HA should be repeated and these intervals might best be determined by an expert reference group, informed by some in-depth research that monitors a cohort of older people undergoing HA.

These data do suggest that Indigenous people may not be receiving an adequate HA service, as coverage levels were lower, variability was higher, and fewer Divisions seemed to be covering more than 3 per 10 eligible people. However, as noted in the first paper of this series, it may be that Indigenous people are receiving equivalent services through Aboriginal Health Services that are not captured through the MBS EPC item numbers. It is also possible that these data do not adequately differentiate Indigenous from non-Indigenous people. Further research to determine whether Indigenous people are receiving adequate EPC services is warranted.

It is encouraging that for CP, coverage across Divisions of General Practice increased quite substantially in the second year of the program, driven by the introduction of the PIP incentives (Commonwealth Department of Health and Aged Care, 2001) as identified in the first paper. Indeed, in many Divisions, the rate of CP increased markedly. This demonstrates once again that a new service can be successfully introduced when the conditions are right. Incentives linked to targets, associated with programs of awareness, support and training through the Divisions of General Practice clearly can have quite some impact. The increase in year 2 in the coverage of HA was substantially less than the increase for CP, and this is explained at least in part by CP having a lower base in year one. Thus, there was a greater opportunity to increase for CP. It is also possible that the incentives to do CP limited the capacity to do more HA. It will be important to monitor trends closely over time to see how uptake levels stabilise.

CC were done at much lower rates, with most Divisions doing very few. In part this is likely to be because they may be perceived to be more complex and just harder to arrange and do. Also, the ease, opportunity and incentive to do HA and then CP may well have limited the capacity to do CC, other than in a few particular circumstances, and once again we will explore these issues in our fieldwork.

Overall, there has been marked variation in the uptake of the various EPC services across Divisions of General Practice, despite the availability of substantial funds to support the introduction of the EPC program. This suggests that the impact of some Divisional programs may have been less than anticipated, and that multiple factors other than the Divisional programs have an important role to play including the organisation, structure, workload and interest of individual practices and doctors (Blakeman 2001; Blakeman 2000). We expect our fieldwork to provide insight into these issues and will report the findings as they become available.

Acknowledgements

Gordon Calcino, General Practice Branch, Department of Health and Ageing, for providing data. Claire Caesar, General Practice Branch, Department of Health and Ageing, for permission to publish and critical input during the evaluation process.

References

- Blakeman TM, Harris MF, Comino EJ & Zwar NA 2001, 'Evaluating general practitioners' views about the implementation of the Enhanced Primary Care Medicare items', *Medical Journal of Australia*, vol 175, pp95-98.
- Blakeman TM, Zwar NA & Harris MF 2002, 'Evaluating general practitioners views on the enhanced primary care items for car planning and case conferencing: a one-year follow up', *Australian Family Physician*, vol 31, pp582-585.
- Commonwealth Department of Health and Aged Care 1999, *Primary care initiatives, Enhanced Primary Care package*, Canberra: Commonwealth Department of Health and Aged Care, September 1999.
- Commonwealth Department of Health and Aged Care 2001, *Practice Incentives Program (PIP) new incentives*, Canberra: Commonwealth Department of Health and Aged Care, October 2001.
- Wilkinson D, McElroy H, Beilby J, Mott K, Price K, Morey S & Best J 2002, 'Uptake of health assessments, care plans and case conferences by general practitioners through the Enhanced Primary Care program between November 1999 and October 2001', *Australian Health Review*, vol 25 no 4, pp1-11.

Table 1. Number, rate per 1000 eligible population, and standardised ratio of health assessments done in rooms and at home for non-Indigenous people, for selected Divisions of General Practice.

Division	State	Population aged 75y+	Total population	Health assessments done	Rate per 1000	Standardised ratio
Selected Divisions with high standardised ratios:						
Great Southern Division	WA	3,102	69,050	1,539	496.132	1.99
North-East Valley Division	Vic	10,368	215,596	4,959	478.299	1.9
Eyre Peninsula Division	SA	2,590	55,752	1,225	472.973	1.9
Adelaide Northern Division	SA	5,334	169,547	2,426	454.818	1.82
Adelaide Central and Eastern Division	SA	14,869	172,332	5,961	400.901	1.59
Hunter Urban Division	NSW	22,929	392,452	9,153	399.189	1.59
Dandenong District Division	Vic	6,822	234,180	2,710	397.244	1.59
Sherbrooke and Pakenham Division	Vic	2,014	67,556	747	370.904	1.49
Selected Divisions with low standardised ratios:						
Mid North Rural SA Division	SA	2,763	45,933	230	83.243	0.33
Dubbo/Plains Division	NSW	4,492	90,455	341	75.913	0.3
Top End Division	NT	1,764	142,654	52	29.478	0.12
Eastern Goldfields Medical Division	WA	1,218	59,805	30	24.631	0.1
North West Slopes NSW Division	NSW	3,053	57,417	71	23.256	0.09
Central Australian Division	NT	759	47,760	13	17.128	0.07
Pilbara Division	WA	406	43,931	3	7.389	0.03
Kimberley Division	WA	620	32,401	0	0	0

Figure 1. Scatter plot of the rate of health assessments per 1000 eligible population (non-Indigenous people) for each Division of General Practice, ordered from highest to lowest.

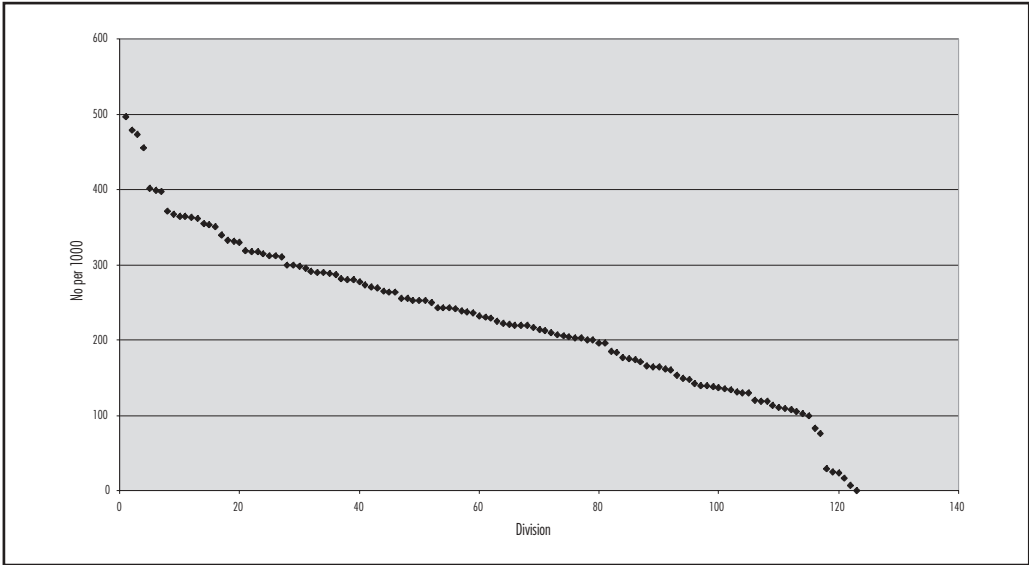


Figure 2. Scatter plot for rate of health assessments per 1000 estimated eligible population (Indigenous people) for each Division of General Practice, ordered from highest to lowest.

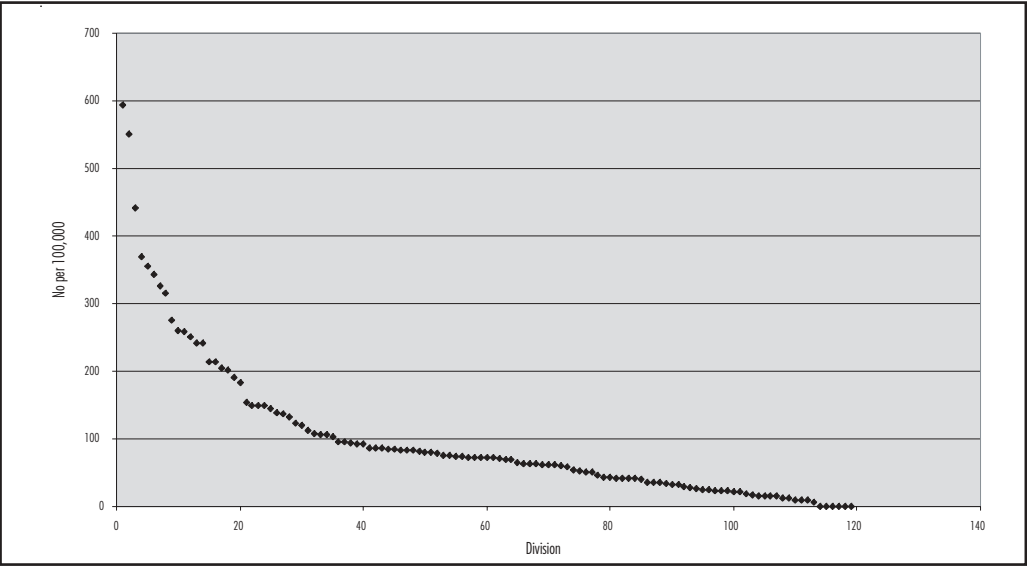
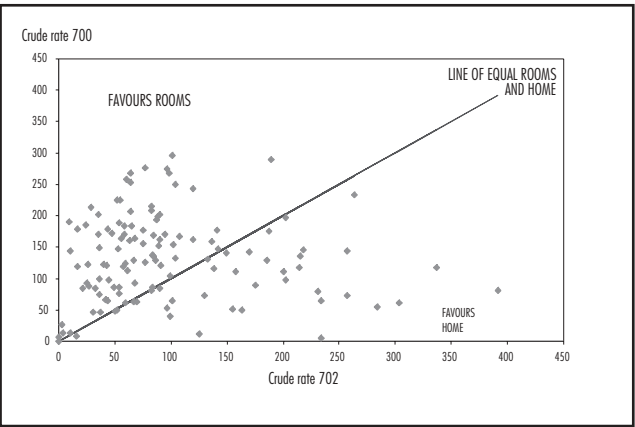


Figure 3. Scatter plot comparing the rate of health assessments done in rooms with the rate done elsewhere for each Division of General Practice.



Note: The diagonal line is a line of equal rates. Thus, in the bottom right corner are Divisions that have done many more HA at home than in rooms, and at top left are Divisions that have done many more HA in rooms than at home. Divisions close to the diagonal line have equal rates.

Table 2. Number, rate per 1000 population and standardised ratio of care plans done, for selected Divisions of General Practice.

Division name	Total population	Care plans done	Rate per 1000	Standardised ratio
Selected Divisions with high standardised ratios:				
The Assn of the Brisbane Inner South Division	115,307	3,347	29.03	4.35
Eyre Peninsula Division	55,752	1,264	22.67	3.83
Port Macquarie Division	86,525	1,598	18.47	2.34
Perth Central Coastal Division	116,336	1,859	15.98	2.26
Yorke Peninsula Division	22,611	343	15.17	1.83
Southern Division	316,723	4,048	12.78	1.94
St George District Division	200,612	2,409	12.01	1.66
Swan Hills Division	131,054	1,571	11.99	2.27
Selected Divisions with low standardised ratios:				
Kimberley Division	32,401	35	1.08	0.21
Murrumbidgee Division	59,904	47	0.78	0.13
NSW Central West Division	171,370	125	0.73	0.12
Flinders and Far North Division	28,608	20	0.70	0.13
Central Queensland Rural Division	75,598	42	0.56	0.12
The Barossa Division	32,350	15	0.46	0.07
Central West Rural Division	19,870	8	0.40	0.07
North West Slopes NSW Division	57,417	16	0.28	0.04

Figure 4. Scatter plot of the number of care plans done per 1000 total population for each Division of General Practice, ordered from highest to lowest.

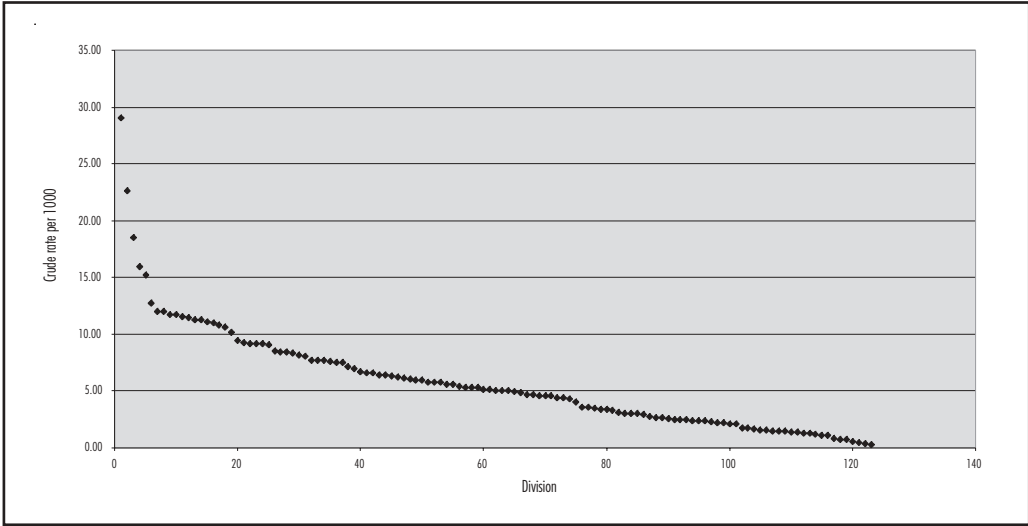


Figure 5. Scatter plot of the number of case conferences per 1000 total population for each Division of General Practice, ordered from highest to lowest.

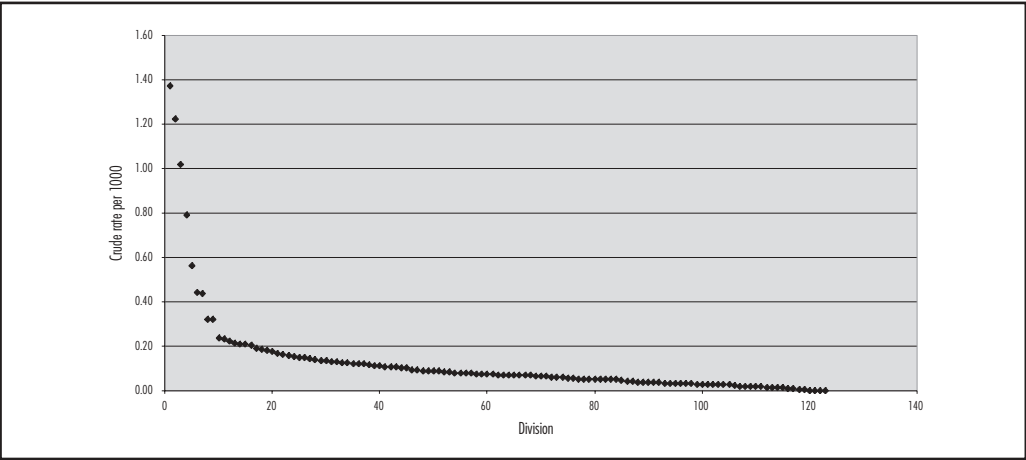


Figure 6. Rate of health assessments per Division of General Practice 19990-2000 and 2000-2001

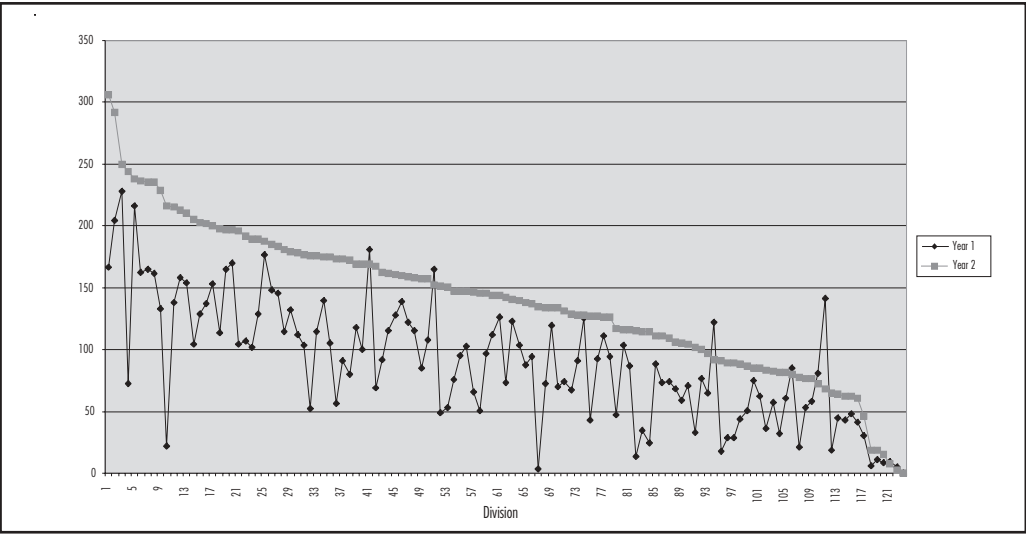


Figure 7. Rate of care plans per Division of General Practice for 1999-2000 and 2000-2001

