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Providing healthcare for people with chronic illness: the views of Australian GPs

John Oldroyd, Judith Proudfoot, Fernando A Infante, Gawaine Powell Davies, Tanya Bubner, Chris Holton, Justin J Beilby and Mark F Harris

CHRONIC DISEASES such as diabetes, cardiovascular disease, asthma, cancer and depression are imposing an increasing healthcare burden in Australia,¹ particularly in general practice, where they account for a high proportion of consultations. There is increasing evidence that care of patients with chronic illness requires a structured multidisciplinary approach across services, involving systems for patient recall, auditing and monitoring, as well as educating and supporting patients in the self-management of their condition.²

However, not all general practitioners in Australia use structured multidisciplinary care, and an estimated 50% of patients with chronic diseases do not receive best practice management.³⁻⁵ To help general practices set up systems for effective chronic-disease care, the Commonwealth Department of Health and Ageing has introduced several initiatives, such as the Enhanced Primary Care [EPC]⁶ package, the Practice Incentives Program [PIP]⁷ and Service Incentive Payments [SIP]⁸ for diabetes, asthma and mental disorders. However, the uptake of these initiatives has been variable.⁹ For example, GPs have made considerable use of the health-assessment and care-planning EPC items, but not of the case-conferencing items.¹⁰ There has also been a highly variable uptake of the diabetes SIP, which can be claimed when a 12-month cycle of evidence-based care has been completed.¹¹

The views of Australian GPs about chronic-disease care and the reasons why they do or do not engage with the

ABSTRACT

Objectives: To explore general practitioners' views on chronic-disease care: the difficulties and rewards, the needs of patients, the impact of government incentive payments, and the changes needed to improve chronic-disease management.

Design: Qualitative study, involving semi-structured questions administered to 10 focus groups of GPs, conducted from April to October 2002.

Participants and setting: 54 GPs from both urban and rural practices in New South Wales and South Australia.

Results: Consistent themes emerged about the complex nature of chronic-disease management, the tension between patients' and GPs' goals for care, the time-consuming aspects of care (exacerbated by federal government requirements), and the conflicting pressures that prevent GPs engaging in structured multidisciplinary care (ie, team-based care involving systems for patient monitoring, recall, and care planning).

Conclusions: Structured multidisciplinary care for people with chronic conditions can be difficult to provide. Barriers include the lack of fit between systems oriented towards acute care and the requirements of chronic-disease care, and between bureaucratic, inflexible structures and the complex, dynamic nature of GP-patient relationships. These problems are exacerbated by administrative pressures associated with federal government initiatives to improve chronic-illness management. Changes are needed in both policies and attitudes to enable GPs to move from episodic care to providing structured long-term care as part of a multidisciplinary team.

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chronic-disease initiatives are not entirely clear.¹² The aims of our study were to:

- investigate how GPs conceptualise chronic-disease care and the barriers to providing effective management;
- explore GPs' perceptions of what patients with chronic illnesses require of general practice;
- investigate GPs' views about the federal government's chronic-disease initiatives; and

- seek GPs' opinions on what organisational systems and structures would improve chronic-disease management.

METHODS

Sample and setting

Meetings with 10 focus groups of GPs were conducted between April and October 2002. Thirty-eight GPs in New South Wales were recruited through one rural and four urban Divisions of General Practice of variable size, selected from those that had an existing collaborative research relationship with the University of New South Wales. In South Australia, a convenience sample of 16 GPs from urban and rural practices associated with the University of Adelaide's Department of General Practice were invited to take part. Our aim was to recruit GPs from a cross-

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section of different-sized practices with varying management structures (eg, solo, group, and corporatised practices) and systems of chronic-illness care.

Procedure

The focus groups each met once and were led by experienced facilitators using a standard interview schedule. The sessions were audiotaped. Transcripts of the tapes were independently analysed by four researchers who elicited common themes, then collectively agreed on a final list of themes (a theme was included only if there was 100% agreement). GPs were reimbursed for participating and received continuing professional development points under the Royal Australian College of General Practitioners' scheme.

Ethical approval

The study was approved by the University of New South Wales and University of Adelaide Ethics Committees.

RESULTS

Fifty-four GPs participated, of which 39 (72%) were men. The mean age of participants was 49 years (range, 31–67 years), and the mean number of years' experience in general practice was 24 (range, 9–41 years). Practice sizes ranged from one to 24 GPs (37% of participants were solo practitioners). Further detail about the practices is given in the Box.

Themes arising in the focus groups fell into seven broad areas.

1. Perceptions of chronic-disease care

Comparison with acute care

GPs considered chronic-disease management to be more complicated and time-consuming than acute care, particularly as comorbidities are common. It was described as "chaotic" and "a burden" by many. Reasons given were that it is emotionally draining, costly (consultations last longer, phone discussions are unpaid, home visits are not economical), and "exposes your inadequacies". However, other GPs felt chronic care was rewarding because it enabled them to get to know their patients better:

If you're doing a good job, you can prevent complications, patients appreciate you and feel happier. They also seem to come to terms better with the chronicity of their illness.

Goals of care

GPs indicated that goals of chronic-disease care are not as clear as those of acute care, progress is hard to define, and therefore providing chronic-disease care is less satisfying. Many GPs felt there was a conflict between their long-term clinical goals and patients' shorter-term quality-of-life goals, between a systematic evidence-based approach and a patient-centred approach, and between patient satisfaction as an outcome versus achieving high-quality care:

[Y]ou explain to the patient what the aims are but you often have to think about what the patient wants. . . . You want to be a perfect doctor and do everything by the book sometimes and then other times you want to just do whatever the patient wants to keep them happy.

2. GPs' role in chronic-disease management

The multiple roles of GPs

GPs saw themselves as coordinators of care as well as advocates for patients, including educating them about their illness, helping them to understand spe-

cialist recommendations and working in partnership with them. Some GPs talked about a tension between the GP as a businessperson, the GP as a patient support and the GP as an evidence-based clinician. A small number indicated they try to avoid chronic-disease care and to dissuade prospective patients with chronic diseases from coming to the practice.

Working with colleagues

Some GPs in group practices spoke about the difficulty of enlisting their colleagues' support when trying to introduce new systems for chronic care. As one GP pointed out:

I'm likely to do it and the rest can't be bothered. The whole financial thing just falls apart, so I'm actually hindered by my colleagues and hindered by a lack of information that makes a business case for me to sell it to them.

3. Effect of patient characteristics on the care provided

Level of patient involvement

GPs described how patient compliance, motivation and capacity influence the type of care given: "In chronic care, you need the cooperation of the patient; it's a team effort involving the practice and the patient." Factors such as the severity of the patient's condition, his/her social situation, level of education and attitude towards the illness all need to be taken into account:

It is purely in a scientific way that we are dealing with it, but what gets left out is the patient aspect of it: how does he feel about the disease, and what does he feel about his condition, how is he going to control it and respond to the treatment?

When patients attend several doctors, problems in overseeing long-term care arise.

Patients' expectations of the GP

GPs believed that some patients want them to take overall control of their condition, listen to and help them deal with their problems (not just treat their symptoms), educate them, and, for older patients, provide social contact. They also want their GP to ensure they have an adequate quality of life. GPs felt that this places great pressure on them.

Practice characteristics of participants (n=54)

	Number of GPs (%)
Bulk-billing practice*	44 (86%)
Accredited practice*	44 (86%)
Practice uses register/recall system*	42 (82%)
Practice uses EPC items for case conferencing†	22 (45%)
Practice uses EPC items for care planning*	39 (76%)
Proportion of work in chronic-disease care*	
25%	7 (14%)
50%	26 (51%)
75%	17 (33%)
100%	1 (2%)

EPC = enhanced primary care. GP = general practitioner. * Data unavailable for three GPs.

† Data unavailable for five GPs.

4. Treatment

Multidisciplinary services

Some GPs stated they were not aware of what multidisciplinary programs or services are available, nor how to access them. A number described the teamwork associated with chronic care as a burden, time-consuming and costly; others described it as a great advantage:

So if I can have the various facilities — say, for example, a psych nurse, a diabetic nurse, an asthma educator at my disposal for me to ask “please do this, educate the patient” — that will save a lot of time.

Consultation requirements

To deal with both the patient's and the GP's agendas, GPs felt that longer consultations are needed. Home visits allowed more time with patients and better quality of care, but they were not cost-effective for GPs who bulkbilled.

5. Role of practice staff

Practice nurses

Practice nurses were seen as playing a key role in providing patient education, generating recalls and reminders, undertaking routine clinical tests, assisting with paperwork, coordinating care and sometimes undertaking reception duties. Many GPs, especially solo practitioners, indicated that they couldn't afford to employ a practice nurse, despite incentives such as the PIP, EPC-item rebates or sharing nurses between practices.

Receptionists

Described as “the eyes and ears of the practice”, receptionists were viewed as playing a valuable role in greeting patients, identifying problems, providing extra (local) information, downloading pathology results and arranging recalls.

Practice managers

Practice managers were seen to have a limited role in chronic-disease management, mainly associated with implementing government initiatives and doing the associated paperwork. Some GPs envisaged a possible role for the practice manager in setting up systems to facilitate chronic-disease care. Many solo practitioners expressed regret that

they were unable to afford a practice manager.

6. Computerisation of practice procedures

Most participants saw computerisation as vital for storing information, operating register/recall systems, accessing educational materials, monitoring patient care and conducting audits:

I think one of the most useful things in helping to manage people with complex problems is that we computerised our practice. You can revise the patients' past history, my record keeping is much better and I can generate more complex healthcare plans.

However, some GPs felt that computerisation adds to the chaos and creates overload in terms of recalling patients: “What is the point of recalling patients if there are no appointment spaces available for them?” A minority were still sceptical about using computers for fear of losing information.

7. Impact of federal government chronic-disease initiatives

Enhanced primary care items

The most useful EPC item was deemed to be care planning, because it involves other staff, coordinates care, encourages patients to take responsibility for their own care and gives a message to patients that their doctors are taking more interest in them. However, changes to the criteria for use and added paperwork have resulted in many GPs feeling that the EPC items are more trouble than they are worth. The case-conference item was generally dismissed as impossible to implement.¹⁰

Register/recall systems

Register/recall systems were viewed as crucial to structured chronic-disease care. Their clinical benefits were acknowledged, but some GPs felt that patients may perceive recalls as efforts by GPs to “drum up business”. A variety of strategies were used to encourage patients to keep appointments, such as limiting the number of repeat prescriptions. However, GPs wondered who should bear the responsibility for patients failing to attend recall visits, as

software problems make tracking recalls difficult.

DISCUSSION

The key finding emerging from our study is that GPs experience conflicting pressures and increasing demands (from patients and from the Department of Health and Ageing) as they attempt to provide better care for patients with chronic disease. Many of the difficulties can be traced to their attempts to carry out effective care in a predominantly encounter-based system oriented towards acute presentations. Highly structured systems imposed from above are not sufficiently flexible to fit the complex needs and variable nature of the relationship between GPs and their patients with chronic disease. A further layer of complexity is added by the interplay of clinical and customer-relations/business issues in chronic-disease management. These seemed to have an impact both on what GPs were prepared to do and (relatedly) what gave them satisfaction.

A secondary finding was that sustained high-quality chronic-disease management requires changes to practice infrastructure that are not always affordable or easily implemented. The complexity of government incentives (paradoxically introduced to improve care of patients with chronic conditions), the paperwork involved and the changes to criteria have acted as disincentives for many GPs. This theme in our focus groups has been corroborated by the recent Productivity Commission report, *General practice administrative and compliance costs*, which highlighted the extent of the burden in general practice.¹³ Since the release of the report, the Department of Health and Ageing has allocated \$31.5 million to help doctors reduce “red tape” by increasing the use of electronic patient records and improving practice systems. Although research evidence has shown that better practice systems will go some way towards improving chronic-disease care,¹⁴ it remains to be seen whether this package will ease the administrative pressures associated with chronic-disease programs or change GPs' percep-

tions about the burden of chronic-disease care.

Our findings suggest that change is also required from within general practice. Overseas research shows that one of the critical factors for improving chronic-disease management is the effective use of non-GP care providers and patient-care teams.^{15,16} While the GPs in our study were open-minded about the role of practice nurses in educating patients, generating recalls and undertaking routine tests, they did not see nurses reducing the GPs' burden of chronic-disease care by taking over clinical duties traditionally performed by GPs. Similarly, GPs' perceptions of the role of practice managers in chronic-disease care was limited, in most cases, to help with paperwork: the potential for practice managers to establish and run systems for patient recall, auditing and monitoring was not being recognised. The difficulties associated with implementing the EPC case-conference item have also acted as a barrier. Thus, in comparison with the United Kingdom and the United States, multidisciplinary teamwork within Australian practices appears to be underdeveloped. The relative weight of logistic versus attitudinal barriers to multidisciplinary care has yet to be ascertained.

Our study was limited by the convenience sampling method used and by the small size and perhaps unrepresentative composition of the sample (our GPs were somewhat older and more experienced than average). Nevertheless, our findings shed light on GPs' attitudes to chronic-disease management and the barriers to implementing structured

multidisciplinary care. The policy implications of these findings are clear. Greater and more systematic involvement of GPs in care for patients with chronic disease is desirable and acceptable to most GPs, but it requires support that is more flexibly matched to the needs of patients and GPs. It will inevitably increase the workload of general practices at a time when many rural and urban areas face workforce shortages. The extra burden could be offset by simplifying the way programs such as the PIP are administered, providing additional funding for longer consultations, supplying financial support and facilitation to extend the role of non-GP practice staff in chronic-disease management, and strengthening the links between practices and state-funded services.

COMPETING INTERESTS

None identified.

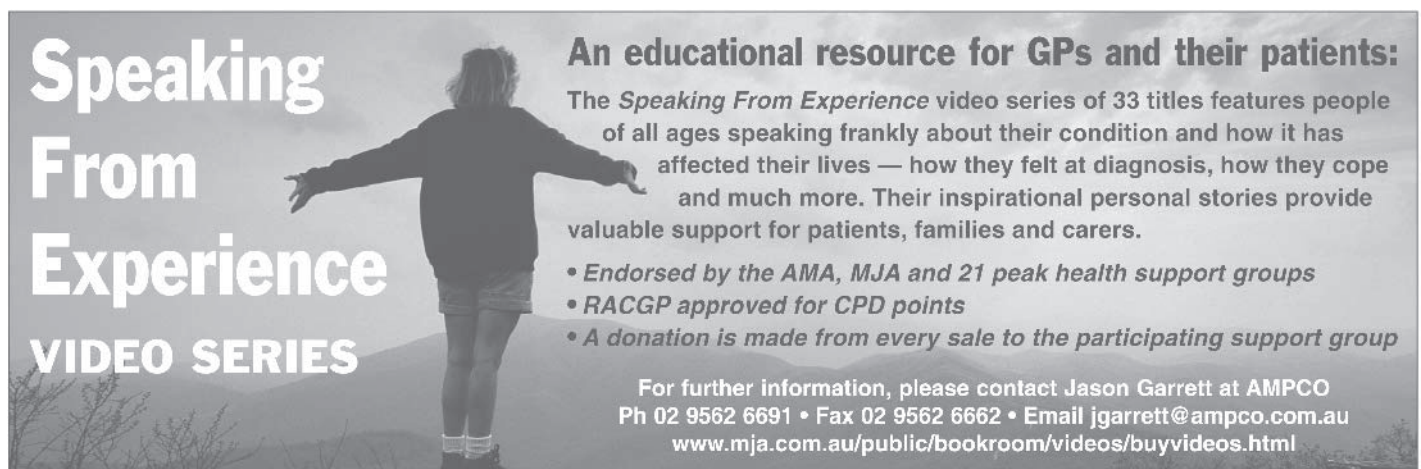
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