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Interfaces between the aged care and health systems in Australia—GP use by people living in permanent residential aged care 2012–13 to 2016–17

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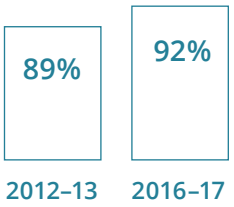
Older people use permanent residential aged care for different reasons: some enter only briefly at the end of life, while others live in permanent residential aged care for an extended period. Facilities generally provide people with assistance with activities of daily living and nursing care, but for most medical needs and other clinical care, people use other health services—some provided inside the facility and others outside of it—such as general practitioners (GPs), specialists and the hospital system.

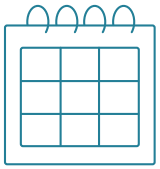
This report focuses on just one aspect of this clinical care: examining GP attendances claimed through the Medicare Benefits Schedule (MBS) for people living in permanent residential aged care (these attendances are referred to in this report as 'GP visits'). Many services are provided by staff working in residential aged care facilities. However, GPs are an important part of the health care team, as they provide whole-of-person clinical care and services such as prescribing and monitoring medicine use, referrals to specialists, and a point of liaison between the many health care professionals a person might see.

For these reasons, regular access to GPs—either through the GPs visiting an aged care facility, or through the resident leaving the facility to visit a GP—is a critical part of quality residential aged care. By looking at data on GP visits, we can better understand whether people are receiving appropriate care.

Key findings



Most people in permanent residential aged care had at least **1 MBS-funded GP visit** while living in care—**and this is increasing**



Residents who visited a GP generally did so about **twice each month**—rising to about 5 times if they were closer to the end of their life

Around **1 in 10** residents had **no MBS claims** for GP visits—but it is likely most of these people still received GP care through other channels, particularly Department of Veterans' Affairs arrangements

This report highlights that patterns of GP visits vary between people, as well as between residential aged care facilities. It also illustrates the benefits of using linked data to better understand the experiences of older people in residential aged care, and points out some of the limitations of only using MBS data. For example, this does not include information about GP services delivered under Department of Veterans' Affairs (DVA) arrangements. The AIHW and DVA will work together to strengthen data arrangements in the future.

How do people in permanent residential aged care use GP services?

People living in permanent residential aged care are often frail and have medically complex care needs. The number of people in care has been increasing steadily over time, as Australia's older population continues to grow. As programs and policies have sought to assist people to live at home for as long as possible, those who enter permanent residential aged care may also do so in an increasingly more frail state, but this is difficult to assess using available aged care data.

Many supports, particularly nursing care and allied health services, are routinely provided in residential aged care. However, people also require access to other health services, such as those provided by GPs. GPs assess people's current medical needs, plan for these into the future, prescribe and review medicines, and liaise with other health care professionals—regular access to GPs is a key part of quality of care in residential aged care.

How was the data collected?

This report forms part of a broader project to better understand how people in aged care use health services. Using 5 years of data (covering the period 2012–13 to 2016–17) on people aged 50 and over, the AIHW created a linked data set which includes:

- Medicare Benefits Schedule (MBS) claims data
- data on prescriptions dispensed under Pharmaceutical Benefits Scheme (PBS)/Repatriation Pharmaceutical Benefits Scheme (RPBS)
- deaths data from the National Deaths Index
- data on aged care program use (in the case of this report, this data was narrowed to only include permanent residential aged care: in 2012–13, there were 224,000 people using permanent residential aged care whose records were able to be linked for this project; by 2016–17, there were 238,000 people in scope).

The MBS data included in this report cover GP services that are subsidised by the scheme. People may receive GP services that are not subsised by the MBS (and therefore not included in this report—either because the service was paid for privately or delivered as part of another service or funding arrangement). Other arrangements can include any services received by veterans or other eligible DVA clients and reimbursed through DVA arrangements; services provided through hospitals; services provided under a state-funded service; and services provided by a salaried GP or any other salaried medical officer arrangement.

This report does not capture all GP visits people had in a year, only those that coincided with their use of permanent residential aged care—in particular, people who only used permanent residential aged care for part of the year may have had GP visits while living in the community that would not be included here.

More information on the data sources is available in the supplementary tables.

GPs commonly visit a facility in person—potentially seeing a number of patients on the same visit—but they may also deliver services through telehealth arrangements, or people can leave a facility to visit GPs at their practice. Targeted programs also operate in residential aged care that may involve a GP (such as hospital or palliative care outreach services and dementia-related support programs), but this report does not cover these services.

Almost everyone sees a GP

GP use among people in permanent residential aged care is increasing. The number of people who had a GP visit while living in permanent residential aged care increased by 9.6% over the 5 years (from 199,000 people in 2012–13 to 218,000 in 2016–17), while the overall number of people living in permanent residential aged care increased by 5.9% (from just over 224,000 people in 2012–13 to almost 238,000 in 2016–17). At the same time, the number of GP visits increased by 30% (from 3.5 million in 2012–13 to 4.5 million in 2016–17).

Most people had at least 1 GP visit while living in permanent residential aged care, rising from 89% in 2012–13 to 92% in 2016–17 (Table 1).

Table 1: People who had at least 1 GP visit while using permanent residential aged care, 2012–13 to 2016–17

	2012–13	2013–14	2014–15	2015–16	2016–17
Proportion with at least 1 GP visit	88.5	88.9	89.8	90.8	91.6
Median monthly rate of GP visits	1.9	2.0	2.1	2.2	2.3

Source: AIHW analyses of linked aged care and MBS data.

This pattern was similar for men and women, but varied by age: those aged 85 and over were less likely to have had at least 1 GP visit (Table S1). This may be related to the fact that the data were restricted to MBS claims only—people may access GP and other health services outside of this particular funding arrangement. For more on this, see the section on 'What about people who have no MBS claims for GP visits?'

How does time spent in permanent residential aged care use affect people's GP visits?

People's time living in permanent residential aged care can vary from days to years, but it often occurs at the end of their lives, as their health care and other support needs increase. When considering how long a person lived in permanent residential aged care, one way to look at this is in terms of how long they lived there before they died. This point of view can provide insights into people's health care needs as they approach the end of their lives.

Types of user

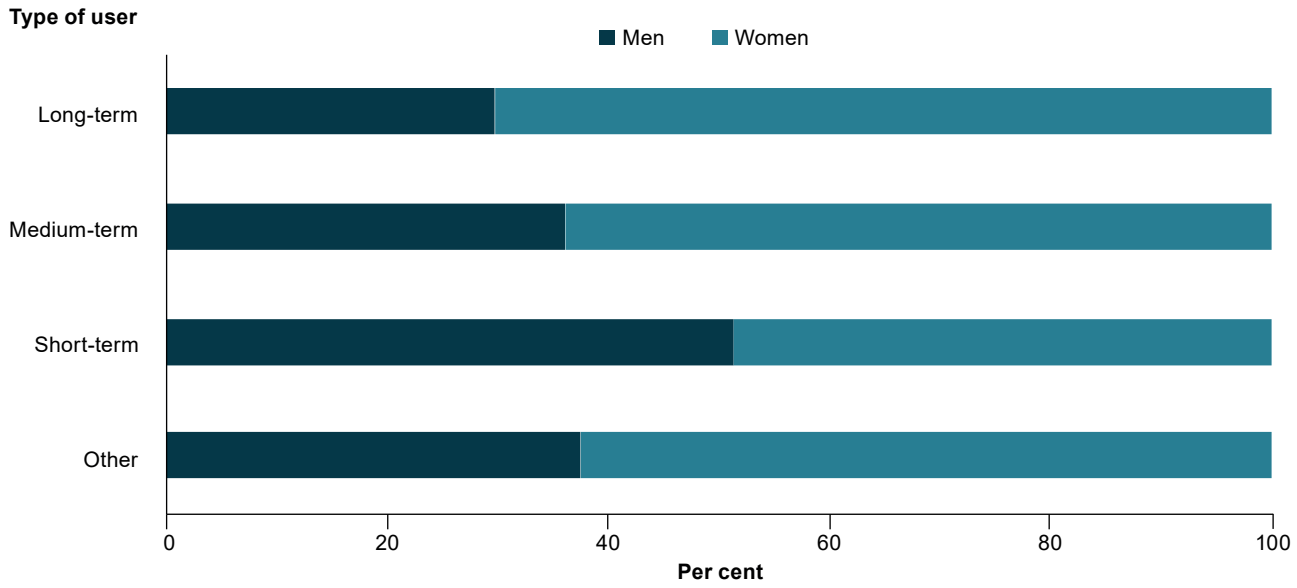
To explore this, people who were in permanent residential aged care in 2016–17 were grouped based on how long they lived in care and when they died. It is important to note that this is a 'snapshot' of their time in care, as some may have been in care long before the start of the year, or continued to stay in care beyond it.

- **Short-term use:** people who entered permanent residential aged care and died within 6 months of entry (their length of stay was up to 6 months), all within 2016–17.
- **Medium-term use:** people who lived in permanent residential aged care at the beginning of the year and died in the second half of the year (their length of stay was between 6–12 months).
- **Long-term use:** people who lived in permanent residential aged care for the full year and who were still alive 6 months later (their length of stay was at least 12 months).
- **Other use:** people who had some other use of permanent residential aged care (i.e. they did not belong to the other 3 groups; they may have moved in or out of care during the year and their length of stay was up to 12 months).

People in the long-term use group accounted for almost half of the total number of people using permanent residential aged care in 2016–17 (107,700 people, or 45%). The medium-term use group accounted for 21,000 people (or 8.9% of the total) and the short-term use group just 10,000 people (or 5.2% of the total). The remaining group of other use was made up of almost 99,000 people (41%).

Around half (51%) of the short-term use group were men, while women made up 70% of the long-term use group and around two-thirds (63%–64%) of the other 2 groups (Figure 1).

Figure 1: People using permanent residential aged care, by type of use and sex, 2016–17



Source: AIHW analyses of linked aged care and MBS data.

The median age for people in both the long and short-term use groups was 85, and slightly older for the other 2 groups (88 for those in the medium, and 86 for other use) (Table S1).

Across all groups, it was common for people to have dementia, musculoskeletal disorders (such as arthritis) and heart disease. Compared with the other 3 groups, people using permanent residential aged care in the short-term were considerably more likely to have cancer, but somewhat less likely to have dementia (Table 2).

Table 2: Proportion of people with selected health condition in permanent residential aged care, by type of user, 2016–17

Condition	Long-term	Medium-term	Short-term	Other	Total
Musculoskeletal disorder	56.4	54.1	35.7	52.7	53.8
Dementia	54.5	59.0	39.4	54.5	54.3
Heart disease	15.7	20.4	25.3	19.8	18.2
Cerebrovascular disease	15.2	15.5	13.5	14.7	14.9
Other nervous system disorders	11.1	10.0	7.7	9.7	10.3
Cancer	4.9	8.1	25.5	8.2	7.4

Note: Health conditions are as captured on the latest available Aged Care Funding Instrument record (any mention of relevant condition).

Source: AIHW analyses of linked aged care and MBS data.

People in care for shorter periods had a higher rate of GP visits

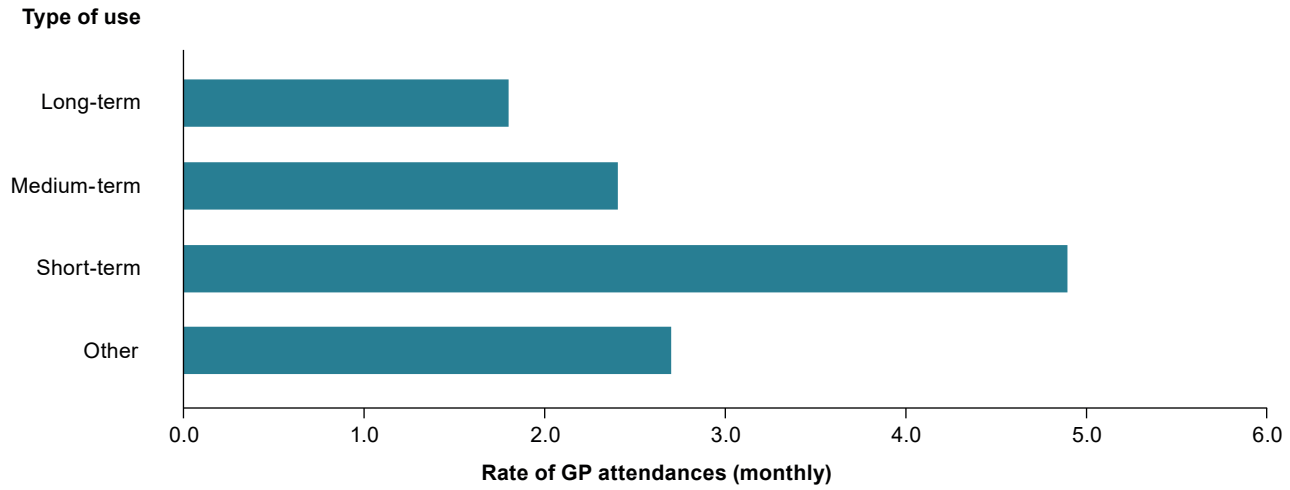
Calculating rates per person

The rate was calculated based on the number of GP visits a person had while living in permanent residential aged care and the number of days they lived in care in the year.

The median length of stay ranged from a full year for the long-term use group to under 7 weeks for the short-term use group. For ease of comparison and to account for this variation, the resulting annual rates of GP visits were adjusted to show monthly rates.

Although by definition people in the short-term use group spent the least amount of time in permanent residential aged care, during their stay they had relatively more intensive use of GPs: their monthly rate of GP visits was 2-3 times as high as that for people in the other 3 groups (Figure 2).

Figure 2: Rate of GP visits for people using permanent residential aged care, by type of use, 2016–17



Source: AIHW analyses of linked aged care and MBS data.

While increased service use is commonly seen in the final year of life, these analyses suggest that other factors may affect the rate of GP use—people in the short and medium-term use groups were both in their final year of life, but only those in care for the short-term had a noticeably higher rate of GP use; people in the medium-term use group who died after living in permanent residential aged care for longer had relatively less intensive use of GPs.

Use of specific GP services in permanent residential aged care

GPs deliver various services to people in permanent residential aged care, ranging from addressing acute health issues to managing chronic conditions or medicines and providing a point of liaison between care staff and specialists. MBS data do not document the experience of care people receive, but examining the specific services that GPs commonly administer and claim for via the MBS can provide some further insight.

Medication management reviews
These are a collaborative process between GPs and pharmacists to reduce potential harm from medicines, claimed by the GP at the conclusion of the review. People may also have their medications reviewed through other channels, for example during hospital stays, and this would not be visible in MBS data.

Chronic disease management plans
These allow for GPs to claim for planning and coordinating the multidisciplinary health care of people with chronic or terminal medical conditions.

Health assessments
These are available to specific target groups—such as older people and people who are permanent residents in an aged care facility. As part of the assessment, GPs can take a patient history, initiate necessary investigations to make an overall assessment, and recommend interventions.

Mental health plans
These allow for planning and delivering mental health-related care (including referring on to allied health consultations). They cannot be used to manage dementia, delirium or intellectual disability.

Only around 1 in 4 (26%) of people had a medication management review while in permanent residential aged care. For chronic disease management plans and health assessments, the proportion rose to around 1 in 3 (37% and 33%, respectively). Just 2.2% of people had at least 1 MBS claim for one of the mental health-related items. People in the short-term use group were less likely to have a claim for items relating to these 4 types of GP services than people in the other 2 groups (Table S4). This may relate to their care needs on entry into permanent residential aged care or the health conditions they have. On the other hand, they would have also lived in the community relatively more recently than people in the long or medium-term use groups, and they may have accessed these services during that time.

Remoteness impacts the rates of GP use

It can be difficult for people in permanent residential aged care to attend appointments or find appropriate services. This can be exacerbated for people living in rural and remote parts of Australia, as these areas often have poorer access to health services overall (AIHW 2018b). Residents in *Major cities* had higher monthly rates of GP visits than those in more remote areas, regardless of how long they had lived in permanent residential aged care (Table S5).

GP use also varied by state or territory. However, the median monthly rate of GP visits again followed the pattern observed earlier between the user groups: regardless of the state or territory, people who lived in permanent residential aged care the longest had the lowest median monthly rate of GP visits (Table S5).

What about people who have no MBS claims for GP visits?

There were around 1 in 10 people (between 8%–11%) in each of the 5 years from 2012–13 to 2016–17 who were living in permanent residential aged care but had no MBS claims for GP visits while in care.

There are several reasons why a person may not have any GP visits recorded. Some people may have visited a GP outside of their period of care in permanent residential aged care (this would particularly affect people who were in care for less than the full year). Others may access a GP through mechanisms that were not part of the available data sources. The lower rate of use of GPs observed for some groups—particularly people aged 85 and over (AIHW 2019)—may not reflect low use of GPs, but rather that they accessed GPs through these other channels more often, and the data sources did not capture this use.

For example, DVA clients' GP visits are not included in MBS claims. This means that some people who appear to have no GP visits may be receiving them through a different arrangement. To examine this potential gap, Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) data for 2016–17 were considered to identify prescriptions dispensed to people using a DVA card. This may indicate whether more people were, in fact, accessing GP services.

Many older people in permanent residential aged care are DVA clients

At 30 June 2017, there were over 26,000 DVA clients in residential aged care, accounting for 14% of people in residential aged care on that date (AIHW 2018a). To better understand the full picture of people's likely ability to access GPs while living in permanent residential aged care, PBS/RPBS data were examined.

People may access GPs through DVA-funded arrangements

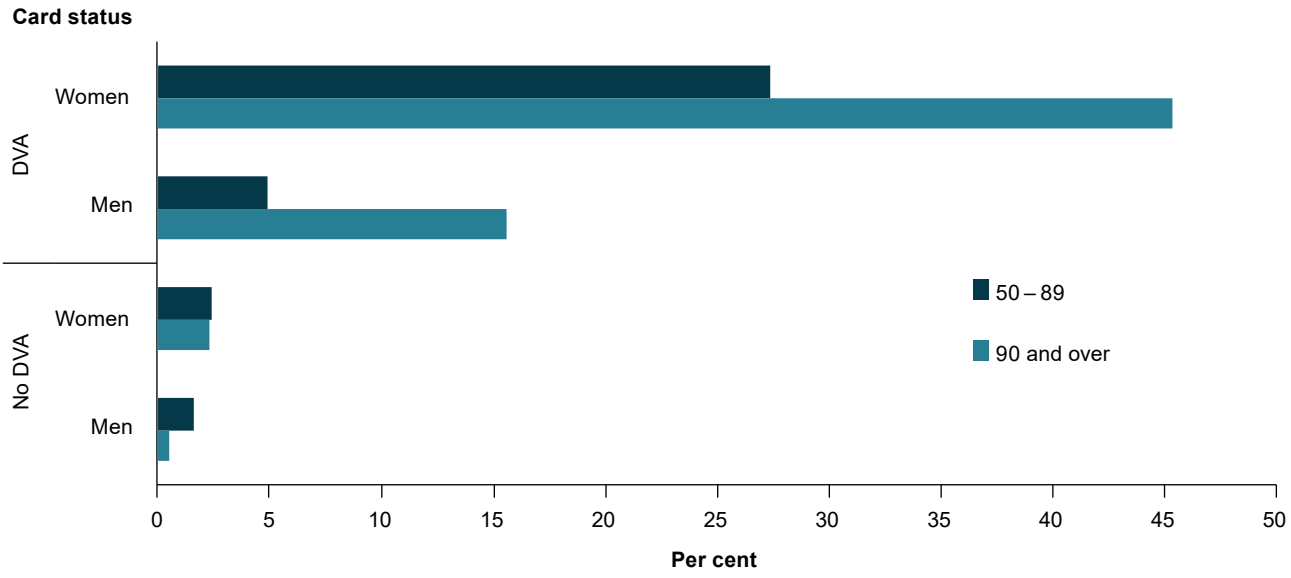
In 2016–17, 92% of people had an MBS claim for a GP visit while living in permanent residential aged care. Of the 1 in 11 (8.4%) who did not, the majority (84%) had nonetheless accessed prescriptions through the PBS/RPBS using a DVA card during the year (meaning that they would have seen a medical professional, potentially a GP, to obtain the prescription).

However, the MBS claims examined here represent the full year of data only for people who lived in permanent residential aged care for the full year, as others only used permanent residential aged care for part of the year and may have made MBS claims that were out of scope (ones that did not take place during an episode of care in permanent residential aged care).

Looking only at those people who were in the long-term use group in 2016–17 (that is, those who lived in permanent residential aged care for the full year and had not died by December 2017), 93% had an MBS claim for a GP visit. Of those 7% who did not, again the majority (93%) had accessed prescriptions using a DVA card. The linked data does not indicate whether the remaining permanent aged care residents accessed services outside of the MBS or DVA arrangements.

People in this group were commonly women and in the oldest age groups, and almost half (48%) were women aged 90 and over. Of the 7,800 people in the long-term use group who had no MBS claims for GP visits, the oldest women were also most likely to have accessed prescriptions using a DVA card. Women aged 90 and over with a DVA card accounted for 45% of people who lived in permanent residential aged care for 2016–17 and who had no MBS claims for GP visits (Figure 3).

Figure 3: People in long-term use group with no MBS claims for GP visits, by whether a DVA card was used for prescription dispensing, sex and age group, 2016–17



Source: AIHW analyses of linked aged care, MBS and PBS/RPBS data.

Combined, 99.5% people in the long-term use group in 2016–17 either made an MBS claim for a GP visit, or may have seen a GP through DVA-funded arrangements. It is not possible to establish using available linked data whether the remaining 0.5% accessed GP services through other funding mechanisms or avenues, but the resultsit suggest that very few people in permanent residential aged care do not access GP services.

How does GP use vary between aged care facilities?

People living in permanent residential aged care across Australia live in one of around 2,700 nursing homes (called facilities here). The variation in GP visits between these facilities provides another lens to examine access to GPs within permanent residential aged care. This analysis looked at the variation in MBS claims for GP visits for permanent residential aged care, but it does not take into account what other services may be available through that facility, or the characteristics of people living in a particular facility.

Comparing facilities

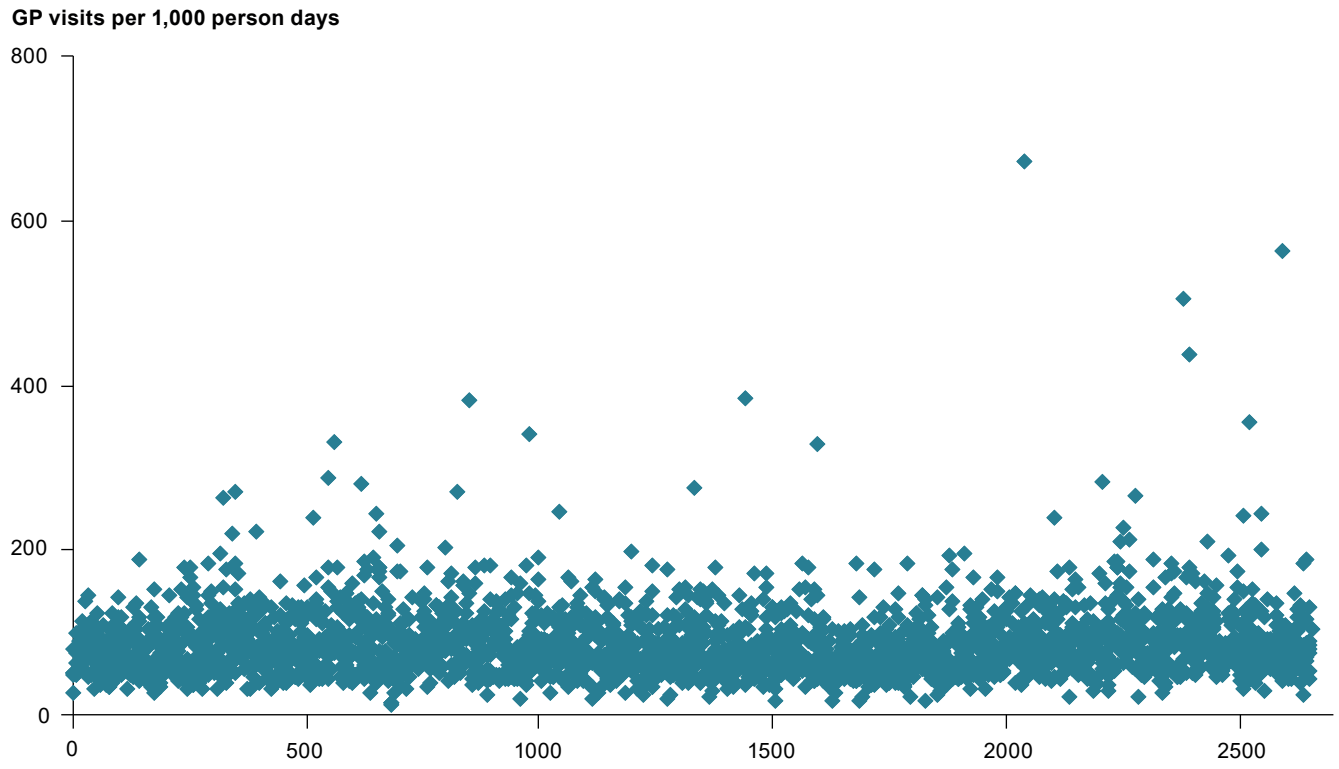
Rates of GP use for facilities were calculated by taking into account the rate of GP visits for people in each facility, as well as how many days of care that facility provided for each person. This creates a rate of GP use for each facility, presented per 1,000 days of care that the facility provided.

The facilities are grouped into service groups based on their organisation type (whether the facility is operated by a not-for-profit, private or government organisation) and the size of the facility (number of beds).

Some facilities have high rates of GP use

Across all facilities, the median rate was 79.1 GP visits per 1,000 days of care in 2016–17. Among individual facilities, the rate of GP visits varied from 12.0 to 671.3 per 1,000 person days (Figure 4).

Figure 4: GP visits by residential aged care facility, 2016–17

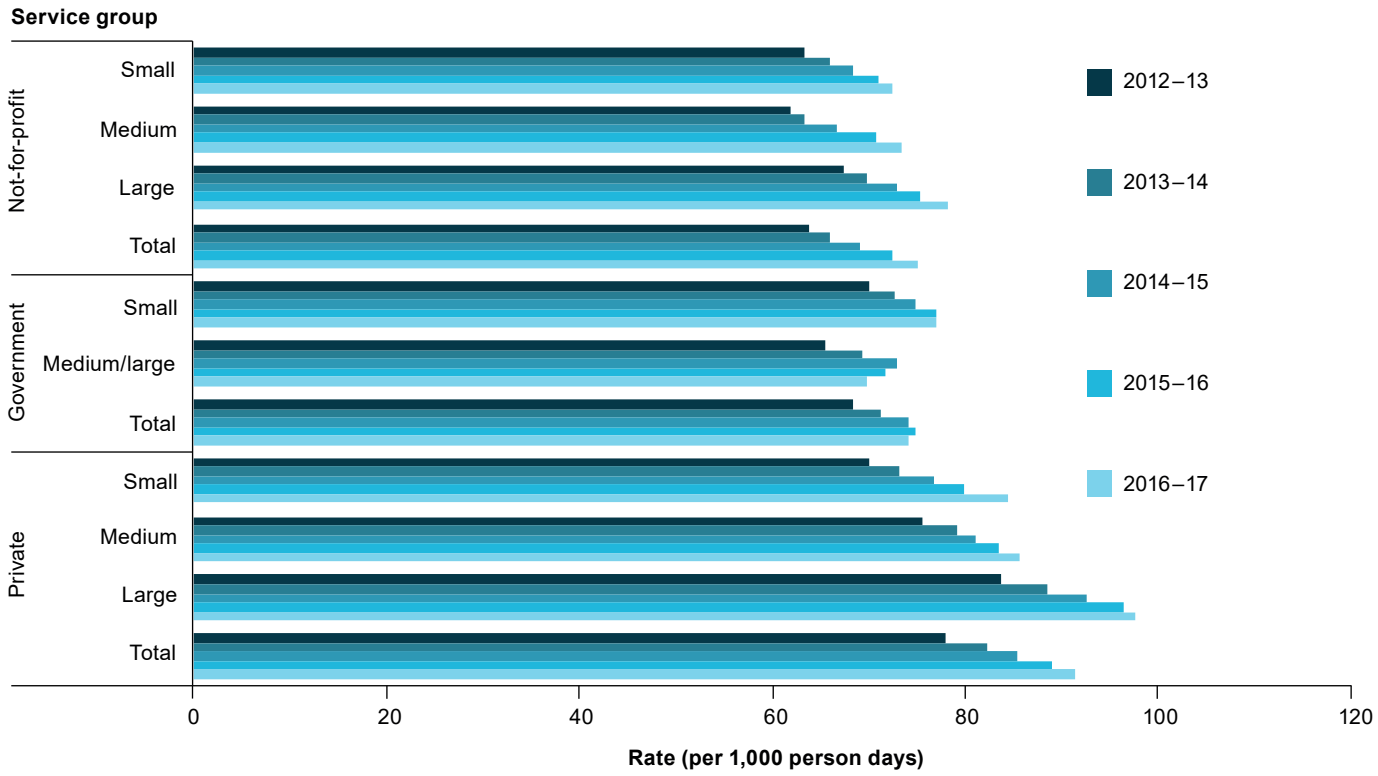


Note: Only those facilities that had operational places at 30 June 2017 and 10 or more GP visits in the year were included.
Source: Linked aged care and MBS data.

When facilities were grouped into service groups based on the ownership type and size, the variation was comparatively small: for example, in 2016–17, the rate of GP visits varied from 74.0 per 1,000 days of care in government-owned facilities to 91.3 per 1,000 person days in privately-owned facilities (Figure 5).

Over the 5 years, the rate increased for each service group, with that of large privately-owned facilities increasing the most (from 83.7 per 1,000 days of care in 2012–13 to 97.7 in 2016–17).

Figure 5: GP visits by residential aged care facility (service group), 2012–13 to 2016–17



Notes:

1. Facilities were grouped as 'small' where they had 50 or fewer operational places, 'medium' where they had 51–100, and 'large' where they had more than 101 operational places.
2. Only those facilities that had operational places at the end of each financial year (30 June) were included.

Source: AIHW analyses of linked aged care and MBS data.

Residents in most facilities see a GP

Overall, a similar proportion of facilities had no GP visits as was observed for individuals, and for half of the residential aged care facilities active at 30 June 2017, 8% or fewer of their permanent residents had no GP visits during their time in care during 2016–17.

However, the distribution also showed that there were a small number of facilities where every permanent resident had at least 1 GP visit during their stay, and there were also a small number of facilities where more than 1 in 5 (20%) permanent residents had no GP visits. This may reflect the characteristics and care needs of the residents, as well as the kinds of services provided by particular facilities. It is not known, for example, whether a facility employed a salaried GP, or specifically catered to veterans, and thus the majority of people at the facility would have been able to access GP services under non-MBS arrangements, such as through DVA arrangements.

Where can I go to for more information?

More information is included in the supplementary data tables. The AIHW reports *Interfaces between the aged care and health systems—first results* and *Interfaces between the aged care and health systems in Australia—movements between aged care and hospital 2016–17* and accompanying supplementary material also provide further information on the linked data asset.

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