

General practice and preventive health care: a view through the eyes of community members

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A key focus of recent health reform in Australia is improving the delivery of preventive care through general practice.¹ General practice is particularly well placed to deliver such care, because it is often the first point of contact that an individual has with the Australian health care system,² it provides continuing care over the life cycle³ and it is used by a large proportion of the population (nearly 90% of Australians attend a general practitioner at least annually).³

However, preventive care interventions in general practice remain underutilised,⁴ forming the primary reason for the consultation in only seven of every 100 clinical encounters.⁵ Concern has been expressed about poor uptake and impact of, and the lack of clear health outcomes⁶ from, recent financial incentives to encourage the delivery and uptake of measures for prevention of chronic disease in general practice. Pivotal to this may be that many patients are unclear about how prevention fits into their primary care consultation,⁷ and have an incomplete understanding about risks and preventive actions.⁸ Structural and organisational factors and professional behaviours may also be problematic.⁹

Our aims in this study were to explore participant engagement with preventive care delivered by GPs, and their sense of the effectiveness of that care, and to identify barriers and enablers to the uptake of preventive care in general practice through focus group discussions with community members.

METHODS

We recruited focus group participants through public notices, letterbox drops, snowballing and age-based community groups from two areas of metropolitan Melbourne identified as being of high and low socioeconomic status (SES). Focus groups were stratified by location (high or low SES), age, and sex (Box 1). Because of low participation rates in six of the initial 12 focus groups, a commercial market research company was engaged to recruit participants for a further six groups. Eighteen focus groups were therefore conducted

ABSTRACT

Objective: To identify barriers to, and enablers of, the uptake of preventive care in general practice from the perspective of community members, and to explore their sense of the effectiveness of that care.

Design, participants and setting: Qualitative study involving 18 focus groups comprising 85 community members aged over 25 years, from two areas of metropolitan Melbourne that were identified as being of high and low socioeconomic status (SES). The study was performed between 25 May and 9 December 2010. Groups were stratified by age, sex and location (high or low SES).

Main outcome measures: Factors related to practitioners, patients and structure and organisation that may act as barriers to and/or enablers of preventive care in general practice.

Results: Participants saw preventive care as legitimate in general practice when it was associated with concrete action or a test, but rated their general practitioners as poor at delivering prevention. Trust, rapport and continuity of care were viewed as enablers for participants to engage in prevention with their GP. Barriers to participants seeking preventive care through their GPs included lack of knowledge about what preventive care was relevant to them, consultations focused exclusively on acute-care concerns, time pressures and the cost of consultations.

Conclusions: A disconnect exists between patient perceptions of prevention in general practice and government expectations of this sector at a time when general practice is being asked to increase its focus and effectiveness in this field.

MJA 2011; 195: 180–183

1 Numbers of participants, stratified by age, sex and location

| Age group | Low socioeconomic status area | | High socioeconomic status area | |
|-------------|-------------------------------|-------|--------------------------------|-------|
| | Men | Women | Men | Women |
| 25–44 years | 6 | 9 | 7 | 7 |
| 45–64 years | 8 | 5 | 8 | 7 |
| > 64 years | 8 | 8 | 7 | 5 |

between 25 May and 9 December 2010, with of a total of 85 English-speaking participants. Each received a \$30 voucher in appreciation of their time. Groups were facilitated by one of the investigators and covered participant understanding and perceptions of and engagement with prevention more broadly, before focusing on preventive care in general practice and the barriers and enablers to that care. In this report we focus on the findings related to general practice.

Focus group discussions were audio-recorded and transcribed verbatim. The constant comparative method¹⁰ was used in conducting a thematic analysis.¹¹

Ethics approval for the study was obtained from the Monash University Human Research Ethics Committee.

RESULTS

Participants understood prevention to mean taking action to maintain a person's current level of health as well as acting to avoid negative health events, and described prevention as involving self-initiated health practices, such as diet and exercise, together with visiting a GP on a regular, typically annual, basis for a check-up to allow for early detection of any problems. Themes and sample quotes from focus group discussions are shown in Box 2 and Box 3.

General practitioner-related enablers and barriers to preventive care

Trust, rapport and continuity of care were key enablers. Participants viewed GPs as trusted authorities on health-related matters and felt that providing information in relation to preventive activities was a key responsibility of GPs. Having a regular GP, and being able to access services when required were viewed as central to establishing a positive rapport with their GP, which in turn facilitated discussion and receptiveness to recommendations to participate in a specific preventive care activity.

GPs were, however, perceived as being focused on acute care. Opportunistic preventive care occurred infrequently, as GPs were not generally proactive in their approach. Acknowledged causes were lack of time and resources, and concentration on diagnosis and management. Some participants described their GPs as resistant to particular preventive activities that they as patients requested (eg, flu vaccination), seemingly because the GP was not convinced of the need for such measures.

As a result of going to different GPs over time, some participants had encountered conflicting opinions in relation to preventive care (eg, using cholesterol-lowering medication or aspirin). This resulted in scepticism and uncertainty. In contrast, in those for whom secondary prevention was more pertinent, chronic disease acted as a trigger to have a regular doctor.

Patient-related enablers and barriers to preventive care

Family history was a key component of a “personal risk assessment” that participants undertook and provided a critical motivator for preventive action and increased awareness of preventive activities. Participants felt that GPs did not usually enquire about family history, and that it was therefore their responsibility to raise this. Conversely, those with no evidence of a relevant family history (eg, heart disease) felt that GP-delivered prevention was irrelevant, as they perceived their level of risk as low.

Participants felt ignorant about what prevention they needed to undertake and when. They wanted to be better informed so that they could take action. Receiving reminders or letters of invitation from their GP prompted action, particularly if these targeted their age or life-stage.

Participants were generally ambivalent about the role of prevention in prompting

2 General practitioner-centred themes and sample quotes from focus groups

Perceptions of the effectiveness of general practice-delivered preventive care

I'd say a [score of] three [out of 10], but there's nothing that they do that's preventative. Like, you just go in and say, blah, this is what's wrong with me and then they say, Here take this. Goodbye. (Woman, 44 years, high SES area)

In my case, probably not very good, probably a [score of] five [out of 10], and that's only because I ask questions. If I didn't ask questions, I probably wouldn't get any information. (Woman, 59 years, low SES area)

General practitioner-related enablers to preventive care

General practitioner recommendation

If the doctor thought that I needed it, like if I complained about low energy levels or sugar highs or lows or whatever... and if she said “you should get your blood tested”, I'd go along with it. Yeah, because if she recommended [a preventive procedure]... if [she] thinks you're going all right, [she won't] suggest it to me. So if she recommended it to me, I'd take the recommendation. (Man, 26 years, low SES area)

Rapport with general practitioner

If they have a good rapport with you, you are more likely to ask for extra things and feel more confident with them. Otherwise, it's just in out. You feel like it's a bit of an in-out production line. (Woman, 46 years, high SES area)

Trust in general practitioner

I've got a wonderful doctor... when I go [to my doctor], she goes into everything. How am I? How have I been feeling? Is anything bothering me? Is this medication good? She's absolutely wonderful, and then twice a year, I will go in, and I have to strip and she'll look over all my body for little moles. I have incredible trust in this one... she's absolutely brilliant, so I have huge trust in her. (Woman, 67 years, high SES area)

General practitioner-related barriers to preventive care

Acute-care focus

When I go to the GP, they just concentrate more on the consult that you have at that moment. They don't really [do more]. Because most of the times [when] I see [them], they are very busy and tend to finish off with you in 5 minutes. They just listen to what you have and then, Take Panadol or some other thing, because they have other patients waiting. I think we need to spend enough time actually with them and [talk about] the whys and what are the actions I can take to be more proactive. (Man, 29 years, high SES area)

Approach to prevention

One factor may be the traditional approach of medicine in the past being more detective as opposed to preventative. The preventative approach is becoming more in vogue now than it was previously, so perhaps the more old-school, traditional GP had a more detective approach. (Woman, 32 years, high SES area)

General practitioner resistance to preventive activity

He actually dissuaded me from having the flu injection. (Woman, 68 years, high SES area)

Conflicting opinions among general practitioners

My doctor put me on Astrix, you know, the very-low-dose aspirin, and then this other doctor heard about it and he said, Oh, no. Don't take them. Don't take any aspirin. They're blood thinning things. (Man, 74 years, high SES area)

SES = socioeconomic status.

an encounter with their doctor. Most reported seeing a doctor only when they needed attention for acute health problems. Patients felt that preventive care was only legitimate in general practice when it was associated with concrete actions or tests, such as cholesterol tests and Pap smears.

Many were also unaware of preventive activities that qualified for Medicare rebates (eg, the 45–49-year-old health assessment), with very few participants being offered this or similar services by their GP.

Organisational and structural enablers and barriers to preventive care

Government screening initiatives (eg, the National Cervical Screening Program and BreastScreen) were well accepted by participants, with many reporting that they were regularly screened within the specified time frame, prompted by the clear screening schedule and recall system.

Critical barriers were the difficulties patients experienced in accessing a GP (getting an appointment) and having only limited consultation time with the GP. Many felt

that if preventive care services were organised more effectively and conveniently (such as workplace-based screening programs like WorkHealth Checks run by Worksafe Victoria, which were highly praised), they would be more inclined to participate. There was a general lack of awareness of the role of practice nurses in the delivery of preventive care in the general practice setting. Consultation costs and out-of-pocket expenses were frequently cited as barriers to preventive care.

Perceptions of the effectiveness of general practice-delivered preventive care

Many participants rated their GPs effectiveness in delivering preventive care as poor because of time constraints and perceived GP focus on acute health care issues. Participants (particularly those without a regular GP) commented that preventive advice was often superficial (eg, a broad statement like “you need to lose weight” rather than specific advice), as GPs appeared complacent and did not always attempt to ascertain or address the issues underlying risk behaviours (eg, low self-esteem, relationship problems).

Findings related to age, sex and location

Younger participants were less likely to have an established relationship with a GP and, unless they had a family, did not perceive that prevention undertaken in the general practice setting (as opposed to lifestyle change) was relevant to them.

Men noted that responsibility for preventive care rested with a female family member, particularly a wife, who would prompt them to visit their GP or make appointments for preventive health activities. Many bemoaned the lack of clear screening guidelines for issues specific to men's health, such as prostate cancer.

We did not note any major differences between groups conducted in different socioeconomic areas in relation to the perceived barriers to and enablers of preventive care in general practice that were identified.

DISCUSSION

Trust in the GP (as described in other studies examining health outcomes¹²), rapport and continuity of care were principal enablers of prevention, as was having a diagnosis or family history of chronic disease. Key barriers were lack of participant knowledge

3 Patient-centred themes and sample quotes from focus groups

Patient-related enablers to preventive care

Awareness of family history

I have looked at my family health, which is not good. My father died of a heart attack when he was young, so did my mother. They both had diabetes... so it pays me to have a blood test for diabetes and if they find something they would send you for a further test. (Man, 72 years, high SES area)

Reminders to attend

This year they actually sent the reminder letter, so I had to go to my doctor, get a referral letter and then make an appointment. So that prompted me, I would have probably otherwise forgot. (Man, 32 years, low SES area)

Age- or life-stage-targeted prevention

The doctor should say, “You're getting to that age where perhaps you could consider doing this on a fairly regular basis”. (Man, 68 years, high SES area)

Encouragement from female family members

My sister actually said to me, “You really should go and get a full medical done.” Yeah, so she was probably the prime driver behind it. (Man, 60 years, low SES area)

Patient-related barriers to preventive care

Lack of awareness of preventive activities

I think prevention requires some identification, but you can't prevent it if you don't know that it even exists, so someone has to identify it, what the problem is. (Woman, 65 years, high SES area)

Acute-care focus

People don't often perceive your primary care setting as... something that you go to, to prevent getting sick. In other words, I basically go to the doctor when I am sick. You know, doctors are really busy and you don't want to sit there and make an appointment and ask how [you] can avoid getting diabetes and avoid getting sick, high blood pressure and that sort of thing. (Woman, 42 years, high SES area)

Time

Other than being sick I rarely [go] to my GP because it's not only [attending], it's just trying to get an appointment, having time to go and I know it's just one appointment for 20 minutes but still I find that I'm just so busy with so many other things. (Woman, 28 years, low SES area)

Organisational and structural enablers to preventive care

Established government-screening initiatives

The Pap smear register and BreastScreen Victoria, all those sort of things that send you out reminders. (Woman, 58 years, low SES area)

Organisational and structural barriers to preventive care

Cost of consultation

I'll sit through the 2-hour wait if they bulk-bill me. I'm happy to do that but the closest doctor to me, where I can be bulk-billed is... an hour on the bus... and if it's late at night, there are no buses. (Woman, 43 years, low SES area)

Prevention, it has to be affordable. For example, if you go to a doctor that bulk-bills, it's OK. But if you have to go to a doctor that doesn't bulk-bill eventually it costs people a lot of money. (Woman, 59 years, low SES area)

SES = socioeconomic status.

about preventive care relevant to them and lack of awareness of the Medicare initiatives available to support preventive care in general practice. Other factors such as consultations being focused exclusively on acute-care concerns, time pressures and the cost of consultations were consistent with results of earlier studies.^{13,14}

Our findings indicate that the strategy of refocusing primary health care towards prevention¹⁵ is only in its infancy and requires more support from policymakers, organisations and GPs themselves. It also suggests that patients need to be involved in

this conceptual shift towards prevention, with initiatives aimed at enhancing health literacy and engagement in preventive care through general practice or other health care providers. An example of a future such initiative may be development and implementation of a consumer guide to resources such as the Royal Australian College of General Practitioner's Redbook Guidelines for preventive activities in general practice.¹⁶

A framework has previously been proposed to explore patient perceptions of general practice care, consisting of the domains of first contact care, longitudinality, coordi-

nation of care, comprehensiveness and the doctor–patient relationship.¹⁷ Of these five domains, participants spoke most about the doctor–patient relationship as central to their decision making about whether to pursue the preventive activities suggested. This has implications for policy changes that support preventive activities by practitioners other than GPs, such as nurses who are trusted by patients, and whose role in prevention is cost-effective¹⁸ and acceptable to patients with specific disease states.^{19,20} It also confirms the need by GPs to identify relevant family history,²¹ and to integrate this with an individual's clinical history and lifestyle risk factors to develop, coordinate and facilitate a clear program of preventive activity.

Despite the self-selection bias that may limit our results and the fact that we did not gather information about the general practice or practitioner participants attended, our study is strengthened by the fact that we incorporated the views of participants of a wide range of ages. The extent to which our findings can be generalised to national and international contexts may also be limited, because the study was conducted in a single metropolitan region of Australia. In addition, we did not ask participants to rank the barriers and enablers they described in terms of importance.

Determining the barriers and enablers to closing gaps in evidence-based practice is essential to planning effective interventions.²² It is also essential for improving the delivery of prevention in primary care. Pertinent to the current Australian context, our study reveals a dissonance between community perceptions of prevention in general practice and government expectations of this sector of the health care system. Policymakers and the profession will need to take heed of these perceptions and respond to these concerns. Although not the subject of our study, the views and perceptions of the profession in this quest are equally important.

COMPETING INTERESTS

None relevant to this article declared (ICMJE disclosure forms completed).

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(Received 9 May 2011, accepted 7 Jul 2011) □