

# 13 Enhanced Primary Care

## Background

Acknowledging the importance of managing chronic conditions in primary care, the Federal government introduced the Enhanced Primary Care (EPC) package in November 1999. The program aims to improve the health and wellbeing of older Australians, and those with chronic and complex care needs by remunerating GPs specifically for the care of these patients.<sup>69</sup> One of the major features of the EPC program includes the provision of new MBS items for GPs to provide services to the older and chronically ill populations in Australia. The items cover three broad areas:

- voluntary, annual health assessments for those aged 75 years and over
- preparation of, involvement in or review of care plans by GPs for those patients with chronic and complex care needs
- organisation of or involvement in case conferences for patients with chronic and complex care needs.<sup>69</sup>

While health assessments are limited to those aged 75 years and over, the MBS items for care plans and case conferences are not restricted by age, although they are recommended for patients aged 65 years and over.<sup>110</sup>

The items were welcomed by the GP community in Australia who had, until then, not received incentives or remuneration specifically to care for the elderly and chronically ill populations.<sup>70</sup> Very few studies have been published concerning the effectiveness of the EPC program, and, of these, most have been confined to small population groups, bringing into question the generalisability of the results.

Health assessments, specifically targeted towards the older population in Australia, are defined as 'the assessment of a patient's health and physical, psychological and social function'. The tools used for assessment are at the discretion of the GP. 75+ Health assessments aim to assist older and elderly people remain independent in the community for as long as they are able. They may be conducted in the doctor's surgery or at the patient's home.<sup>111</sup>

Various studies have been conducted, both in Australia and internationally, evaluating the effectiveness of such health assessments for older people. The results show considerable variation in the outcomes of health assessment. Results from a meta-analysis of trials studying health assessments found that those based in the home contributed to decreased mortality. It was also found that these assessments reduced the number of people admitted to hospital and other aged care facilities, while assessments conducted in places other than the home did not significantly contribute to improved health outcomes.<sup>112</sup> In contrast, a systematic review of research into health assessments based in the home found that only half the studies examined reported positive outcomes as a result of the health assessment.<sup>113</sup>

In a similar Australian review it was reported that the positive outcomes as a result of health assessments for older people could be attributed to the fact that the populations eligible for the assessments were well defined in terms of age, usually being restricted to those aged at least 75 years. However, a lack of consistency in the methods used to conduct health assessments was also identified.<sup>114</sup>

A review of the effectiveness of the EPC items for health assessments found that patients who had health assessments performed were more likely to be immunised, and to have problems the authors described as 'non-medical' (for example psychological and social problems).<sup>115</sup>

Anecdotal evidence and published research have shown that the EPC items have proven difficult to implement in everyday general practice. Barriers to their implementation into everyday general practice, particularly in relation to care plans and case conferences (which must be multidisciplinary) include difficulties in the organisation and coordination of members of the multidisciplinary team, time limitations, and the perception that government requirements are often too arduous to make the incentives worthwhile.<sup>71-73</sup>

However, studies have shown that GPs who have claimed for care planning and case conferencing EPC items found these to be useful for the management of their patients with chronic and complex care needs.<sup>71</sup> Other GPs reported having conducted care plans and case conferences in the normal course of their work without claiming the Medicare fee available, due to the laborious government requirements.<sup>73</sup>

The reported reluctance of GPs to use the items due to government requirements may be in part due to the many changes in the definition and funding over the course of the scheme. For example, in February 2001 the EPC items for care planning were added to the Practice Incentives Program (PIP), which enabled GPs who completed care plans for at least 10% of their practice aged 65 years and over (the reference population) to gain an additional payment (through PIP) on top of payments given for the EPC items.<sup>116,117</sup> This incentive led to a rise of almost 420% in care plan claims for the nine months after the incentive was introduced, and in April 2002 the Federal government announced that, as a result of the success of the incentive, the PIP payment would be withdrawn in November 2002, one year earlier than planned.<sup>118</sup>

A recently published set of papers evaluating EPC items using the HIC dataset of EPC claims found that the majority of EPC items claimed by GPs in the first two years of the program were health assessments, with most of these taking place in the GPs' rooms. The rising trend over time towards care plans was noted, rising particularly after the introduction of the PIP payments.<sup>119</sup>

GPs claiming EPC items were found to be younger. A particular concern for the authors surrounded the fact that almost half the EPC item claims were from a small number of GPs. They concluded that these figures may indicate either that GPs were discerning when choosing patients eligible for EPC items, or that large numbers of GPs question the usefulness of EPC items.<sup>120</sup> Patients for whom EPC items were claimed were found to be 'older', defined in these studies as aged 55 years or more.<sup>121</sup>

## **Objectives**

The objectives of this chapter are to:

- determine the representativeness of the BEACH sample in relation to EPC items
- determine the distribution of GPs who recorded EPC items in BEACH
- determine the age and sex distributions of patients for whom EPC items were recorded, by each type of EPC item
- report the morbidity managed at encounters where EPC items were recorded, for each type of EPC item.

## Method

This chapter examines only those encounters in BEACH for which an EPC item was recorded. The items examined included:

- 75+ health assessments—items 700, 702
- care plans—items 720, 722, 724, 726, 728, 730
- case conferences—items 734, 736, 738, 740, 742, 744, 746, 749, 757, 762, 765, 768, 771, 773, 775, 778, 779.

To test the representativeness of the BEACH sample of EPC items, all EPC items claimed through the HIC were examined,<sup>97</sup> and the two sources of data compared.

## 13.1 Comparison of BEACH dataset with national data

### EPC items claimed through the HIC

Table 13.1 shows the frequency of EPC items claimed through the Health Insurance Commission (HIC) during the two-year period between April 2000 and March 2002.

A total of 515,958 claims were processed by the HIC for EPC items over these two years. Of these, the majority were for health assessments (48.8%), followed by claims made for care plans (48.4%). Very few claims were made for contributions to case conferences (2.7%).

Claims for EPC items through the HIC increased threefold between the first and second year examined, from 126,485 claims between April 2000 and March 2001, to 389,473 between April 2001 and March 2002.

In the first year (April 2000 to March 2001), the vast majority of EPC items processed were health assessments for patients aged 75 years and over (76.5%). Care plans made up 20.2%, and case conferences only 3.3%. Between April 2001 and March 2002 the distribution of EPC items changed extensively. As a proportion of the total, care plans were the most frequently claimed (57.6%), while health assessments made up 39.9% of EPC items and case conferences remained uncommon, representing only 2.5% of EPC items processed.

It is interesting to note the trends in EPC items processed over the study period. While total EPC items increased numerically from the first year to the second, the rate of increase differed between groups. In 2001–02, the number of care plans processed was nine times the number processed in the first year. While the number of health assessments processed increased by only about 50%, this group still constituted a large proportion of EPC items claimed for the year. The number of case conferences processed doubled, but remained only a small proportion of total items processed (Table 13.1).

**Table 13.1: EPC items processed through HIC—April 2000 to March 2002**

EPC item type	2000–01		2001–02		Total 2000–02	
	Number	Per cent <sup>(a)</sup>	Number	Per cent <sup>(a)</sup>	Number	Per cent <sup>(a)</sup>
75+ health assessments	96,702	76.5	155,261	39.9	251,963	48.8
Care planning	25,600	20.2	224,376	57.6	249,976	48.4
Case conferencing	4,183	3.3	9,836	2.5	14,019	2.7
<b>Total (n, %)</b>	<b>126,485</b>	<b>100.0</b>	<b>389,473</b>	<b>100.0</b>	<b>515,958</b>	<b>100.0</b>

(a) Percentages may not equal 100.0 due to rounding.

## EPC items recorded in BEACH

Table 13.2 shows the frequency and relative rates of EPC items recorded in the BEACH survey over the same period (April 2000 to March 2002). While the overall rate of EPC items recorded in BEACH increased significantly from the first (0.1%, 95% CI: 0.05–0.12) to the second year (0.2%, 95% CI: 0.15–0.31), the rates in both years were extremely low, representing a very small proportion of total GP claims.

Overall, health assessments were the most frequently recorded, with 177 health assessments claimed during the two-year period. Items for care plans were also recorded at a relatively high frequency, with 126 plans recorded, while very few case conferences were recorded during this period.

As already discussed, the EPC package was introduced in November 1999. Thus, at the beginning of the period examined (April 2000), the package had been implemented for only five months. The frequency of EPC items was quite low in the first year, health assessments for those patients aged 75 years and over being the most frequently recorded EPC item, accounting for 84.1% of total EPC items claimed (Table 13.2).

Both care plans and health assessments were recorded more frequently in the second year, with the frequency of care plans increasing more than tenfold from the previous recording year. Health assessments also increased from 74 in the first year to 103 in the second year. However, as a proportion of the total EPC items recorded, health assessments declined from 84.1% in the first year to 46.4% in the second year examined. The number of case conferences recorded was very low over the two years, and did not reflect the increasing usage for the other EPC items (Table 13.2).

EPC items comprised 0.1% and 0.2% as a proportion of total encounters in BEACH. Extrapolated to all encounters in Australia, this equals only 300,000 encounters, whereas 515,958 encounters were actually claimed through the HIC over the same period. Therefore, BEACH underrepresents EPC encounters overall and this is due to the relative infrequency of these events in general practice and their skewed distribution across only a proportion of active GPs. However, looking at each type of EPC item claimed, numbers recorded in BEACH are proportionally similar to those claimed overall.

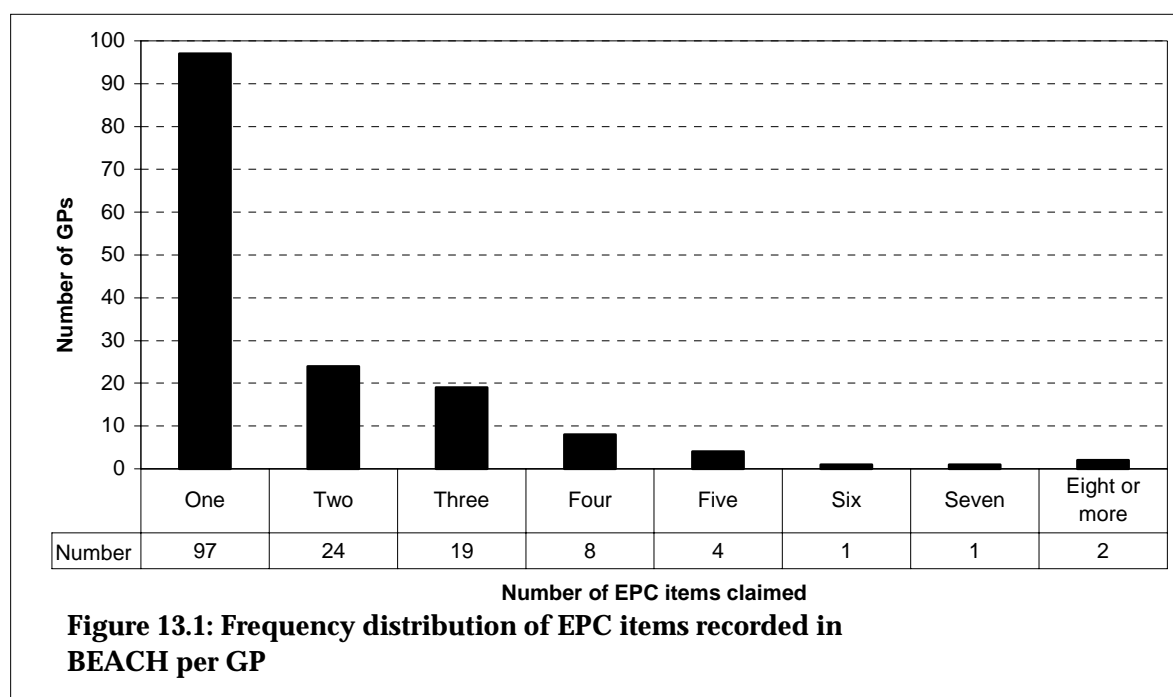
**Table 13.2: Frequencies of EPC items recorded in BEACH**

EPC item type	2000–01		2001–02		Total 2000–02		Relative rate
	Number	Per cent <sup>(a)</sup>	Number	Per cent <sup>(a)</sup>	Number	Per cent <sup>(a)</sup>	
75+ health assessments	74	84.1	103	46.4	177	57.1	0.69
Care planning	10	11.4	116	52.3	126	40.6	0.06
Case conferencing	4	4.5	3	1.4	7	2.3	0.00
<b>Total (n, %)</b>	<b>88</b>	<b>100.0</b>	<b>222</b>	<b>100.0</b>	<b>310</b>	<b>100.0</b>	—
<b>Per cent of total encounters</b>	—	<b>0.1</b>	—	<b>0.2</b>	—	<b>0.2</b>	—

(a) Figures may not equal 100.0 due to rounding.

## 13.2 Distribution of EPC items in BEACH across GPs

The 310 EPC items recorded in the BEACH study between 2000 and 2002 (Table 13.2) were recorded by only 8.0% of the total GP sample ( $n = 156$ ). Of those GPs who recorded EPC items, over half (97 GPs) recorded only one EPC in their 100 encounters sampled for BEACH (Figure 13.1). Twenty-four GPs recorded two EPC items, while 19 GPs recorded three items. Only eight GPs recorded five or more EPC items. One GP recorded 35 EPC items in the 100 encounters recorded for BEACH.



## 13.3 75+ health assessments

### Age and sex distribution

The Federal Government stipulates that health assessments for the elderly must only be performed for patients aged 75 years and over.<sup>111</sup> Table 13.3 gives the age and sex distribution of patients at encounters where health assessments were performed. Of the 177 health assessments recorded in BEACH, there were three assessments claimed for patients who were aged less than 75 years. The majority (49.2%) were for patients aged between 75 and 79 years. One-quarter (26.6%) were performed for patients aged 80 to 84 years, while forty (22.6%) were made for patients aged 85 years or more. Patients aged between 75 and 79 years, and 85 and 89 years, were the most likely groups to have health assessments performed, with age-specific rates of 0.75 and 0.80 respectively. The least likely group eligible to have health assessments performed was those aged between 90 and 94 years (age specific rate: 0.45). The sex-specific rates for health assessments were identical for both males and females at 0.11 (Table 13.3). It is interesting to note that 65.0% of 75+ health assessments recorded in BEACH were performed in the surgery, with the remainder done in the patient's home (results not presented).

**Table 13.3: Age and sex distribution of patients for whom health assessments were performed**

Age group	Males		Females		Missing	Total		Age-specific rates <sup>(b)</sup>
	Number	Per cent <sup>(a)</sup>	Number	Per cent <sup>(a)</sup>		Number	Per cent <sup>(a)</sup>	
Less than 75	1	1.4	2	1.9	—	3	1.7	0.00
75–79	43	60.1	44	42.7	—	87	49.2	0.75
80–84	18	25.4	28	27.2	1	47	26.6	0.60
85–89	8	11.3	23	22.3	2	33	18.6	0.80
90–94	1	1.4	6	5.8	—	7	4.0	0.45
<b>Total (n, %)</b>	<b>71</b>	<b>100.0</b>	<b>103</b>	<b>100.0</b>	<b>3</b>	<b>177</b>	<b>100.0</b>	—
<b>Sex-specific rates<sup>(b)</sup></b>	<b>0.11</b>	—	<b>0.11</b>	—	—	—	—	—

(a) Figures may not add to 100.0 due to rounding.

(b) The age-specific or sex-specific rate is the number of health assessments divided by the total number of encounters, for each sex or age group.

### Diagnostic frequencies

There was a very broad range of problems recorded during general practice encounters where health assessments were recorded, with low relative rates of any specific individual diagnoses. Therefore, diagnostic frequencies have been reported according to their chapter in ICPC-2 (see Chapter 2 Methods), together with the most frequent individual diagnoses and the proportion of the total diagnoses they comprised.

During the 177 health assessments recorded in BEACH 2000–02, 286 problems were managed. Almost half of the problem labels related to the general and unspecified chapter of ICPC-2 (47.9% of the total), of which the majority of individual diagnoses related to the

term 'health assessment', such as partial (23.8% of the total) and complete (15.7% of the total) health evaluations (Table 13.4).

**Table 13.4: Diagnostic frequency of problems managed in health assessments for patients aged 75 years and over by ICPC-2 chapter**

Chapter	Number	Per cent of total problems managed
<b>General and unspecified</b>	<b>137</b>	<b>47.9</b>
Health evaluation (partial)	68	23.8
Health evaluation (complete)	42	15.7
<b>Blood, blood forming</b>	<b>1</b>	<b>0.3</b>
<b>Digestive</b>	<b>9</b>	<b>3.1</b>
Oesophageal disease*	3	1.1
<b>Eye</b>	<b>3</b>	<b>1.0</b>
<b>Ear</b>	<b>2</b>	<b>0.7</b>
<b>Cardiovascular</b>	<b>46</b>	<b>16.1</b>
Hypertension*	29	10.1
Ischaemic heart disease*	4	1.4
<b>Musculoskeletal</b>	<b>15</b>	<b>5.2</b>
Osteoarthritis*	4	1.4
<b>Neurological</b>	<b>4</b>	<b>1.4</b>
<b>Psychological</b>	<b>10</b>	<b>3.5</b>
Dementia	3	1.0
<b>Respiratory</b>	<b>12</b>	<b>4.2</b>
Immunisation; influenza*	7	2.6
<b>Skin</b>	<b>21</b>	<b>7.3</b>
Carcinoma, skin	4	1.4
<b>Endocrine, metabolic and nutritional</b>	<b>9</b>	<b>3.1</b>
Diabetes*	3	1.0
Lipid disorder*	3	1.0
<b>Urinary</b>	<b>13</b>	<b>4.5</b>
Urinary tract infection	7	2.4
<b>Female genital</b>	<b>2</b>	<b>0.7</b>
<b>Male genital</b>	<b>1</b>	<b>0.3</b>
<b>Social problems</b>	<b>1</b>	<b>0.3</b>
<b>Total</b>	<b>286</b>	<b>100.0</b>

\* Includes multiple ICPC-2 or ICPC-2 PLUS codes.

Note: Figures may not equal 100.0 due to rounding.

Almost one in six diagnoses related to the cardiovascular system (16.1%), and of these, hypertension was by far the most frequently recorded, representing 10.1% of the total problems managed during health assessments.

'New' problems that had not previously been managed by the GP were managed at a relative rate of 20.1 per 100 encounters (results not tabled).

Problems relating to the skin chapter accounted for 7.3% of problems managed, and 4.5% related to the urinary system (Table 13.4).

## Management techniques

This section provides an overview of the outcomes of encounters at which health assessments were recorded. As shown in Table 13.5, medications were prescribed to patients at a rate of 87.6 per 100 health assessment encounters. Of these, over one in five were for the prescription of a new medication (20.3 per 100 health assessment encounters). Non-pharmacological treatments (such as advice/counselling or minor procedures) were also provided at one in five health assessments (20.9 per 100 health assessment encounters). Referrals were given at a rate of 13.0 per 100 health assessment encounters, while investigations were ordered at a rate of 32.2 per 100.

**Table 13.5: Management techniques provided at encounters where health assessments were recorded**

Treatment type	Health assessments ( <i>n</i> = 177)		
	Rate per 100 encounters	95% LCL	95% UCL
Total medications	87.6	62.7	112.5
New medications	20.3	8.7	32.0
Non-pharmacological treatments	20.9	11.2	30.6
Referrals	13.0	6.3	19.7
Investigations	32.2	17.8	46.6

Note: LCL—lower confidence limit; UCL—upper confidence limit.

## Discussion

The rate of medications given during health assessments was significantly lower than the rate of medications given at encounters with all patients aged 75 years and over. Of those, over one-fifth were new medications. In the requirements of health assessments, it is specified that a medication review is to occur.<sup>111</sup> It may be that, on review, GPs are identifying inappropriate medication interactions, or problems that require treatment by additional medication.

Investigations were ordered at a rate of 32.2 per 100 encounters. The requirements for health assessments state that health assessments should not be a form of health screening.<sup>111</sup> The high rate of investigations may indicate, therefore, that problems are being identified that require further investigation during health assessments.

Non-pharmacological treatments were given during health assessments at significantly lower rates than overall at encounters with patients aged 75 years or more. This result was not expected, and may indicate that GPs, while looking holistically at patient health during health assessments, feel that advice/education or procedural treatments would be better addressed during subsequent encounters.

## 13.4 Care plans

### Age and sex distribution

While recommended for older patients, care plans have not been restricted to any age group. Therefore, GPs are able to contribute to multidisciplinary care plans for patients of any age meeting the 'chronic and complex' criteria stipulated.<sup>111</sup>

Of the 126 care plans recorded in BEACH, half were prepared for patients aged 65 years and over, and half for those aged less than 65 years (Table 13.6). Despite this, the age-specific rates of care plan preparation were quite different. Patients aged between 65 and 74 years were the most likely to receive a care plan, with an age-specific rate of 0.14. The age-specific rate of care plan preparation was a little lower (0.10) for patients aged 75 years and over, while patients aged less than 65 years were the least likely to have a care plan prepared (0.04).

Overall, the sex-specific rates show that males were more likely than females to have care plans prepared (0.09 for males compared with 0.06 for females), despite the fact that more care plans were prepared for females than males (63 compared with 60 care plans) (Table 13.6).

**Table 13.6: Age and sex distribution of patients for whom care plans were prepared**

Age group	Males		Females		Missing	Total		Age-specific rates <sup>(b)</sup>
	Number	Per cent <sup>(a)</sup>	Number	Per cent <sup>(a)</sup>		Number	Per cent <sup>(a)</sup>	
Less than 65	29	48.3	33	52.4	1	63	50.0	0.04
65–74	20	33.3	15	23.8	1	36	28.6	0.14
75+	11	18.3	15	23.8	1	27	21.4	0.10
<b>Total (n, %)</b>	<b>60</b>	<b>100.0</b>	<b>63</b>	<b>100.0</b>	<b>3</b>	<b>126</b>	<b>100.0</b>	—
<b>Sex-specific rates<sup>(b)</sup></b>	<b>0.09</b>	—	<b>0.06</b>	—	—	—	—	—

(a) Figures may not equal 100.0 due to rounding.

(b) The age-specific or sex-specific rate is the number of health assessments divided by the total number of encounters, for each sex or age group.

### Diagnostic frequencies

There was a very broad range of problems recorded during general practice care plan encounters, with low relative rates of any specific individual diagnoses. Therefore, diagnostic frequencies have been reported according to their chapter in ICPC-2 (see Chapter 2 Methods), together with the most frequent individual diagnoses and the proportion of the total diagnoses they comprised. Only diagnostic frequencies for patients aged 65 years and over have been reported in this section, in keeping with the focus of this report.

There were only 63 care plans recorded for patients in this age group, for which 101 problems were recorded. The majority were related to the endocrine, metabolic and nutritional chapter of ICPC-2, comprising 41.6% of the total problems managed (Table

13.7). Within this chapter, diabetes was the most frequent individual problem managed, at 36.6% of encounters where care plans were recorded.

Problems related to the general and unspecified chapter of ICPC-2 were the next most frequently recorded in care plans (17.8% of the total). Within this group the term 'administrative documentation' was the highest recorded individual problem label, accounting for 5.9% of the total problems recorded during encounters where care plans were claimed (Table 13.7).

Problems related to the cardiovascular system comprised 11.9% of the problems recorded in encounters related to care plans. Within this chapter, the vast majority of diagnoses were hypertension (8.9% of the total problems managed).

Musculoskeletal problems made up 7.9% of the problems. Osteoarthritis was the most frequent individual problem in this group, accounting for 2.0% of total problems recorded (Table 13.7).

**Table 13.7: Diagnostic frequencies of problems managed in care plans for patients aged 65 years and over by ICPC-2 chapter**

Chapter	Number	Per cent of total problems managed
<b>General and unspecified</b>	<b>18</b>	<b>17.8</b>
Admin; document	6	5.9
<b>Digestive</b>	<b>4</b>	<b>4.0</b>
<b>Eye</b>	<b>1</b>	<b>1.0</b>
<b>Cardiovascular</b>	<b>12</b>	<b>11.9</b>
Hypertension*	9	8.9
<b>Musculoskeletal</b>	<b>8</b>	<b>7.9</b>
Osteoarthritis*	2	2.0
<b>Neurological</b>	<b>4</b>	<b>4.0</b>
<b>Psychological</b>	<b>6</b>	<b>5.9</b>
<b>Respiratory</b>	<b>1</b>	<b>1.0</b>
<b>Skin</b>	<b>1</b>	<b>1.0</b>
<b>Endocrine, metabolic and nutritional</b>	<b>42</b>	<b>41.6</b>
Diabetes*	37	36.6
<b>Urological</b>	<b>2</b>	<b>2.0</b>
<b>Male genital</b>	<b>1</b>	<b>1.0</b>
<b>Social problems</b>	<b>1</b>	<b>1.0</b>
<b>Total</b>	<b>101</b>	<b>100.0</b>

\* Includes multiple ICPC-2 or ICPC-2 PLUS codes.

Note: Figures may not equal 100.0 due to rounding.

## Management techniques

Medications were prescribed at a rate of 92.1 per 100 care plan encounters. New medications accounted for 17.3% of these, being prescribed at a rate of 15.9 per 100 care plan encounters. Non-pharmacological treatments were provided at one-third of the

encounters where care plans were recorded (33.3 per 100 encounters), while referrals were made at a rate of 31.7 per 100 and investigations ordered at a rate of 44.4 per 100 (Table 13.8).

**Table 13.8: Management techniques provided at encounters where care plans were recorded**

Treatment type	Care plans ( <i>n</i> = 63)		
	Rate per 100 encounters	95% LCL	95% UCL
Total medications	92.1	44.4	139.7
New medications	15.9	3.1	28.7
Non-pharmacological treatments	33.3	10.0	56.7
Referrals	31.7	0.1	63.4
Investigations	44.4	20.3	68.6

Note: LCL—lower confidence limit; UCL—upper confidence limit.

## Discussion

Medications were given at a rate of 92.1 per 100 encounters, with almost one-fifth of these being new medications. This may indicate that the GP, after consultation with other care providers, is adjusting the patient’s medication, or providing new medications that the care plan team feels are appropriate for the patient.

Non-pharmacological treatments were provided to older patients at one-third of care plan encounters. Considering that the patient was present at the majority of care plan encounters, this may indicate that the GP is providing counselling or giving advice to the patient about the plan or, as a result of the care plan, educating the patient about areas identified during the care plan as being appropriate for the patient, e.g. dietary advice.

While not statistically significant due to the small sample of care plans, referrals were given at a very high rate during care plans. This may suggest that the multidisciplinary team, looking at the patient’s health from multiple perspectives, identifies the need for other providers to be included in the care process, in accordance with the specifications of care plans, which state that the care plan team should investigate the types of services or treatment the patient may require.<sup>111</sup>

## 13.5 Case conferences

No age and sex distributions have been stated for case conferences, due to the small numbers recorded in BEACH.

### Diagnostic frequencies

Of the seven case conferences performed for patients aged 65 years and over, only seven problems were recorded (Table 13.9). Of these seven, one related to the general and unspecified chapter of ICPC–2, and was recorded as an administrative procedure rather than a diagnosis. Of the other problems managed, two were psychological. Other problems recorded in case conferences related to the cardiovascular, neurological and male genital systems, while the remaining diagnosis was a social problem.

**Table 13.9: Diagnostic frequency of problems managed in case conferences for patients aged 65 years and over by ICPC-2 chapter**

Chapter	Number	Per cent
General and unspecified	1	14.3
Cardiovascular	1	14.3
Neurological	1	14.3
Psychological	2	28.6
Male genital	1	14.3
Social problems	1	14.3
<b>Total</b>	<b>7</b>	<b>100.0</b>

*Note:* Figures may not equal 100.0 due to rounding.

## Summary

This chapter has demonstrated that BEACH provides a representative sample of encounters where EPC items were claimed. The majority of GPs recorded only one EPC item in the 100 encounters recorded for BEACH. The age and sex distributions for health assessments have shown that the group most likely to have had a health assessment performed are those aged between 85 and 89 years, while both males and females had an equal likelihood of having a health assessment. The age group most likely to have a care plan performed were those aged between 65 and 74 years, but half the care plans recorded in BEACH were for patients aged less than 65 years.

Diagnostic frequencies recorded for EPC items showed that the majority of problem labels recorded in health assessments were administratively based, while for care plans, conditions from the endocrine and metabolic system (e.g. diabetes) were the most frequently recorded. Very few case conferences were recorded in BEACH, reflecting the slow uptake of this type of EPC item by GPs.

These issues will be examined in further detail in Chapter 14 Discussion.