11 Patient employment status and occupation

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: Employment status, occupation, problems managed for retirees, unemployed and occupational groups

Sample: 4,385 encounters from 110 GPs; data collection period: 30/03/1999 – 30/04/1999

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distribution of the respondents was similar to the expected distribution of general practice patients, with the majority (58.1%) being female.

 Of the 4,385 respondents, 59.8% were not in the labour force. Those not in the work force were mainly retirees (22.9%) and students (19.7%).

The main industries that the respondents in the work force were currently employed in were retail trade (15.4%), manufacturing (11.8%) and health and community services (11.7%).

Current occupation was analysed using the Australian Standard Classification of Occupations (ASCO) major groups, subgroups and individual occupations. Current occupation by major group showed most patients describing themselves as 'intermediate clerical/sales/service' workers (20.0%), followed by 'professionals' (17.3%). The most common current occupations at the ASCO 6 digit level were 'sales assistant' (8.0%), 'general clerk' (6.7%) and 'school teacher' (2.8%).

Problems managed at the consultation were analysed in relation to the occupation group and employment status of the patient and compared with problems managed at all patient encounters from the same period.

For all respondents, the most common problems managed were immunisation, upper respiratory tract infection and hypertension. Hypertension was managed at a lower rate for employed patients than for all respondents but managed at a significantly greater rate for retirees (17.0 per 100 encounters, CI: 13.0–20.9) than for all respondents (6.9 per 100, CI: 5.4–8.4). Back complaints were managed at an apparently higher rate amongst labourers (5.4 per 100 encounters) than amongst all respondents (2.2) but number of encounters with labourers were too small to test for significance. Likewise, depression (4.1) was managed at an apparently higher rate for professionals than for all respondents (2.9).

For other related abstracts see: 6 Employment status and workers' compensation claims, 80 Employment status and workers compensation claims in general practice patients.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **OCCUPATION & SMOKING STATUS.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Occupation and work activities

Ask patients (aged 15 years or more) each of the four questions about occupation and work. Two examples are shown below.

Example 1: Chris has worked for many years as a factory worker in a clothing company.

Current occupation:	*Process worker*
Industry of current employment:	*Clothing*
Main lifetime occupation:	*Process worker*
Main work activity:	*Making clothing*

Example 2: The second, Pat was the manager of a retail outlet until recently being retrenched.

Current occupation:	*Unemployed*
Industry of current employment:	*None*
Main lifetime occupation:	*Manager*
Main work activity:	*Running hardware store*

Patient's current employment status

Ask all patients aged 15 years or over, how they would describe their current employment status?

(Including part-time and casual employment)

Select ONE category only.

NB: **Main work activity** may be thought of as the *main tasks* performed by the person in their work. The aim of this question is to help us clarify occupation.

Work activity usually relates to **current occupation**. However, if the patient is retired or unemployed, then work activity relates to their **main lifetime occupation.**

Smoking status
Ask patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

Hours in paid employment

Ask all patients how many hours they would spend in paid jobs each week, on average.
(Including casual work).

Write the number of hours in the box shown.

PATIENTS 15yrs+: How would you describe your current employment status?

Self-employed	1	Student & not working	6
Employed by other	2	Retired	7
Unemployed	3	Unable to work due to health problems	8
Home duties	4	Other (specify)	9
Student & working	5		

How many **hours** do you normally spend in all paid jobs each week? ☐ hrs per week

What is your current occupation?

In what industry are you currently employed?

What was/is your main lifetime occupation?

What was/is your main work activity?

If patient is 18+yrs:

Smokes daily	☐
Occasional smoker	☐
Previous smoker	☐
Never smoked	☐

B11S

12 Smoking & passive smoking in general practice patients

Organisation supporting this study: General Practice Statistics and Classification Unit

Issues: Exposure to passive smoke at home; current smoking status; proportion of daily smokers who attempted to quit.

Sample: 3,784 encounters from 197 GPs; data collection period: 30/11/1999 – 18/02/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the patients was similar to the expected distribution of general practice patients, with the majority of patients (59.7%) being female.

When asked about smoking in the home, one-third of respondents (32.9%, 95% CI: 29.3–36.4) reported 'people are not permitted to smoke anywhere'. A further 38.7% (95% CI: 35.0–42.4) indicated 'smoking is permitted outside only', and in 5.0% 'people are permitted to smoke in certain areas only'. 'Smoking in the home occasionally' was allowed by 10.4% of respondents and 13.0% (95% CI: 11.4–14.5) said 'people frequently smoke in the house'.

These results show that in over two-thirds of patient households there was no passive smoke in the home (71.6%, 95% CI: 69.4–73.8). In a further 15.4% of household there was limited passive smoke (where smoking is permitted only in certain areas, or smoking in the home is only occasional), and in 13.0% (95% CI: 11.4–14.5) there was unlimited passive smoke.

Patients aged 18 years and over were asked to indicate their smoking status. About half (49.5%) had never smoked and 27.8% were previous smokers. Daily smokers accounted for 18.2% of the patients and a further 4.5% reported smoking occasionally.

There was no passive smoke in the home of 30.1% of daily smoker households (95% CI: 26.2–34.0), 45.1% (95% CI: 35.3–55.0) of occasional smokers' households, and 84.5% (95% CI: 82.2–86.8) of never smokers' households.

Adult daily smokers were asked about their quit and reduction attempts during the previous 12 months. Of the 578 adult daily smokers, data on their quit/reduction attempts was available for 553. They could indicate more than one quit/reduction option attempted. Just over one in ten (10.3%, 95% CI: 7.8–12.9) had successfully given up smoking for 1 month or more (but subsequently started again), and almost one-third (31.5%, 95% CI: 26.7–36.3) had a failed quit attempt during the past 12 months. About one in five adult daily smokers (19.4%, 95% CI: 14.9–23.8) had changed brand of cigarettes to a lower tar or nicotine brand, and about a quarter (26.4%, 95% CI: 21.8–31.1) had reduced the number of cigarettes smoked a day during the previous 12 months.

In the previous 12 months: four in ten adult daily smokers (39.4%, 95% CI: 34.2–44.7) attempted to quit smoking; over a third (36.4%, 95% CI: 30.9–41.8) attempted to reduce smoking effects by changing brand and/or reducing the number of cigarettes smoked; 26.9% tried to quit but did not try to reduce smoking; 23.9% attempted to reduce but not to quit; 12.5% tried both quitting and reduction; 36.7% (95% CI: 31.5–41.9) did not attempt to quit or reduce smoking.

For other related abstracts see: 35 Smoking status of adults and their attempts to quit, 53 Smoking status of adults and their attempts to quit, 74 Smoking and passive smoking in the home and Section 4.3 Smoking.

Further reading:

Valenti, L., Charles, J., & Britt, H. 2005, 'Passive smoke in Australian homes: 1999 to 2004 [letter]', *Australian and New Zealand Journal of Public Health*, vol. 28, no. 4, pp. 387–388.

Doran, C. M., Valenti, L., Robinson, M., Britt, H., & Mattick, R. P. 2006, 'Smoking status of Australian general practice patients and their attempts to quit', *Addict.Behav.*, vol. 31, no. 5, pp. 758–766.

Degenhardt L, Knox S, Barker B, Britt H, Shakeshaft A. The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug Alcohol Rev* 2005; 24(6):499–506.
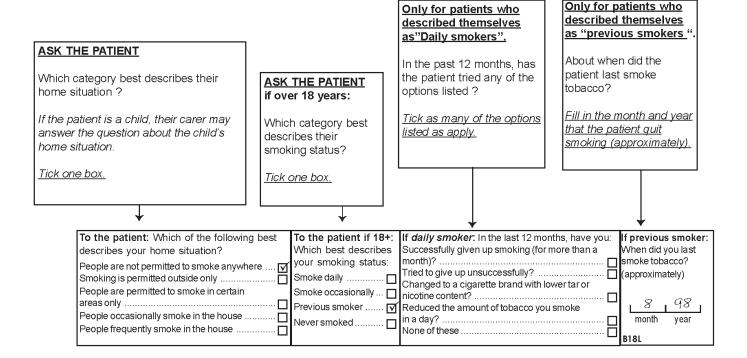
The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section in the following forms asks questions about **SMOKING**.

PLEASE FILL IN <u>QUESTIONS</u> FOR <u>ALL</u> PATIENTS SEEN. Note: The home smoking question is asked of all patients, but smoking status is only asked of <u>patients over 18</u>.

<u>INSTRUCTIONS</u>

This form has been filled in as an example.

NB The term 'smoking' here is used to mean tobacco smoking of any kind, including cigarettes, pipes, and cigars.

<u>ASK THE PATIENT</u>

Which category best describes their home situation ?

If the patient is a child, their carer may answer the question about the child's home situation.

<u>Tick one box.</u>

<u>ASK THE PATIENT</u> if over 18 years:

Which category best describes their smoking status?

<u>Tick one box.</u>

<u>Only for patients who described themselves as"Daily smokers".</u>

In the past 12 months, has the patient tried any of the options listed ?

<u>Tick as many of the options listed as apply.</u>

<u>Only for patients who described themselves as "previous smokers ".</u>

About when did the patient last smoke tobacco?

<u>Fill in the month and year that the patient quit smoking (approximately).</u>

To the patient: Which of the following best describes your home situation?	To the patient if 18+: Which best describes your smoking status:	If *daily smoker*: In the last 12 months, have you:	If previous smoker: When did you last smoke tobacco?
People are not permitted to smoke anywhere .... ☑		Successfully given up smoking (for more than a month)? .... ☐	(approximately)
Smoking is permitted outside only .... ☐	Smoke daily .... ☐	Tried to give up unsuccessfully? .... ☐	
People are permitted to smoke in certain areas only .... ☐	Smoke occasionally ... ☐	Changed to a cigarette brand with lower tar or nicotine content? .... ☐	
People occasionally smoke in the house .... ☐	Previous smoker .... ☑	Reduced the amount of tobacco you smoke in a day? .... ☐	*8* *98*
People frequently smoke in the house .... ☐	Never smoked .... ☐	None of these .... ☐	month year
			B18L

13 Perceived stress

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: Perceived stress in general practice patients in Australia

Sample: 2,891 encounters from 90 GPs; data collection period: 22/02/2000 – 27/03/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: A four-item version of the Cohen Perceived Stress Scale (PSS) Instrument was used to measure the degree to which the patient regarded situations in their life as stressful.[1] *This was provided on a card to patients at the encounter.*

Summary of results

A Perceived Stress Scale (PSS) score was calculated for 2,891 patients over the age of 15, seen by 90 randomly selected GPs in March 2000. The PSS score ranges from zero, indicating no perceived stress, to sixteen, which indicates the highest level of perceived stress.

Of the 2,891 respondents aged over 15 years, 12.6% were aged between 16 and 24 years of age. The majority of patients (61.3%) were aged between 25 and 64 years of age, and 26.1% were 65 years or older, and likely to be retired from the workforce. Almost two-thirds (64.2%) of respondents were female.

The mean PSS score for all responding patients was 5.0 (95% CI: 4.7–5.2). The mean PSS score for male patients (4.7) did not differ significantly from that of female patients (5.1). However, significant differences in PSS score were apparent between different age groups. Respondents aged 65 to 74 and 75 years or older (i.e. those likely to be retired) had significantly lower PSS scores than patients aged 25–64.

A review of the literature did not locate any published grading of PSS scores to indicate the severity of stress. We therefore classified a PSS score between 9 and 16 as 'high' perceived stress, as a score above 8 indicates that a patient perceives their life to be stressful more than just 'sometimes'. All other patients (PSS score of between zero and 8) were classified as 'low' perceived stress for ease of reference.

A comparison of the patient demographics of 'high' and 'low' perceived stress was conducted. There were no significant differences in the age distribution, sex, non-English-speaking background (NESB) status or rurality of respondents with 'high' perceived stress and those with 'low' perceived stress. However, patients with 'high' perceived stress were more likely to hold a health care card than those with 'low' perceived stress.

1.   Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. J Health Soc Behav. 1983 Vol. 24:385–396.

For other related abstracts see: 2 Anxiety/stress, consultation time, level of education.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **STRESS & SMOKING.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

This form includes four items about stress, and one smoking question.

You will need to read each question to the patient and ask for their response.

A patient response card has been included in your pack.

You may give the *response card* to the patient to assist them in making their response.

Smoking status
Ask patients aged 18yrs+:

Which of the four categories best describes their smoking status?

Tick one box.

Ask all patients aged 16 and over:

Ask the patient how often, in the last month, they have experienced each of the items described.

Circle ONE option for each question.

Ask patients 16yrs and over: IN THE LAST MONTH, how often have you felt....				If patient is 18+yrs:
Unable to control the important things in your life?	**Difficulties** were piling up so high that you could not overcome them?	**Confident** about your ability to handle your personal problems?	**That things** were going your way?	Smokes daily .... ☐
Never 1	Never 1	Never 1	Never 1	Occasional smoker .. ☐
Almost never 2	Almost never 2	Almost never 2	Almost never 2	Previous smoker ..... ☐
Sometimes 3	Sometimes 3	Sometimes 3	Sometimes 3	Never smoked .... ☐
Fairly often 4	Fairly often 4	Fairly often 4	Fairly often 4	
Very often 5	Very often 5	Very often 5	Very often 5	**B20S**

Ask patients 16yrs and over: IN THE LAST MONTH, how often have you felt....			
Unable to control the important things in your life?	Difficulties were piling up so high that you could not overcome them?	Confident about your ability to handle your personal problems?	That things were going your way?
Never .... 1 Almost never............. 2 Sometimes .... 3 Fairly often .... 4 Very often 5	Never .... 1 Almost never............... 2 Sometimes .... 3 Fairly often .... 4 Very often 5	Never .... 1 Almost never............... 2 Sometimes .... 3 Fairly often .... 4 Very often 5	Never .... 1 Almost never............... 2 Sometimes .... 3 Fairly often .... 4 Very often 5

14 Co-medications

Organisation supporting this study: General Practice Statistics and Classification Unit (GPSCU)

Issues: This substudy investigated the extent to which the medications received at the encounter (prescribed, supplied or advised for over-the-counter purchase), reflect the total medications currently used by the patient. It assessed: the proportion of patients taking medications not received at the encounter ('other medications'); the number and type of other medications; the relationship between encounter medication, other medication and all co-medication; and GP knowledge of patient other medications.

Sample: 12,318 respondents from 211 GPs; data collection period: 28/03/2000 – 05/06/2000

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of respondents was similar to the distribution of the total BEACH sample with 58.5% being female. Respondents who had no encounter or other medication made up 17.2% of all respondents. Over two-thirds (69.5%) received encounter medication. Almost half (43.4%) indicated they were currently using at least one other medication. One-third (30.1%) had encounter medication and were currently using other medication. Females were significantly more likely to be using at least one other medication (47.5%, 95% CI: 43.3–51.6) than were males (37.7%, 95% CI: 33.9–41.6). The likelihood of use of other medication increased with age. The highest prevalence of use was among female patients aged 75 years and over (65.8%). One other medication was being used by 28.9%, 19.2% used two medications, 12.5% three medications, and 22.2% four or more medications.

There were in total 27,764 co-medications (encounter medication plus other medication) recorded, an average of 2.25 per respondent or an average of 3.2 per respondent who was taking at least one medication (*n*=8,569). Other medications accounted for half (49.4%) of all co-medications. This suggests that data on encounter medications represent half the total medications being used by patients

The difference between the numbers of co-medications and encounter medications ranged from 0.1 medications in male infants to a maximum mean of 3.7 medications in elderly women (75 years +). Encounter medication for male infants far more closely represents their co-medication than that recorded at encounters with elderly women.
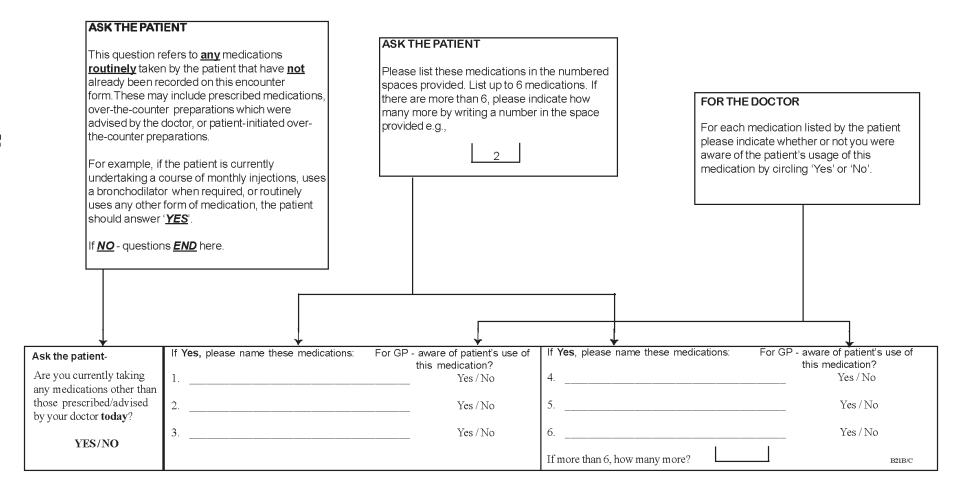
The largest proportion of other medications were cardiovascular which accounted for 21.3% of the total, followed by those acting on the central nervous system (13.0%) and those for nutrition and metabolism (10.7%). Other medications accounted for 86.3% of medications for nutrition, 61.4% of urogenital co-medications, 60.1% of anti-neoplastics, 60.0% of contraceptives hormones and 58.3% of cardiovascular medications. In contrast, over 90% of the antibiotics were prescribed at that encounter.

The GP stated they were aware that their patient was using 86.6% of other medications. Awareness was highest for cardiovascular medications (98.2% aware), lowest for vitamins (34.8% aware) and minerals and tonics (67.4% aware).

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT USE OF CONCURRENT MEDICATIONS.**

You may tear out this page as a guide to completing the following section of forms.

<u>**INSTRUCTIONS**</u>

ASK THE PATIENT

This question refers to **any** medications **routinely** taken by the patient that have **not** already been recorded on this encounter form. These may include prescribed medications, over-the-counter preparations which were advised by the doctor, or patient-initiated over-the-counter preparations.

For example, if the patient is currently undertaking a course of monthly injections, uses a bronchodilator when required, or routinely uses any other form of medication, the patient should answer '**YES**'.

If **NO** - questions **END** here.

ASK THE PATIENT

Please list these medications in the numbered spaces provided. List up to 6 medications. If there are more than 6, please indicate how many more by writing a number in the space provided e.g.,

| 2 |

FOR THE DOCTOR

For each medication listed by the patient please indicate whether or not you were aware of the patient's usage of this medication by circling 'Yes' or 'No'.

| Ask the patient-

Are you currently taking any medications other than those prescribed/advised by your doctor **today**?

YES / NO | If **Yes**, please name these medications:
1. _____

2. _____

3. _____ | For GP - aware of patient's use of this medication?
Yes / No

Yes / No

Yes / No | If **Yes**, please name these medications:
4. _____

5. _____

6. _____

If more than 6, how many more? | For GP - aware of patient's use of this medication?
Yes / No

Yes / No

Yes / No |

B21B/C

15 Lipid lowering medication

Organisation supporting this study: Commonwealth Department of Health and Ageing (Pharmaceutical Benefits Branch).

Issues: This substudy investigated the proportion of general practice patients receiving lipid lowering medications and for those on lipid lowering therapy the prevalence of coronary heart disease (CHD) and risk factors for CHD. The types of medications used for lipid lowering therapy and the levels of cholesterol for different risk factors were examined.

Sample: 5,669 patients from 189 GPs; data collection periods: 06/06/2000 – 10/07/2000, 15/08/2000 – 18/09/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age–sex distribution of the respondents was similar to the distribution for BEACH overall, with the majority, (57.7%) of patients being female.

Overall, 10.2% of respondents were taking lipid lowering drugs (*n*=576) at the time of the encounter. Rates of lipid lowering drug therapy were comparable for males (11.0%) and females (9.5%). Patients aged 45 years and over were more likely than younger patients to be on lipid lowering therapy. Those most likely to be on lipid lowering drugs were aged between 65 and 74 years (27.2%).

Five per cent of respondents on lipid lowering therapy (29/530) were commencing therapy at the encounter. There were 564 medications used for lipid lowering therapy, very few patients using more than one lipid lowering medication. The most common generic medication used was simvastatin, accounting for 40% of all lipid lowering medications, followed by atorvastatin (36.5%) and pravastatin (13.5%). CHD was reported as present in 35.0% (*n*=203) of those on lipid lowering therapy.

Hypertension was the most common risk factor, reported by 55.0% (*n*=317) of those on lipid lowering therapy. Hypertension without CHD was reported for 31.3% of those on lipid lowering therapy. One in six (16.3%, *n*=94) of those on lipid lowering therapy had diabetes, 26.2% (*n*=151) had a family history of hypercholesteraemia and 23.7% (*n*=137) had a family history of coronary heart disease. One in ten (10.6%, *n*=61) had peripheral vascular disease. Sixteen per cent (*n*=91) of those on lipid lowering therapy did not report any of the listed risk factors/conditions.

For those commencing therapy the mean cholesterol level of the most recent test was 6.9 mmol/L. For those continuing therapy the mean cholesterol level at the start of therapy was 7.2 mmol/L.

There were few differences in cholesterol levels for patients with different risk factors, although those with coronary heart disease had started therapy at lower levels of cholesterol (mean 6.9 mmol/L) than those without coronary heart disease (mean 7.4 mmol/L, *p* <0.001).

For other related abstracts see: 20 Screening and management of blood cholesterol, 30 Lipid lowering medications and coronary heart disease, 46 Coronary heart disease, risk factors and lipid lowering medication, 58 Lipid lowering medications: patient eligibility under PBS, 64 Current use of statins by general practice patients, 67 Risk factors of patients on lipid lowering medications, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 97 Statin medication use among high CHD risk patients attending general practice, 99 Lipid management in patients with high risk conditions.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT USE OF LIPID LOWERING MEDICATIONS.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

This question refers to any **lipid lowering drug therapy** taken by the patient which may have been prescribed today or at a previous encounter.

For example, if the patient is currently undertaking a course of lipid lowering medication or is about to commence a course of lipid lowering medication as a result of today's consultation, you should answer '**YES**'.

If **NO** - questions **END** here.

If **'YES'** please tick a box to indicate whether the therapy is commencing or continuing.

Please write the **name of any lipid lowering medications** the patient is using/commencing.

If the patient is **changing** their lipid lowering medication as a result of this encounter (i.e. trying a new lipid lowering drug) please write the name of the **medication/s they are changing to.**

ASK THE PATIENT

Please indicate by ticking the corresponding box/es whether the patient has **existing coronary heart disease** or any of the **risk factors** listed.

FOR THE DOCTOR

For patients who are **commencing** therapy today, please write the patient's present total levels of Cholesterol, Triglycerides and HDL in mmol/L i.e the levels shown from the most recent test.

For patients who are **continuing/changing** therapy which commenced at a previous encounter, please write the patient's total cholesterol level prior to commencement of treatment (if known).

Is this patient currently using lipid lowering drug therapy?

☐ **YES** - continue ⇨

☐ **NO** - end questions

If 'YES' is the patient

☐ commencing therapy or

☐ continuing/changing therapy

Name of medications currently used

1 _____

2 _____

Does the patient have (please tick)
☐ existing coronary heart disease?
☐ diabetes mellitus?
☐ familial hypercholesterolaemia?
☐ family history of coronary heart disease (1st degree relative <60 yrs of age)?
☐ hypertension?
☐ peripheral vascular disease?

(for patients commencing therapy)
From the most recent test, what is the patient's **present** total level of

Cholesterol _____ Triglycerides _____ HDL _____ mmol/L

(for continuing/changing patients)
What was the total cholesterol level when treatment was commenced?

_____ mmol/L

BL23B

16 Effect of day and time of GP visit on billing method

Organisation supporting this study: Commonwealth Department of Health and Aged Care (General Practice Branch).

Issues: This substudy investigated the effect of day and/or time of the GP–patient consultation on billing method (bulk billed versus patient billed).

Sample: 5,201 Medicare claimable encounters from 196 GPs; data collection period: 06/06/2000 – 10/07/2000 and 19/09/2000 – 23/10/2000.

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

For the 5,201 Medicare claimable encounters, three-quarters (74.3%) were bulk billed and the remainder (25.6%) were patient billed.

Patients aged 65 years and over were bulk-billed significantly more often than younger patients. The difference was most striking when comparing the 45–64 with the 75+ age group, who were bulk billed at 68.1% (95% CI: 63.1–73.0) and 86.7% (95% CI: 83.0–90.5) of Medicare-claimable encounters respectively.

The billing method (bulk or patient billed) was related to the day of the encounter (X^2_6=41.5, p<0.001). Encounters on Saturday (n=248) were significantly more likely to be bulk billed (84.7%) than encounters on Tuesday (n=1,413, 69.9% bulk billed). More generally, the billing method and whether the encounter was during the week or on the weekend were significantly related (X^2_1=15.0, p<0.001). Weekend consultations (n=274) were more likely to be bulk billed (84.3%) than weekday consultations (n=4,927, 73.8% bulk billed).

Most encounters on any day (55.4%) were during the 8am–1pm ('morning') session, 38.3% were during the 1pm–6pm ('afternoon') session, and 6.4% were 'over-night' (6pm–8am). Billing method was significantly related to time of consultation (X^2_2=9.0, p<0.001). If an encounter was during the 'afternoon' session, it was significantly less likely to be bulk billed (72.2%) than if it was 'over-night' (77.3% bulk billed).

Billing method was significantly related to the combination of day (weekday or weekend) and time (morning, afternoon or over-night) of the encounter (X^2_5=26.7, p<0.001). Weekend morning sessions (n=227) were significantly more likely to be bulk billed (87.2%), than weekend afternoon sessions (n=32, 71.9% bulk billed) and weekend over-night sessions (n=14, 71.4% bulk billed).

Weekend morning encounters (n=227) had the highest bulk billing rate (87.2%), followed by weekday over-night encounters (n=316, 77.5% bulk billed). The lowest bulk billing rates were on weekend afternoon (n=32, 71.8%) and weekend over-night encounters (n=14, 71.4%).

For other related abstracts see: 41 Time of visit and billing status.

Further reading:

Pegram, R. W. & Valenti, L. 2004, 'Factors influencing billing status in general practice [letter]:, *Medical Journal of Australia,* vol. 181, no. 2, p. 115.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **TIME OF VISIT AND BILLING STATUS.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

This question refers to the weekday on which the consultation is taking place.

Please indicate by ticking the appropriate box which day of the week this encounter is taking place.

FOR THE DOCTOR

Please indicate by ticking the corresponding box, the time of day during which the consultation is taking place.

FOR THE DOCTOR

If a Medicare item number is applicable to the consultation, please indicate by ticking the appropriate box whether the consultation was bulk billed to the government or whether the patient has been billed.

For this consultation please tick day of week	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

For this consultation please tick time of day	☐ 7.00 am - 8.00 am ☐ 8.00 am - 1.00 pm ☐ 1.00 pm - 6.00 pm ☐ 6.00 pm - 8.00 pm ☐ 8.00 pm - 11.00 pm ☐ 11.00 pm - 7.00 am

If a Medicare item number has applied to this consultation please indicate method of billing	☐ Bulk billed ☐ Patient billed

BL23C

17 Private prescription products

Organisation supporting this study: Roche Products Pty Ltd

Issues: This substudy investigated the proportion of patients receiving, or being considered for, private prescription products, and the conditions for which the products were being considered. Reasons why these products were or were not being prescribed, were also examined.

Sample: 5,222 respondents from 192 GPs; data collection period: 11/07/2000 – 14/08/2000 and 19/09/2000 – 23/10/2000

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age and sex distribution of the 5,222 respondents was similar to those for BEACH as a whole, the majority of respondents (59.8%) being female.

GPs prescribed or considered prescribing a private prescription product for 647 (12.4%) of the 5,222 respondents. Eleven per cent of male patients and 13.3% of female patients were prescribed or considered for a private prescription product.

The conditions for which private prescription products were most frequently prescribed or considered were obesity, female contraception, acne, back pain, arthritis, immunisation and osteoarthritis. Other conditions for which these products were prescribed or considered included pain, asthma, insomnia, migraine and anxiety.

GPs discussed the probable cost of the private prescription product with 464 (79.2%) of the 647 respondents considered for a private prescription product, prior to prescribing. Multiple responses were allowed, and for the majority of patients the GP had indicated one (64.9%) or two (15.9%) reasons for prescribing. The most common reason given by GPs for prescribing a private prescription product (for 346 (53.5%) of the 647 respondents) was that no equivalent PBS product was available. Other reasons given by GPs for prescribing a private prescription product, in order of frequency, were: at doctor's initiative (*n*=163, 25.2%), at patient's request (*n*=124, 19.2%), doctor believed patient could pay (*n*=69, 10.7%), patient privately insured (*n*=33, 5.1%) and other (*n*=30, 4.6%).

The most frequent response for electing not to prescribe a private prescription product, which would have been a suitable treatment for the patient's condition, was that the patient could not pay (*n*= 55, 8.5% of 647 respondents). Other reasons include: a non drug therapy used instead (*n*=23, 3.6%), other (*n*=22, 3.4%) and therapy available on PBS (*n*=15, 2.3%).

The patient's capacity to pay for treatment is a major consideration for GPs in the management of a variety of problems.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PRIVATE PRESCRIPTION PRODUCTS.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

This question refers to any **private prescription product** which you have prescribed, or considered prescribing, for this patient **for any condition** in the past **12 months**.

Please tick the appropriate box to indicate whether or not you have prescribed/considered a private prescription product for this patient during this time.

If **'YES'** please write the condition/s for which you have prescribed/considered the private prescription product/s (e.g., cardiovascular/obesity/sexual dysfunction/influenza/other).

For example, if you have prescribed/considered prescribing for a cardiovascular condition during one encounter and for an obesity condition at another encounter within the past 12 months, please write

1. *Cardiovascular*
2. *Obesity*

Please indicate by ticking the appropriate box whether or not you **discussed the probable cost** of the product **with the patient** before you prescribed (or didn't prescribe) the private prescription product.

If you decided to prescribe a private prescription product, please indicate by ticking the appropriate box the **reason** you prescribed the private prescription product for this patient.

Please circle a number to indicate **which conditon** you are referring to **from the previous question**.

For example, if you prescribed because there was **no PBS product available** for the **cardiac condition** listed in the previous (example) question, please write

                 (for condition)

☑ No PBS product available   ①   2

If you did **not prescribe** a private prescription product for this patient where the private prescription product might have been appropriate for their condition, please indicate by ticking the appropriate box **why you did not prescribe** the product.

Please circle a number to indicate the condition to which you are referring.

For example, if a private prescription product may have been appropriate for the **cardiac condition** previously mentioned, but the patient indicated that they were unable to afford this product, please write

                 (for condition)

☑   Patient cannot pay   ①   2

Have you prescribed, or considered prescribing a **private prescription product** for this patient in the past **12 months**?	If 'YES' for what **condition/s** did you consider/prescribe a private prescription product/s?	Before prescribing, did you **discuss** the **probable cost** of the product?	Why did you prescribe this product? (For condition)			If a product **was appropriate** and **NOT** prescribed, **WHY NOT?** (For condition)		
☐ YES	1. _____	☐ YES	☐ No PBS product available	1	2	☐ Therapy available on PBS	1	2
			☐ At patient's request	1	2	☐ Patient cannot pay	1	2
			☐ Doctor's initiative	1	2	☐ Non drug option offered	1	2
			☐ Patient privately insured	1	2	☐ Disliked patient requesting specific therapy	1	2
☐ NO BL24B	2. _____	☐ NO	☐ Believed patient could pay	1	2	☐ Contra indicated with other drugs/conditions	1	2
			☐ Other	1	2	☐ Other	1	2

18 Drugs for the treatment of peptic ulcer and reflux

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: This substudy investigated patients who were currently taking omeprazole or other proton pump inhibitors (PPIs), histamine receptor antagonists (H₂RAs) or cisapride. Concurrent use of H₂RAs and antacids, the relationship between endoscopy and medication choice, and between diagnostic finding and medication choice were examined. The life prevalence of peptic ulcer disease and use of Helicobactor (H. pylori) eradication therapy were assessed independently of the other questions.

Sample: 95 GPs responded to questions on behalf of 2,856 patients; data collection period: 11/07/2000 – 14/08/2000

Method: Detailed SAND methods are provided in Chapter 2.

Summary of results

The age-sex distribution of patients at encounters was similar to the distribution of the BEACH sample, with the majority (59.9%) of patients being female.

Of the 2,856 patients, 8.3% (*n*=236) were currently taking at least one PPI, H₂RA, or cisapride. The majority of these were taking H₂RAs (61.4%, 145/236), followed by omeprazole (28.4%), other PPIs (9.3%) and cisapride (5.5%).

Of the 133 respondents on H₂RAs who responded to a question on level of antacid use, 51.7% had never used antacids in conjunction with H₂RA medication. Twenty-two per cent (22.1%, 32/133) used antacids infrequently (<once per week) and more frequent use was reported by 18.0% (9.0% >once per week; 9.0% 'daily' use).

Of the 224 patients who were currently taking these medications and also indicated endoscopy status, 164 (73.2%) had undergone an endoscopy. It was common for patients currently taking omeprazole (92.5%, 62/67) and other PPIs (86.4%, 19/22) to have undergone an endoscopy. However, 37.2% (54/145) of those on H₂RAs had never undergone an endoscopy.

The predominant diagnosis on endoscopy was reflux oesophagitis (39.4%, 65/164), followed by ulcerative oesophagitis (21.8%, 36/164). Peptic ulcer disease (PUD) was diagnosed for 14.5% (24/164).

The most common diagnosis (post endoscopy) for patients on H₂RAs was reflux oesophagitis (39.3%, 33/84), while for those on omeprazole, reflux oesophagitis (40.3%, 25/62) and ulcerative oesophagitis (40.3%) were most common.

Of the total sample less than one in twenty (4.4%, *n*=125) reported having been diagnosed with PUD at some time. Of these, 39% had received H. pylori eradication therapy. For the 71 patients who had not, it was 'not considered appropriate' for 24 (32.4%), and the opportunity to undergo an H. pylori test was 'not available' to 27.

For other related abstracts see: 24 Gastro-oesophageal reflux disease (GORD) in general practice patients, 34 Gastro-oesophageal reflux disease (GORD), 51 Use of proton pump inhibitors for gastrointestinal problems, 60 Prevalence of GORD and associated proton pump inhibitor use, 62 Use of proton pump inhibitors by general practice patients, 91 Prevalence and management of gastrointestinal symptoms, 100 Gastrointestinal symptoms in patients attending general practice.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **GASTRO-OESOPHAGEAL REFLUX DISEASE AND PEPTIC ULCER DISEASE.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

PART 1

FOR THE DOCTOR
Please indicate by ticking the appropriate box whether this patient is **currently taking** any of the **medications listed**, even if they were not prescribed at today's encounter.

You may tick more than one box if more than one medication is being taken.

Beside each medication ticked, please write the length of time since the patient began taking this therapy. For example, the patient may have been taking omeprazole for 6 months and cisapride for 18 months.

If the patient is **not currently taking** any of these medications, please **go directly to PART 2** for the remaining questions.

If you have indicated in the first question that this patient is **currently taking H₂RAs**, please indicate by ticking the most appropriate box whether or not the **patient also uses antacids** and, if so, **how frequently**.

Please indicate by ticking the appropriate box **when** the patient last underwent **endoscopy**. If the endoscopy was **more than 3 years ago**, please write the **year** when the last endoscopy took place.

Please indicate by ticking the appropriate box, which of the options most closely matches the **predominant diagnosis** resulting from the patient's **most recent endoscopy.**

PART 2

FOR THE DOCTOR
Please indicate by ticking the appropriate box whether this patient has **ever** had **Peptic Ulcer Disease.**

If "NO" end questions.

If the patient has had **Peptic Ulcer Disease**, please indicate by ticking the appropriate box whether the patient was treated with **H. Pylori eradication** therapy.

If "YES" end questions.

If the patient has had **Peptic Ulcer Disease** and was **not treated** with **H. Pylori eradication** therapy, please indicate by ticking the appropriate box **why** the patient was **not given** this therapy.

Is this patient currently taking any of the following? (Duration)	For patients currently taking H₂RAs, do you also take **antacids**?	The patient's **last endoscopy** was	The predominant **diagnosis resulting from endoscopy** was	Part 2 — Has this patient ever had **Peptic Ulcer Disease**?	Was the patient given **H.Pylori eradication** therapy?	If 'No' **why not**?
☐ omeprazole ____ mths ☐ other PPIs ____ mths ☐ H₂RA ____ mths ☐ cisapride ____ mths **If 'No' go to Pt 2→**	☐ Never ☐ < once per week ☐ > once per week ☐ daily	☐ Never ☐ 1 year ago ☐ 2 years ago If **>3 yrs** ago, what year? 19 ____	☐ Reflux oesophagitis ☐ Peptic Ulcer Disease ☐ Ulcerative oesophagitis ☐ No finding ☐ Other diagnosis	☐ Yes → ☐ No **(end)**	☐ Yes **(end)** ☐ No →	☐ contra-indicated for medical reason ☐ not considered appropriate ☐ H.Pylori test not available ☐ other reason

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19 Osteoporosis

Organisation supporting this study: Aventis Pharma Pty Ltd

Issues: This substudy examined patients with risk factors for osteoporosis and whether any patients had sustained fractures after minor trauma. The screening and diagnosis of osteoporosis, and medications being used to treat the disease, were also investigated.

Sample: 2,710 respondents from 90 GPs; data collection period: 15/08/2000 – 18/09/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: The One-Minute Osteoporosis Risk Test designed by the International Osteoporosis Foundation was used as a risk factor list provided to patients on a card. Risk factors included family or personal history of fracture following minor trauma, menopause prior to 45 years of age or amenorrhoea (women), low testosterone (men), long term corticosteroid use, height loss >5cm, regular heavy alcohol use, coeliac or Crohn's disease.

Summary of results

The age–sex distribution of respondents was similar to the distribution for BEACH as a whole, with the majority (57.5%) of patients being female.

One in five (22.2%) of the 2,710 respondents reported having one or more risk factor for osteoporosis, such as early menopause or prolonged corticosteroid use. In gender specific terms, 17.1% of males and 22.4% of females had risk factors. The presence of risk factors increased steadily with age from 1.25% of patients aged 15–24 to almost half of those aged 75 years or more.

Of the 2,332 patients who responded to the question on fractures following minor trauma, 134 (5.8%) had at some time suffered such fractures, and they made up 3.2% of male and 7.5% of female respondents. Again, these proportions increased with age up to 20.0% of those aged 75 years or over. One hundred and five patients responded to the question on how many fractures they had suffered, and 90 of these (85.0%) reported having sustained one or two fractures, with the most common fracture sites being the wrist and the vertebral column. Patients who reported having risk factors were more likely to have sustained fractures.

The question on screening for osteoporosis was answered by 2,016 patients and 249 (12%) had previously been screened for osteoporosis either by x-ray or bone mineral density scan (BMD). Of these, 95 (40.0%) had been diagnosed with osteoporosis.

Eighty-four respondents, 90.0% of patients diagnosed with osteoporosis, were taking medication for that disease. Calcitriol accounted for almost 30.0% of these medications, followed by calcium carbonate (27.4%) and alendronate (17.7%). A greater proportion of medications had been initiated by a GP (69.0%) than by a specialist (31.0%).

For other related abstracts see: 85 Management of osteoporotic fractures.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **RISK FACTORS FOR OSTEOPOROSIS**.

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

This question refers to the **risk factors listed on the card** which the patient has previously read through.

(NB - *The patient is **not required** to indicate **which** risk factor/s.***)**

Please ask the patient if they have **1 or more** of the **risk factors** listed and tick 'yes' or 'no' to indicate the patient's response.

Please ask the patient if they have ever suffered **fracture/s** following **minor trauma** such as a bump or light fall. Please tick the appropriate box to indicate the patient's response.

If the patient has suffered fracture/s following minor trauma, please write the **total number of fractures** and **which body sites** were involved.

For example, if the patient fractured a wrist two months ago and a hip seven months ago, the total would be **2** and the body sites would be

1. _Wrist_
2. _Hip_

The question refers to the **screening** techniques of **X-ray** and **Bone Mineral Density** (**BMD**). Please indicate by ticking the appropriate box whether this patient has been **referred today** for screening, has ever been **screened previously**, or has **never been screened or referred** for screening. Please circle the type of screening which the patient has been referred for or previously received.

For example, if you are referring the patient today for BMD and the patient was previously screened with X-ray, please write:

	Type of Screen
☑ referred today for screening?	X-ray/(BMD)/both
☑ screened previously?	(X-ray)/BMD/both
☐ never screened or referred?	

If previously screened, was the patient **diagnosed** as having **osteoporosis** as a result of that screening?

If 'No' end questions.

If the patient has been **diagnosed** as having **osteoporosis**, please indicate by ticking the appropriate box the patient's **current treatment regime**. You **may tick more than one** box. Please write the **name of any medications** for this condition and circle an option to indicate who **initiated** this medication, or who is **providing any counselling**. For example, if the patient is taking Rocaltrol which was prescribed by a specialist, is receiving counselling from you, and is also having other treatment such as hydrotherapy, please write:

If 'Yes' the patient's **current treatment regime** is -

☑ Medication (**name**)	Initiated by
1. _Rocaltrol_	GP /(Specialist)
2. _____	GP / Specialist
☑ Counselling (**provided by**)	(GP)/Specialist /Other
☑ Other	
☐ No treatment	

Do you have **1 or more** of the **risk factors** listed on the card?	Have you ever suffered **fracture/s** following **minor trauma?**	If yes, **how many** fractures? _____ Which body site? (e.g. vertebral, hip, wrist) 1. _____ 2. _____ 3. _____	Has this patient been - ☐ referred today for screening? ☐ screened previously? ☐ never screened or referred?	**Type of Screen** X-ray/BMD/both X-ray/BMD/both	If previously screened, was the patient **diagnosed** with **osteoporosis?** ☐ Yes → ☐ No (**END**)	If 'Yes' the patient's **current treatment regime** is - ☐ Medication (**name**) Initiated by 1. _____ GP / Specialist 2. _____ GP / Specialist ☐ Counselling (**provided by**) GP /Specialist /Other ☐ Other ☐ No treatment
☐ Yes ☐ No	☐ Yes → ☐ No					BL25B

Please read this card and tell your doctor if you answer 'yes' to **1 or more** of the questions. You **do not** have to tell the doctor **which questions** you have answered 'yes' to, unless you wish to do so.

The One-Minute Osteroporosis Risk Test**

1. Have either of your parents broken a hip after a minor bump or fall?

2. Have you broken a bone after a minor bump or fall?

3. For Women: Did you undergo menopause before the age of 45?

4. For women: Have your periods stopped for 12 months or more (other than because of pregnancy)?

5. For Men: Have you ever suffered from impotence, lack of libido or other symptoms related to low testosterone levels?

6. Have you taken corticosteroids tablets (cortisone, prednisone, etc) for more than 6 months?

7. Have you lost more that 5 cm (2 inches) in height?

8. Do you regularly drink heavily (in excess of safe drinking limits)?
   (Safe = 4 standard drinks daily for men, 2 daily for women)*

9. Do you suffer frequently from diarrhoea (caused by problems such as coeliac disease or Crohn's disease)?

** Test designed by the International Osteoporosis Foundation

* Pols R.G. & Hawkes D.V (1992) *Is there a safe level of daily consumption of alcohol for men and women?* Australian Government Publishing service, Canberra

20 Screening and management of blood cholesterol

Organisation supporting this study: AstraZeneca (Australia) Pty Ltd

Issues: This substudy investigated the proportion of general practice patients having existing coronary heart disease (CHD) or risk factors for CHD, the proportion who had their blood cholesterol tested and the treatments used in the management of 'high cholesterol level' and the effectiveness of different management in decreasing cholesterol level.

Sample: 2,905 respondents from 97 GPs; data collection period: 24/10/2000 – 27/11/2000

Method: Detailed SAND methods are provided in Chapter 2.

Methods for this study: Risk factors included: existing coronary heart disease, diabetes, familial hypercholesteraemia; family history of coronary heart disease, hypertension and peripheral vascular disease.

Summary of results

The age–sex distribution of respondents was similar to the distribution for BEACH overall, with the majority (58.5%) of patients being female.

Over one-third (37%) of the 2,905 respondents had at least one risk factor related to CHD.

Overall, more than half (55.0%) of the 2,771 patients who responded to the question on cholesterol tests, stated that their cholesterol had been tested. Of the 1,027 patients who had one or more risk factors for high cholesterol and responded to the question about initial cholesterol test, 14.0% had never had a cholesterol test.

The mean cholesterol level for those with one or more risk factors (n=834) was 5.88 mmol/L compared with 5.35 mmol/L for those with no risk factors (n=604). Of the 764 respondents using some form of treatment(s) for 'high cholesterol level', 61.3% were relying on diet/exercise only, 23.3% were on both diet/exercise and any statin medication, and 13.6% were using any statin medication only.

Among 415 respondents who were under cholesterol management and had both initial and most recent cholesterol levels recorded, a significant decrease in cholesterol levels was found for those using both diet/exercise and any statin (t_{224}=9.7, $p<0.001$), or using any statin alone (t_{111}=–7.9, $p<0.001$), compared with those using diet/exercise only. There was no significant difference between those using diet/exercise and any statin compared with those using any statin alone in the extent of cholesterol reduction (t_{225}=0.2, p=0.82).

There was a significant reduction in cholesterol levels for those using any statin compared with those on diet/exercise only (t_{386}=11.6, $p<0.001$). Patients using any statin had a significantly greater decrease in cholesterol levels than those not using any statin (t_{402}=10.8, $p<0.001$).

For other related abstracts see: 15 Lipid lowering medication, 30 Lipid lowering medications and coronary heart disease, 46 Coronary heart disease, risk factors and lipid lowering medication, 58 Lipid lowering medications: patient eligibility under PBS, 64 Current use of statins by general practice patients, 67 Risk factors of patients on lipid lowering medications, 79 Hypertension and dyslipidaemia – comorbidity and management in general practice patients, 97 Statin medication use among high CHD risk patients attending general practice, 99 Lipid management in patients with high risk conditions.

The following page contains the recording form and instructions with which the data in this abstract were collected.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT BLOOD CHOLESTEROL LEVELS & MANAGEMENT.**

You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

FOR THE DOCTOR

This question refers to **any initial cholesterol test** for this patient.

If the patient's **total cholesterol** has been tested as a result of a previous encounter, please **write in the result** in mmol/L.

If **NO** - questions **END** here.

This question refers to **subsequent cholesterol testing** for patients whose cholesterol level was 'high' at the initial test.

Please write in the **patient's cholesterol level** at the **most recent test** if re-testing occurred, regardless of whether the result was high or normal.

If the patient's cholesterol was **not re-tested** since the inital test, **end questions** here.

ASK THE PATIENT

Please indicate by ticking the corresponding box/es whether the patient has **existing coronary heart disease** or any of the **risk factors** listed.

If the patient's cholesterol level was 'high' please tick the appropriate box which best describes the treatment regime commenced by the patient. **You may tick more than one box if more than one option applies** e.g. if you have recommended a diet & exercise program and prescribed a statin you should tick both boxes and write the name of the statin prescribed.

You do not need to write the name of drugs other than statins.

If the patient' cholesterol was re-tested, please tick the appropriate box to indicate the **next step in the patient's cholesterol management**. You may tick **more than one box** if more than one option applies.

Does the patient have (please tick)	Has this patient ever had a cholesterol test?	If 'high' was the patient treated with -	Has the patient's cholesterol been re-tested?	If 'Yes', the next step in cholesterol management was
☐ existing coronary heart disease? ☐ diabetes mellitus? ☐ familial hypercholesterolaemia? ☐ fam. history of cor. heart disease (1st degree relative <60 yrs of age)? ☐ hypertension? ☐ peripheral vascular disease?	☐ Yes - the result was _____ mmol/L ☐ No - **end questions**	☐ diet / exercise ☐ HMG CoA reductase inhibitor (statin) - which statin? _____ ☐ other drug therapy	☐ Yes - level at most recent test was _____ mmol/L ☐ No - **end questions**	☐ initiate statin - which one? _____ ☐ prescribe same statin, same dose (for previous users) ☐ prescribe same statin, increased dose ☐ change statin - to which one? _____ ☐ additional therapy - which one? _____ ☐ other - specify - _____ ☐ stop therapy

BL27B