Primary Health Care — David Wilkin

J. H. Hibbard and C. R. Pope. 'Age differences in the use of medical care in an HMO: An application of the behavioural model'. *Medical Care*, **24** (1986), 52–66.

L. G. Branch and K. T. Nemeth, 'When elders fail to visit physicians'. *Medical Care*, **23** (1985), 1265–1275.

Both of these papers deal with patterns of utilisation by the elderly of primary medical care in the USA. Branch and Nemeth present results from the Massachusetts Health Care Panel Study, a longitudinal investigation of the health and social needs of older Americans. They followed up in 1980 825 of the 1,625 people over the age of 65 first interviewed in 1974. They were concerned to examine the extent of and reasons for under-utilisation, to identify the characteristics of elderly people associated with specific access barriers and to assess the impact of these barriers on non-utilisation and over all physician utilisation rates.

Ninety-five per cent of respondents had Medicare coverage, but even so 61% also held private insurance and 17% had Medicaid coverage. Seventeen per cent reported that there were instances when they did not seek medical care when they thought they should due to one or more of four possible reasons: thought problem due to age (12%); travel difficulties (3%); cost (3%); or no available appointment (3%). Lower income, lower morale and lower health-status scores were significantly and consistently associated with reported access barriers (travel, cost and appointments). People who reported not visiting a physician because they thought the problem was due to age had lower perceived health, but *fewer* functional problems than other respondents. As well as reporting specific instances of not visiting a physician, this group also had a lower overall utilisation rate and were more likely to be 'out of annual contact' with a physician. The authors point to a need for education to emphasise the possible adverse consequences of failure to consult a physician. This despite the fact that their analysis shows that those out of contact for at least a year had fewer functional problems and higher morale.

The second of these papers by Hibbard and Pope also deals with utilisation by the elderly of primary care physicians, but among people enrolled in the Kaiser Permanente Health Maintainance Organisation (HMO) in Portland. The research attempted to discover whether predisposing, enabling and medical need factors were equally important in explaining utilisation rates among older and younger enrollees and what combination of factors was most predictive of utilisation. A total

of 2,603 adults were interviewed, but the analyses presented include only those under 50 years (1,454) and 65 + years (455). The dependent variables examined were the annual rates of doctor office visits, preventive visits, and initial doctor visits (i.e. first visit in a new episode of morbidity). The independent variables consisted of pre-disposing factors (e.g. socio-demographic factors, health beliefs and behaviour), enabling factors (distance to medical-care facilities, waiting time, attachment to physician) and medical need factors (self-reported health status, mental health index and symptom reports). The analytic approach was to compare the relative proportion of variance in utilisation accounted for by the independent variables using regression analysis.

The findings suggest that while the independent variables explain about the same amount of variation (16%) in total visits for younger and older people, the predictor variables are not the same. Predisposing factors (e.g. gender, concern with health, tendency to adopt sick role) were more important among younger enrollees, and enabling factors (e.g. attachment to physician and travel time) were more important among the older enrollees. Medical need explains about the same amount of variation in utilisation for both age groups, suggesting that medical need does not become a more important predictor of service use with increasing age. Although older people were more concerned with health and more sceptical of physicians these factors were not related to their use of services. While general self-reported health status was the strongest predictor of total utilisation for both age groups, mental health status was the strongest predictor of initial visits for the elderly. The authors suggest that primary medical care may be too orientated to a biomedical model rather than a psychosocial model of health and that the importance of enabling factors for the elderly requires that we look carefully at the accessibility of medical care for this age group.

COMMENT

These two papers from the USA confirm the key findings from British studies concerning utilisation of primary medical care by the elderly, both in terms of the actual results and the interpretations placed upon them. Branch and Nemeth seem to begin with the assumption that under-utilisation is a particular problem among the elderly, rather than testing this proposition. Hibbard and Pope address a somewhat different problem by comparing younger and older adults in terms of the factors influencing utilisation. However, in both cases the authors make

suggestions as to how utilisation might be increased. Ford and Taylor have suggested, at least in the British context, that underconsultation among the elderly is exaggerated.[1] There is nothing in either of these papers to refute this proposition.

Nevertheless, both papers raise interesting questions. Is the consultation-seeking threshold similar at all ages? Although the factors which appear to account for variations in utilisation may be different, the overall propensity to consult with given symptoms may be similar. There is substantial evidence in the literature of medical sociology to suggest that people of all ages sometimes fail to consult a physician when they think they ought to. At what point does this 'failure' result from attributing health problems to the ageing process? What neither study is able to address is the extent to which patterns of utilisation are attributable to experiences of the outcomes of previous episodes of care. In order to address these sorts of questions a different type of research is necessary. Too much of existing research on utilisation of health care by the elderly relies upon analysis of crude social indicators and use data. There is a need for sociological studies which employ qualitative approaches to explore issues concerning utilisation and outcomes of primary medical care.

NOTE

1 Ford, G. and Taylor, R. The elderly as underconsulters. *Journal of the Royal College of General Practitioners*, **35** (1985), 244–247.

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Social Work and Social Services — David Challis

Teh-Wei, Hu, Lien-Fu Huang and W. S. Cartwright, 'Evaluation of the cost of caring for the senile demented elderly: a pilot study', *Gerontologist*, **26**, (1986), 158–163.

Policy debate has been concerned increasingly with the most appropriate means of providing care for elderly people diagnosed as suffering from dementia. This paper reports a small pilot study of the cost of providing care for elderly people suffering from senile dementia. Of these 16 were male and 28 female; 25 were living in nursing homes and 19 in their own homes. Patients suffering from severe physical handicaps as well