The perceived performance, barriers and solutions for the good preventive care of elderly people in Israel

Anthony D Heymann MB BS MHA
Director of Department of Community Medicine, Maccabi Healthcare Services, Tel Aviv, Israel; Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

Neta Bentur PhD
Professor, Centre for Research on Aging, Myers-JDC-Brookdale Institute, Jerusalem, Israel

Leora Valinsky RN MPH
Director of Health Promotion, Maccabi Healthcare Services, Tel Aviv, Israel; Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

Johnathan Lemberger MA
Director of Care for the Elderly, Maccabi Healthcare Services, Tel Aviv, Israel

Asher Elhayany MD MPH
CEO Meir Hospital, Cfar Saba, Israel

ABSTRACT

Background Many elderly people, who experience functional and cognitive deterioration, visit their family physician or general practitioner (GP) who is well placed to administer preventive care; however, this provision is often suboptimal.

Aim To examine barriers to preventive care among the elderly and examine self-perceived skills and knowledge among Israeli physicians.

Design Quantitative and qualitative research methods involving focus groups were used.

Setting Two Israeli primary care preferred provider organisations.

Methods Eighty-five physicians participated in 12 focus group discussions on preventive medicine for the elderly. The discussions were analysed using Atlas.ti software. Before each discussion, the physicians answered a self-report questionnaire which addressed his or her perceived skills in these areas.

Results Family physicians felt less skilled in identifying cognitive deterioration, detecting signs of depression or treating urinary incontinence than in dealing with visual decline, and reported fewer skills than geriatricians. Most of the GPs felt that preventive medicine in the elderly was worthwhile but that they lacked the time and skills to undertake this task. Proposed solutions included the need for educational and training programmes, protected time, incentives and the involvement of nurses.

Conclusion Although the issue of ‘lack of time’ is usually considered a major barrier to successful implementation of preventive care, lack of family physician knowledge and skills, and organisational barriers should also be addressed.

Keywords geriatrics, preventive medicine, primary health care
How this fits in with quality in primary care

What do we know?
It is known that implementation of preventive medicine in the elderly is sub-optimal, and improving preventive care would result in reduced morbidity and improved quality of life.

What does this paper add?
This study based on physician focus groups indicates that increasing physicians’ knowledge and skills together with changes within general practice could result in significant improvements in care.

Introduction

The necessity for proactive involvement regarding health behaviour in chronic disease has been recognised by health policy makers since the 1986 Ottawa Charter for Health Promotion.1 Age-dependent diseases are becoming one of the great challenges facing the community health system.2,3 The importance attributed to lowering morbidity and disability rates has increased willingness to adopt measures to promote prevention and early detection of illnesses.4,5

The elderly population in Israel comprises about 10% of the general population, most of its members (96%) living in the community. Life expectancy at birth in Israel is high, 79 years for men and 86 for women. At the age of 65 years, life expectancy is 20 years for women and 18 years for men.6 Elderly people who experience physical, functional and cognitive deterioration visit their general practitioner (GP) frequently. Therefore the GP is in an excellent position to administer preventive care and to discuss health behaviour.

The Israeli healthcare system is government financed, comprehensive and fully computerised. All citizens choose to be members of one of the four health maintenance organisations (HMOs) which provide a basket of medical services that is updated on an annual basis by the Health Ministry. All HMOs have a structured administrative and professional hierarchy overseeing the work of both physicians and nurses. Primary care is delivered mainly by GPs who are able to refer patients when needed for a full geriatric assessment. Nevertheless, GPs’ performance has been shown to be lacking in the areas of preventive care and in discussing health behaviour. Despite their theoretical agreement with recommendations for preventive care, they do less than is recommended.7,8 Among the barriers to appropriate care are pressure of work at the GPs’ clinics, a lack of awareness regarding the effectiveness of elderly health promotion and GPs’ low self-efficacy regarding their ability to reduce risk factors and change behaviour patterns in the elderly.9,10 As opposed to GPs, geriatricians are more aware of risk factors and illnesses among the elderly11 but they mostly work in secondary or tertiary care and see a relatively small and more unwell elderly population.

The main goal of this study was to examine the barriers to preventive health care among family physicians and to identify tools and devices that could help physicians augment these activities. A secondary aim was to examine differences between GPs and geriatricians regarding this issue.

Methods

The study used quantitative and qualitative methods of the focus group type.

The study population included 85 physicians who were working in the community in two districts of Israel for the country’s two largest HMOs, serving 75% of the nation’s population.

They were asked to participate in focus group discussions on preventive medicine and health promotion for the elderly. The focus groups were held during weekly staff meetings or a continuing education programme. Most of the physicians invited took part in the focus groups. Each group had a homogenous mix of participants, with regard to areas of specialisation. We conducted six focus groups with specialists in family medicine, two with residents specialising in family medicine, two with non-specialist GPs and two with geriatricians. Each focus group met once for approximately an hour and a half, and all were facilitated by the same experienced researcher. A second researcher was present at each meeting and transcribed verbatim what was heard, noting the names of the speakers. In addition, the meetings were audiotaped. On the same or the following day the written notes were typed and compared with the audiotape. This overcame the difficulty of identifying who was speaking on audiotape or if several people spoke at the same time. The whole text was analysed using Atlas.ti software by the researcher who led the focus group. Focus group texts can be segmented into quotations, codes and comments which then leads to a conceptualisation phase that involves higher-level interpretive work and theory building.
The discussion in each group began with a presentation of the topic to be discussed and participants were invited to respond to the topic, saying whatever came to mind. The discussion began with open questions asking the participants for their views regarding preventive medicine in the elderly. New topics were introduced after everyone wishing to express their opinions had finished doing so. The main topics which were then introduced were:

- factors that may encourage or prevent physicians from addressing prevention in the elderly
- whether their approach was different with younger people
- how they could be helped to perform more effectively.

The first stage of the research consisted of ten focus groups, in which the participants raised new topics, perceptions, ideas and opinions. After it appeared that no new issues were being raised, two further focus groups with new participants were conducted to consolidate the findings of the earlier groups and to obtain deeper insights about them. In every group, an attempt was made to find out the most commonly held opinions and identify the perceptions for which there was the widest consensus.

For the qualitative assessment, before each discussion the physicians completed a short questionnaire that included demographic characteristics, knowledge about health promotion and their perceived health promotion skills. The nine skills chosen for self-assessment were those that were recommended by the Framework for Geriatric Prevention, published by the Ministry of Health. These were derived from guidelines that had been developed in other countries. These skills can be divided into three categories. The first one included primary and secondary prevention of physical problems: explaining the importance of the influenza vaccination; monitoring, examining and giving guidance on treatment for urinary incontinence; maintaining stable blood pressure; referring for hearing and vision tests and referring for stool occult blood testing. The second category was assessing cognitive deterioration and detecting signs of depression. The third category referred to healthy lifestyle, and included giving guidance about nutrition and encouraging patients to take physical exercise.

### Results

In total, 12 focus groups were conducted, each including between six and 14 physicians. Forty-two physicians were specialists in family medicine, 14 were residents specialising in family medicine, 17 were non-specialist GPs and 12 were geriatricians. Their mean age was 43.2 years; 67% were female. Two-thirds of the physicians (68%) were working in the community and 32% were working in both the community and in hospitals. Each group had a homogenous mix of participants, with regard to areas of specialisation: specialists in family medicine or geriatrics or physicians with no specialisation.

The results of the self-report questionnaire on perceived skills are shown in Table 1. Regarding testing for early detection of visual and hearing deterioration, 86% of all participants reported that they were competent or had adequate skills. The picture changes when it comes to early detection of problems such as identifying and treating urinary incontinence, with up to 38% reporting no skills in this area. Likewise, physicians felt less skilled in identifying cognitive deterioration or detecting signs of depression. The proportion of geriatricians who reported that they were competent or had adequate skills in these three areas was far higher than that of the GPs – specialists and non-specialists alike. The final area concerning the physicians’ perceived skills was that of counselling patients regarding a healthy lifestyle. For example, when advising patients about nutrition and physical activity, 41% of physicians felt they had no skills in nutritional advice and 27% that they possessed no skills to advise on physical activity. We found a significant difference between the GPs (specialists and non-specialists) and the geriatricians. Two-thirds of geriatricians compared with one-tenth of the GPs reported being competent in giving guidance about nutrition.

The results of the focus groups are presented as physician factors that are barriers to preventive care, then patient factors with suggestions on how to improve such care. All the quotes that are presented are attributed to the non-geriatricians, unless otherwise indicated. We have quoted the participants if their thoughts were expressed in the majority of the focus groups.

### Physician factors

Analysis of the focus group transcripts demonstrates the enormous importance that the physicians attributed to the brief amount of patient contact time. This was raised in the very first stage of every focus group, and most of the participants agreed that this was the most important factor that prevented them from addressing prevention. When we encouraged the physicians to identify other factors, this provoked statements such as:

‘Addressing lifestyle demands not only more time but also more attention than acute care.’
'When you talk about incontinence, you open up a Pandora’s box.'

As the discussions developed, the family physicians raised other, non-time-related factors that constituted barriers. A few of them expressed a lack of willingness or motivation to address the issue. A typical quotation was:

'I’m not sure I want to be the one. I want to deal with the next level, not with the basic issues.'

An important set of obstacles mentioned by several participants in most of the focus groups concerned the implications of old age and how this affected their practice. A few of the physicians expressed qualms about treating the elderly. One physician even said:

'They have multiple problems and it is hard to treat them. I feel frustrated because I want to help and can’t'.

Another said, even more directly:

'There needs to be a rethinking of priorities. In addition to mammography or colon cancer screening we should be screening for cognitive decline.'

A few physicians expressed positive attitudes about guiding the elderly toward improved health behaviour. One of them said:

'Some age groups are more disposed toward preventive medicine. Young people are less interested and ask less.'

The geriatricians’ approach was different from that of the primary care physicians, and expressed the view that we are obliged to promote health in the elderly.

'This should be a central goal of the health system.'

A different geriatrician stated that:

Table 1  Self-perceived diagnostic and treatment skills in preventive care and health promotion for elderly persons (%)

<table>
<thead>
<tr>
<th></th>
<th>No skills</th>
<th>Adequate skills</th>
<th>Competent</th>
<th>Differences between geriatricians and GPs (specialists, residents and non-specialists grouped together) using the chi-square test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explaining the importance of the influenza vaccination</td>
<td>8</td>
<td>47</td>
<td>45</td>
<td>NS</td>
</tr>
<tr>
<td>Explaining the importance of monitoring and maintaining stable blood pressure</td>
<td>6</td>
<td>43</td>
<td>51</td>
<td>NS</td>
</tr>
<tr>
<td>Referring patients for hearing and vision tests</td>
<td>14</td>
<td>52</td>
<td>34</td>
<td>NS</td>
</tr>
<tr>
<td>Encouraging patients to test for occult blood in the stool</td>
<td>14</td>
<td>52</td>
<td>34</td>
<td>NS</td>
</tr>
<tr>
<td>Assessing cognitive deterioration</td>
<td>23</td>
<td>44</td>
<td>33</td>
<td>$P &gt; 0.01$</td>
</tr>
<tr>
<td>Detecting signs of depression</td>
<td>15</td>
<td>53</td>
<td>32</td>
<td>$P &gt; 0.01$</td>
</tr>
<tr>
<td>Examining and giving guidance on treatment for urinary incontinence</td>
<td>38</td>
<td>38</td>
<td>25</td>
<td>$P &gt; 0.01$</td>
</tr>
<tr>
<td>Giving guidance about nutrition</td>
<td>41</td>
<td>38</td>
<td>21</td>
<td>$P &gt; 0.05$</td>
</tr>
<tr>
<td>Encouraging patients to take physical exercise</td>
<td>27</td>
<td>55</td>
<td>18</td>
<td>NS</td>
</tr>
</tbody>
</table>
A feeling of powerlessness and frustration was expressed by about one-third of the family physicians, and this was raised with them in all of the focus groups. A factor contributing to their sense of frustration was the limited number of tools at their disposal, lack of skills in certain areas and lack of professional knowledge regarding lifestyle advice. Typical quotations included:

‘Cognitive deterioration is rather frustrating. It’s not like depression where after a month or two you see improvement.’

‘The treatments for incontinence are complex and the results aren’t that good ... I don’t feel I have the skills to counsel them.’

Here the geriatricians expressed a very different view stressing the importance of overall assessment and family support:

‘My work with the patient also involves supporting the family.’

Several family physicians stated that they did not have enough scientific knowledge about the effectiveness of preventive care and early detection in the elderly. They expressed willingness to learn and develop, but said that they were not offered suitable courses.

The suggestions made by physicians of ways to increase their awareness and involvement in promoting the health of the elderly can be divided into two main categories. The first concerns public authorities while the second related to the medical system within which they worked. Family physicians as well as geriatricians claimed that the HMO did not support them in such activities. One of them said:

‘(The HMO) greatly limits the possibility of practicing good medicine, since it does not provide conditions for it.’

Nevertheless, family physicians perceived external intervention in their work to be positive and desirable. Most of family physicians and the geriatricians supported the use of clinical guidelines and had positive opinions about computerised medical records and feedback as a tool for improving their performance in preventive care and health promotion. However, a few of them were critical of this approach. One of them said:

‘Even if you are a good doctor with a holistic perspective, you are sidetracked toward things that are measured, and in the end, it’s the doctor who is measured.’

In addition, all the family physicians liked to see nurses more involved in preventive care and health promotion for the elderly but it was important for nurses’ job descriptions to be written, clear and recognised. In addition, suggestions were made as to how to deal with the lack of time, such as making preventive medicine appointments for elderly patients once a year, especially if financial incentives could be organised.

Patient factors

At least one family physician in every focus group noted that other patient-related factors often make it hard to give appropriate guidance to the elderly. Examples included lack of adequate education and low levels of awareness about health promotion among the elderly. Some participants said:

‘Doctors invest huge efforts in preventive medicine and it falls on deaf ears.’

‘People are more aware of influenza because they want to avoid severe illness, but it’s harder to convince a man who’s feeling good to use his hearing aid.’

‘It’s not that the elderly don’t want it; they don’t know how to help themselves.’

The geriatricians expressed a more balanced view of treatment adherence among their patients. Physicians stressed the need to expand existing educational programmes and develop new ones based on guidance for healthy behaviour at all stages of life, from infancy to old age, a finding which arose many times in the discussions. They also emphasised that it was not possible to place the responsibility for public health solely on the shoulders of the health system and certainly not on the shoulders of individual doctors. Another mechanism to enhance user involvement in maintaining a healthy lifestyle, which was supported by most of the participants, was to increase the public’s knowledge of maintaining their health through advertising and the media. The advantage of an advertising campaign was that it encouraged the public to talk about health problems, including stigmatised conditions such as urinary incontinence.

Discussion

Many but not all family physicians and geriatricians see themselves as playing a role in prevention, early detection and maintaining their patients’ health. The findings indicate that most of the participants recognised the importance of preventive care, and showed willingness and a desire to address it. However, for various reasons they felt frustrated by the many barriers to preventive medicine and health education in the elderly. A large number of issues need to be addressed in order to improve physicians’ performance.

Most physicians perceived external facilitators to preventive care and health promotion, such as increased use of clear directives from employers and financial incentives, as factors that could enhance their performance. Educational and training programmes, as well as longer, protected time per visit for elderly people, were perceived to be of special importance. It has been
shown that among the elderly a close relationship between the doctor and patient contributes significantly to level of use of preventive practice and that almost all patients (between 91 and 100%) noted that the physician initiated the preventive health care and that non-compliance was due to patient preferences.\(^8\)

This supports our physicians’ statements that more emphasis should be placed on increasing patients’ awareness of preventive care, including use of the media. Physicians supported the idea of transferring a considerable share of this type of activity to nurses. Cooperation between physicians and nurses in preventive care and in maintaining the health of the elderly should therefore be enhanced.

We compared GPs (specialist and non-specialist) and geriatricians. While most GPs reported skills regarding early detection of visual and hearing deterioration, in other areas that were particularly pertinent to the elderly, geriatricians had a distinct edge over GPs, whether or not they were specialists in family medicine. Other researchers have also found a small difference between geriatricians’ and GPs’ attitudes, knowledge and competence in caring for the elderly.\(^8\) However, in our study these differences seem more pronounced. Our findings show that some GPs may lack knowledge and skills in critical areas, particularly detection of cognitive decline, depression and lifestyle counselling. These findings are consistent with previous findings.\(^8,19\)

In order to improve this situation, competency-based approaches in the training, assessment and development of the workforce are needed.\(^20\) Physicians are unaware of cognitive impairment in more than 40% of their cognitively impaired patients, although physicians with training in geriatrics recognised early cognitive impairment more often than did those without it.\(^21\) In light of this, the study findings indicate the need to augment the geriatric training of family doctors in early detection of conditions that are specific to the elderly. Geriatric training should probably be augmented at different stages of a physician’s career. For example, medical education programmes for doctors should include modules that address early detection of conditions specific to the elderly, such as impaired vision and hearing, depression, cognitive deterioration and incontinence.\(^22\) Such a strategy might be of benefit for some GPs, especially those who do not perceive health promotion as an important issue.\(^23\) This is especially true with regard to less well known risk factors for disability.\(^24\) More than half the articles from the published literature show an association between board certification status and positive clinical outcomes.\(^19\) Although this supports the hypothesis that additional training could improve clinical outcomes, it should be remembered that not only physician training but also practice-level characteristics have been associated with differences in the delivery of services.\(^8\)

**Strengths and limitations**

Focus groups are a useful method for increasing understanding about an issue where there are many differing or conflicting opinions.\(^9,10\) or for gaining further information from a specific population group.\(^25\) Focus groups, or group interviews, are particularly useful for generating hypotheses, but are limited in this case by the fact that participants may not fully represent primary care physicians and may form a biased sample (selection bias). In addition, the conclusions may not be transferable to other populations. The survey findings were limited in that self-reported physicians’ skills may be misleading compared to observations of actual behaviour and different groups of physicians may assess their own skills differently. We cannot be sure of the extent to which responses were influenced by what the respondents felt to be socially desirable answers.

**Conclusion**

Since most family physicians in Israel recognise the importance of preventive care, and show willingness to address it, it is imperative to deal with their feeling of frustration due to the many barriers to preventive medicine and health education in the elderly. Although the issue of ‘lack of time’ was a major barrier to implementation, other barriers were identified which include lack of physician knowledge and skills and organisational barriers. The HMOs are in a unique position to improve preventive care in the elderly. Barriers that are focused on physicians’ practice can be addressed and physicians were willing to learn. Such intervention in conjunction with national patient education campaigns could make a positive impact on the health of the elderly population.

**REFERENCES**

Perceived performance, barriers and solutions for good preventive care of elderly people in Israel


**PEER REVIEW**
Not commissioned; externally peer reviewed.

**CONFLICTS OF INTEREST**
None.

**ADDRESS FOR CORRESPONDENCE**
Dr Anthony Heymann, Maccabi Healthcare Services, 27 Ha Mereed Street, Tel Aviv 68125, Israel. Email: heymann_t@mac.org.il

Received 6 November 2009
Accepted 21 March 2010