A qualitative study of staff perspectives of patient non-attendance in a regional primary healthcare setting

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ABSTRACT

Background
Non-attendance at health appointments reduces health service efficiency, is costly to services, and can risk patient health. Reminder systems are widely used to overcome forgetfulness, the most common reason for non-attendance; however, other factors, such as patient demographics and service accessibility, may also affect attendance rates.

Aims
There is limited primary research on the reasons for patient non-attendance in the Australian healthcare setting, although the success of preventative health initiatives requires ongoing monitoring of patients. This study aims to improve our understanding of the Australian experience by examining staff perspectives.

Method
This qualitative study explored staff perspectives of the reasons for non-attendance in a large, regional general practice super clinic, which has a low socioeconomic catchment, and serves a large Aboriginal population.

Results
The practical barriers to attendance of travel, cost, and waiting times had largely been overcome with transport provision, free medical care and responsive appointment times, but paradoxically, these were seen to devalue allocated appointments and reinforce the expectations of "on-demand" health care. For Aboriginal patients specifically, a distrust of authority, combined with poor health literacy was perceived to impact negatively on the uptake of diagnostic tests, filling of prescriptions, health monitoring, and adherence to medication.

Conclusion
The results suggest a complex interplay between poor health literacy and low patient self-worth; a funding system that encourages "five-minute medicine and prevents doctors getting to the root cause of patient problems or having the ability to provide health education.

Key Words
Non-attendance, super clinic, Aboriginal, adherence, reminders

What this study adds:

1. What is known about this subject?
Most research into non-attendance at medical appointments has focused on accessible patient populations where forgetfulness, access, patient expectations, and experience are found to influence attendance.

2. What new information is offered in this study?
Wider social issues, including low socioeconomics status and low health literacy, are perceived as important determinants of non-attendance for some groups, where locally modifiable factors such as reminder systems and transport are in place.

3. What are the implications for research, policy, or practice?

The current healthcare funding model encourages "five-minute medicine", which is unlikely to modify the attendance behaviour of hard-to-reach populations, who are likely to have the greatest health needs.

Background

Patient non-attendance at appointments is a major concern for healthcare service providers in Australia. Non-attendance prevents efficient healthcare delivery,[1–3] results in inefficient use of staff, and illness prevention is compromised when people do not attend scheduled follow-up appointments. [4–6]

Previous studies suggest that non-attendance is caused by negative patient-staff relationships, patients' perceived knowledge about the diseases and patients' experience with treatment regimens,[5] forgetfulness,[2,7–9] administrative errors regarding making and cancelling appointments, lack of transport,[8–10] and that forgetfulness is the most common reason for non-attendance at scheduled appointments.[7,8] However, other factors such as low socioeconomic status, age and gender, are associated with non-attendance in high income countries.[5,11] The extent of non-attendance in the Australian population has not been systematically documented, even though non-attendance has been identified as a problem in primary care settings. [2,7]

A recent systematic review and realist synthesis of reminder interventions designed to reduce non-attendance[12] proposed a conceptual framework for patient attendance and made several suggestions for enhancing attendance. The majority of the recommendations related to patient interaction with the reminder system. There was a distinct lack of published evidence on hard-to-reach populations, which this study helps to address.

The Setting

The Lismore General Practice Super Clinic (LGPSC) is a privately run, primary care practice, which is free to all patients at the point of contact, funded by Medicare payments. The clinic has a stable patient base of approximately 8,000 patients, of these, 1,700 identify as Aboriginal and Torres Strait Islander. The staff comprises five doctors, eight nurses, five administration staff, and a transport officer as well as two non-medical managing directors. The doctors are from Bangladesh, India, and Australia, including one Aboriginal doctor as well as an Aboriginal liaison officer and transport officer.

A sustainable business model based on Medicare payments requires high levels of service efficiency, with little staff "down time" and high patient throughput. This study arose because the LGPSC identified non-attendance as a significant problem resulting in inefficient use of staff and multiple unfilled appointments with overrepresentation of Aboriginal and Torres Strait Islander patients. From here on the term "Aboriginal" is used to refer to the diverse Aboriginal and Torres Strait Islander peoples.[13] The LGPSC introduced several strategies to reduce non-attendance, including reminder phone calls, patient transport, and a trial introduction of incentives. Aboriginal administrators, transport workers, and medical staff were employed to work with the Aboriginal population. These initiatives had some success, but some population groups still have rates of non-attendance of between 10–20 per cent.

To help address these issues and identify potential solutions, we undertook a multi-method study to gain insights into reasons for non-attendance and develop strategies to increase attendance. This qualitative paper reports the perspectives of the clinical and administrative staff on implications of and reasons for and non-attendance.

Method

All practice staff that had worked at the clinic for more than three months were invited to be interviewed. Staff unable to participate in individual interviews were invited to attend a group discussion and/or provide a written response on a short questionnaire. Interview and survey questions reflected the research question and explored staff perceptions of: the impact of non-attendance on the clinic and patients; reasons for non-attendance; risk factors for non-attendance; and strategies that might improve attendance. All modes of data collection used the same open-ended questions to explore the impact of non-attendance on the clinic; factors that influenced non-attendance; at-risk groups and strategies to reduce non-attendance. Most interviews were recorded (with permission) and where permission was refused, detailed notes were taken. Ethics approval was obtained from Southern Cross University (Approval number ECN-13-100).

All recorded interviews were transcribed verbatim. NVivo10 qualitative data analysis software was used to assist with analysis. Thematic analysis was undertaken using Template Analysis[14] by the primary author to identify patterns within the data. A priori themes were identified from the interview questions, and new themes

arose in Nvivo. The analysis was verified by all co-authors. Survey responses were incorporated into the qualitative themes generated but not managed in Nvivo.

Results

Clinic staff are drawn from three distinct cultural backgrounds: Aboriginal, non-English speaking, and English speaking as illustrated in Table 1.

Table 1: Cultural background of participating staff at the LGPSC and the total number of staff from each background

Cultural background	Participants	Total
Aboriginal	2	3
Non English Speaking	3	3
English speaking	10	14

Of the 20 clinic staff, 15 were interviewed. Four staff were unavailable and one declined to participate (Table 2). The interviews are not attributed to protect staff identity.

Table 2: LGPSC Staff participation by role

Role (Total number employed)	Interview	Survey	Group discussion	Total
Admin/ reception (6)	1		4	5
Nurse (8)	2	3		5
Doctors (5)	4	1		5
Transport officer (1)				0

Implications of non-attendance

The implications of non-attendance included the perceived waste of taxpayer money due to the high fixed staff costs and the inability for staff to plan their workload around patients. Staff also pointed out that they spend at least two hours every day confirming the following day's appointments.

"We might wait for an hour for patients to show up. If they don't show up we're still sitting here waiting, our boss can't really send us home because someone can walk in the door any minute and it's hard to even begin a project because you don't know at any moment in time they might turn up 10 minutes late."

There was also a negative impact on service efficiency, affecting appointment waiting times and accessibility for other patients as highlighted in the following quote.

"Non-attendance blocks the appointments for the other patients who could have seen the doctor instead… we lost out on money for the clinic… it has implications in certain circumstances for patients' health and wellbeing."

The reasons for non-attendance

Initial staff impressions for the reasons for non-attendance varied widely and included a range of personal, environmental, and social factors. These are summarised under the headings of patient-specific risk factors, clinical risk factors and doctor-patient interaction.

Patient specific risk factors for non-attendance
Socioeconomic status

Several respondents highlighted the complex interplay between low socioeconomic status and poor education, a low sense of self-worth, and a lack of value and understanding of the importance of health. One consequence of this is that health falls below other priorities in what can be a chaotic lifestyle for many of the LGPSC patients. This was seen to be an issue for all low socioeconomic groups, regardless of ethnicity.

"So you know basically if, depending on all the other factors that are going on in their lives, like if their auntie's unwell, or their kids are unwell, that's gonna take precedence over their own health."

"Because you know white or black they're still overwhelmed by so many other things going on in their lives, that you know like their health takes a really low kind of priority when it should be number one, 'cos you can't really do anything else without it."

"Low SES [socioeconomic status], chronic illness, lack of knowledge of health"

"People who generally have health on their side and don't see their health as particularly important or the older people who are genuinely it's a real struggle for them to get here, whether it be they're in too much pain, for example, they just sometimes feel and say, I just couldn't even get out of bed, I couldn't get out of bed to make a phone call. Sometimes you'll hear genuine stories of why people couldn't attend."

Age

Participants varied in their impressions of the effect of age on appointment attendance, as the following quotes illustrate.

"I think the younger or the older are the same."

"You probably tend to value your health more and you probably tend to value yourself a bit more, so it probably happens less with older patients."

"Young mums are pretty good at keeping their appointments and were seen to be 'protective' of their kids as well. The moms did their best."

"Young [Aboriginal] guys do not care. They are dispossessed and have lost their identity."

Lack of health knowledge

Lack of health knowledge encompassed a range of factors perceived to influence non-attendance, including lack of understanding of health, health problems, preventive approaches, and the importance of follow-up. There was a general perception that patients only attend the clinic when they have acute symptoms, with few voluntarily attending for health promotion or prevention activities.

"They only come here when they are very very sick… So when they want to see a doctor they show up and they want to get in then …You'll find lots of them won't show 'cause they aren't really interested in that… they're sick now and they wanna be treated now so… And I don't think they grasp the idea that our clinics are for preventative health… I don't believe that they get how that works."

"Patients often don't take their medication because they don't understand what it's for. The liaison officer takes them to the chemist, but they go home empty handed."

"I think that the number one issue is that people, especially in Indigenous community haven't been given the self-belief that their health is you know important: that they're worthy of good health. And it's not just indigenous people. I think that that happens in the lower socioeconomic sector."

Population mobility

The mobility of the Aboriginal population was perceived to influence non-attendance with patients not answering the phone and phone numbers not being correctly updated. This reduced the ability of the clinic to send reminders or transport to access services.

"Sometimes they do not answer the phone or they don't pick the phone. Or maybe the phone is off."

"They like to move around and I don't know and just have prepaid mobiles."

Significant community events

Several staff reflected on the priority given by Aboriginal patients to the funeral of a community member, an obligation that took precedence over a clinic appointment and resulted in substantial non-attendance over a one-week period.

"If they have got any community business going on like if there's been a death well that just cancels out any prior commitments full stop you know, that's it, that's what you're doing for the next couple of weeks or however long. And so there's so many of those issues, but it think that the number one issue is about self-worth."

"I can't think of anything that affects them quite as much (as a funeral)…. like that's such a big deal."

Confidentiality and distrust of authority

A lack of trust and understanding about the handling of patient information was mentioned by several participants as factors that not only influenced attendance, but were also barriers to effective health care. In particular, patients were concerned about the confidentiality of their data. This issue was particularly relevant for Aboriginal patients.

"They worry about their confidentiality… they don't really understand that what happens between the doctor and the nurse is not repeated… They just think, like, if they tell us something everyone will know."

This also had implications for the uptake of tests and adherence to medication.

"We'll give them a pathology form and they'll just walk straight out the door and ignore that because they don't want people knowing what they've drunk or what they've taken or how they live their lives."

Although, one respondent suggested that non-Aboriginal staff were perceived to provide greater confidentiality for Aboriginal patients because they are not part of the same community.

"They like coming to (non-Indigenous) people because they're not part of the community so they don't know their health problems… cause the community can be pretty close and if they know…. it's depend on the person, I guess."

Clinic-specific reasons for non-attendance

The clinic-specific issues fell under two broad themes: accessibility of services (transport, cost, and waiting times) and the lack of consequences of non-attendance.

Accessibility of services

The LGPSC has gone to great lengths to overcome barriers to access to services, including provision of transport, reminder systems, and providing a free service. These were all identified as being successful; however, as the following quotations show, they were seen as part of a more complex perception of patient interactions with the service where patients fail to value the service.

"So the reason people find it hard to even turn up to appointments is obviously multi-factorial… in more rural areas there are like distance and transport and the finance issues… but … here none of those issues apply. We've got a transport officer… most people live in this vicinity. They live really close by and… it's a bulk bill practice so there's no financial blockage.'

The clinic is free to all patients at the point of access. This model is facilitated by "bulk billing" where the clinic does not charge the patient directly, but receives payment from Medicare for each patient visit. For this model to be cost effective, general practitioners must achieve a high patient throughput so they are limited in the time they can spend with patients. While there was general recognition that having a free service reduces the financial barriers to accessing care, respondents reported that it put pressure on the quality of the doctor-patient interaction, and devalued the service to the patients.

'*Quick access and getting them in quickly… but I think that you lose out in the long term if you're not actually attending to your patient care as a holistic kind of generalist… and you don't even put those issues together as one package; lets deal with what's underlying that. If we could do that then they won't have to keep coming back over and over."*

"It's five-minute medicine. If you have got a complex issue you've got to come back, and then you know like if you don't have the knowledge to attend to all those complex issues you tend to suppress that information anyway."

"We're not funded to do education, because it takes too much time in the consultation."

"Because it's a free clinic they don't really care. It's not gonna cost them money so they just don't come—they think they've got something better for the day. If you look through their

records, the ones that haven't turned up, they're not really in control of their health either so, maybe they had something better to do for the day."

One respondent suggested that it might be more appropriate to take the care directly to the patients, rather than expecting them to attend a clinic.

*"If we could just take a **lap** top and do consultations at their place with teams of two, I know that would be perhaps an expensive and inefficient exercise but in terms of reaching the community... It might mean going to the square or going to a place that's downtown or you know in a café where they get a cup of tea or something so that's it's some level of appeal without it being you know just about, I don't know what the answer is."*

Generally, patients did not have to wait long between making their appointment and seeing the GP; however, paradoxically, staff identified that the easy access to the services decreased patients' perceptions of the importance of attending their appointment on time, or at all. In other words, better access to services was perceived to cause reduced attendance in some cases.

"Easy access makes people think that patients can come and go as they like."

However, patients that do attend appointments sometimes have to wait and this was seen to have a potentially detrimental effect on appointment behaviour.

"You don't have to wait for a long time here… but everybody knows that if you want to see a doctor, you always have to wait. Because, there'll always be some emergencies."

"People turn up late and it's like well I had to wait an hour last time it's like okay yeah maybe you did, maybe someone had chest pain and we had to attend to them, we're actually running on time today and so if you turn up an hour late you know it throws a spanner in the works."

Patient consequences of non-attendance

The majority of staff commented on lack of consequences for patients not turning up for an appointment, and that the clinic never asks patients for a reason for non-attendance.

"We are not that strict… so what we do, when they turn-up, we just make another appointment."

"Nothing will happen if they do not turn up… they have their Medicare card. They can see the doctor… easy."

One participant considered the use of co-payments to increase attendance:

"We bulk bill and there's no charge and there's no consequence... I wonder if we were to charge $5 for an appointment if that would make people more likely to show up, more likely to care about their appointment, more likely to care about outcomes. That whole idea when people get something for nothing I think people don't value things as much when they're getting something for nothing and being a bulk billing practice I think that's part of it."

Cancellation of appointments
The administrative staff also observed that many patients do not cancel their appointments, or they cancel just before or after the appointment when it is impossible to reschedule that appointment slot.

"Sometimes they do [call], sometimes they do not" 'Hey…look! I am not coming today!' … We say, 'Okay! Don't worry about that!'"

"It might be 10 minutes after their appointment, but they do phone and they say hey I'm not coming. It's like that's okay it was 10 minutes ago anyway, don't worry about it."

Again, the clinic had gone to great lengths to make cancellation and rebooking easy, by confirming all appointments within 24 hours of the due appointments and providing multiple telephone lines so that patients would rarely be unable to telephone the clinic.

"We've got four [telephone] lines coming in so yeah, people ring back… I don't think that's a major issue for us."

The importance of the doctor-patient relationship on attendance
All staff, including the doctors, highlighted the importance of doctor-patient relationships on non-attendance. These were linked to gender and culture appropriateness, doctor-patient communication, and short consultation times.

Doctor-patient interaction
Several participants mentioned doctor-patient communication. Three of the general practitioners are from a non-English speaking background, which initially created some challenges in understanding because of their accents.

"The accent of the non-Caucasian doctors is a problem for the patients."

However, there was general acceptance that the quality of the interaction and the intent behind it was more important than the actual language.

"But once you actually sit down and talk with people and you have them understanding where the doctor's coming from then they know, it makes it easier for them. They can go and talk to the doctor and they still might not physically be able to understand what he's saying, but they can, they know what he means."

"Like I've had at least five people today say 'I didn't feel heard by the other GPs'… If people had the time to listen then people would be heard… And people won't come if they're not feeling heard."

However, communication barriers were also evident from the patient perspective, reflecting the need for greater health literacy.

"It might be just a communication thing for the doctors that they deal with people who really don't know anything about their health. They don't understand what medicine is going to help them... then they go straight home."

The appropriateness of the doctor for the specific conditions or patient needs was also identified as an issue. For instance, the clinic has few female doctors, which was perceived as a barrier to women talking to doctors for "female issues".

"They'll be very reluctant to talk to the doctor about their female issues, they'll say, 'Oh, I really don't want to talk to the male doctors about this', and you know just reassuring them that's their job, they're trained to do this, they do this every day but maybe they would prefer to see… well, I'm sure they'd prefer to see a female doctor when it comes to those issues, most women, yeah."

While short consultations are integral to the financial viability of the LGPSC under current Medicare funding, several of the doctors mentioned that this impacted on their ability to spend the time with patients to develop appropriate rapport.

*"It [short consultation time] does not allow accepted cultural behaviours. You have not got time to start with proper protocol... you need **to** have **a** yarn (chat) about the family. 'How's your Auntie?' or 'Is your mob from this*

area?' It is kind of rapport building with patients. It is even more than rapport. Build rapport and then ask what happens with health. The problem is that it makes them (the clinic) run late... they are often sitting two hours in the waiting rooms.'

There was also a perceived lack of understanding of the needs of mental health patients.

"Well, doctors need to spend more time with their patients, they need to be trained in mental health issues and as self-worth is like the number one determinant of mental health issues, that's got to be the number one focus. You know it's got to start right from the very beginning like I'm you know, trying to encourage the guys here to start, you know, doing longer appointments for special mental health and chronic disease…"

Discussion

While this study only presents the perspectives of staff, it highlights a complex interplay of factors that can contribute to patient non-attendance.

The LGPSC has addressed most of the structural barriers to accessing health services, including transport, waiting times, and cost. They have also introduced several measures to address the cultural barriers to accessing care by employing Aboriginal staff, and their reminder phone calls serve to overcome the problem of forgetfulness. However, providing an affordable service within a sustainable business model means that appointment times are inevitably short, which may explain the finding that patients in economically disadvantaged areas are less likely to be assigned long consultations in Australia.[15] Brief appointments prevent the delivery of necessary health promotion and education to patients most in need. This, in turn, impacts negatively on health literacy, which further reduces the likelihood of patients attending their appointment. When patients fail to attend their appointment, there are no consequences, and rebooking or unscheduled attendances are accommodated by the service. The result is that the service becomes a revolving door of patients with acute health needs, with little planned care, reduced opportunities for prevention, and a heightened expectation that the services are available on demand. The limited cancellation and rebooking by patients suggests that they place little value on the service, and have little consideration of the impact of their actions on service availability for others.

One possible solution to this problem is to increase funding to primary healthcare services so that appointment times can be increased. This solution has been proposed for Aboriginal Australians;[16] however, this study and others suggest that the same consideration should apply to all low-socioeconomic groups given the independent association of household income with multimorbidity.[17] There were suggestions within the study that a patient co-payment for services may be appropriate; however, in a low-socioeconomic community, this risks decreasing, not increasing appointment attendance. Others suggest the introduction of fines for non-attendance; however, these are difficult to administer and enforce and could undermine hard-won community trust.[18]

Another solution is to inform patients about the effect of non-attendance. Successful interventions introduced in other settings include verbal and written commitments between the health service, such as writing down the appointment (to reduce forgetfulness).[19] Other effective interventions include "communicating the right norms" by installing signs showing rates of attendance or non-attendance in the clinic waiting room.[19] Engaging service users to help identify solutions to non-attendance has resulted in novel solutions such as installation of a free telephone number for cancellation.[20] This may help to overcome the perception that services are available on a "drop-in" basis.

Patient behaviour is also determined by previous experience. For instance, patients who have experienced long waiting times in the clinic previously are more likely to be late. Advising patients on potential delays and demonstrating respect for patient time may result in improved adherence to set appointment times. Technologies such as short messaging service (SMS) could play a role here.

From the patient perspective, there is a clear need for improved health literacy among the Lismore population, particularly the lower socioeconomic groups and specifically tailored to the needs of the Aboriginal community.[21] The LGPSC has worked closely with the local Aboriginal football club (Northern United Football Club) as one approach to addressing health literacy amongst the community. Problems with comprehension and communication of medical recommendations could be usefully addressed by increasing the cultural literacy of clinical staff.[22,] While enhancing all aspects of adherence, health literacy could improve attendance at nurse-led chronic disease monitoring appointments and so has the potential to reduce morbidity while providing economic benefits for the clinic.[23]

The findings suggest that Aboriginal people particularly distrust authority, and have concerns about the

confidentiality of their data. While all health services are required to uphold standards of data confidentiality, it may be valuable to communicate this explicitly, in a user-friendly way to patients to help overcome this distrust. This issue needs to be managed alongside the general distrust of any written health record or test.

A non-Indigenous primary care service in Queensland, Australia introduced a range of specific strategies to increase engagement with Aboriginal and Torres Strait Islander patients.[24] These included employing Indigenous staff; modifying the waiting room to be more culturally appropriate (playing Aboriginal radio, and displaying appropriate artefacts and posters); raising cultural awareness of the staff;[25] and liaising with local Aboriginal and Torres Strait Islander networks. The number of Aboriginal and Torres Strait Islander consultations increased tenfold following the introduction of these strategies. Some of these strategies may be appropriate to reduce non-attendance in the LGPSC Aboriginal population.

The latter example reinforces the common perception that Aboriginal people prefer to be seen by Aboriginal staff. Our study suggests that non-Aboriginal staff present less threat to the divulgence of personal information because they are not part of the same community structure. This perception requires further investigation to ensure that the services are truly culturally "friendly".

From the perspective of the LGPSC, a simple solution may be to overbook doctors' appointments; however, this only addresses the financial model of the clinic, rather than the health of those who most need it. This may also negatively affect patient behaviour by increasing waiting times, and reinforce the model of "five-minute medicine".

Important unplanned events such as funerals are unavoidable, and substantially reduce appointment attendance in the Aboriginal community during and for several days after the event. In these cases, the clinic needs to be able to respond by adjusting to the changed service throughput, either by reducing staffing, or by inviting other patients to attend. Services could establish pro-active strategies to identify significant community events, and then be able to adapt to the changing throughput, although this suggests a flexibility of staffing that is generally not available.

As one participant suggested, the solution to addressing the needs of the most resistant attenders may be to take the health care to the community, rather than expecting them to attend a clinic. This would require some major changes to the way health care is delivered, but may be a novel solution to a challenging problem.

Limitations

Further qualitative and quantitative research is being undertaken to examine the patient perspective and risk factors for non-attendance and will be reported separately. However, we acknowledge the limited perspective of this paper in presenting only the perspectives of staff. Within the group interviews some staff may have felt constrained in the level of information they were willing to share. The sampling method suited the aim of this small study, which was to gain the provider perspectives on non-attendance from staff within a specific clinic.

Conclusion

This study has identified a range of factors, from the staff perspective, that influence patient risk of non-attendance at their healthcare appointments. These include factors that can be modified locally by the clinic, and those that require wider social support and change to influence. The locally modifiable factors include reminder systems, enhancing service accessibility, and introducing culturally sensitive services. That the LGPSC has introduced many of these initiatives and still has high rates of non-attendance by some groups highlights the challenges of addressing the wider social issues. These include patient-specific factors, (specifically low-socioeconomic status and low health literacy), unplanned significant cultural events, and the model of healthcare funding that makes healthcare affordable, but promote a model of "five-minute medicine".

Most of the research into non-attendance and reminder systems tends to focus on the more accessible populations and the more easily modifiable solutions.[12] While these solutions are likely to help the large majority of people, they exclude the hard-to-reach populations who are also likely to have the greatest health needs. We have identified several strategies to reduce the rates of non-attendance; however, substantially more research is needed to determine the best ways to engage with hard-to-reach populations in primary health care.

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CONFLICTS OF INTEREST

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ETHICS COMMITTEE APPROVAL

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