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Home visits in general practice: an exploration by focus groups

by

Van Royen P.[1, 2], De Lepeleire J.[1, 3], Maes R.[1]

Abstract

Objectives: *To determine in depth the added value, the disadvantage and/or benefit of a home visit versus an office encounter and to study the factors which determine the request and performance of home visits.*

Method: *Focus group research was conducted with general practitioners (GPs), patients and representatives of health insurance companies in Antwerp, Belgium. The major themes in the topic guide were value and/or disadvantages of a home visit, the patient's request for the home visit, the influence of health care and practice organisation, and the doctor him/herself. The discussions were tape-recorded, transcribed and systematically analysed.*

Results: *Content analysis of transcribed texts was undertaken and 77 items, related to the number and performance of home visits by GPs, were identified. These different codes were then classified into the 8 categories of a theoretical framework: different patient groups/illnesses,*

Correspondence: Paul Van Royen, University of Antwerp, Department of General Practice – Universiteitsplein 1, 2610 Wilrijk – Antwerpen/Belgium. Tel: 00-32-3-820 25 29, Fax: 00-32-3-820 25 26, E-mail: paul.vanroyen@ua.ac.be

[1] Department of Research, Scientific Society of General Practitioners (WVVH), Berchem, Belgium.

[2] Department of General Practice, University of Antwerp (UIA), Belgium.

[3] Department of General Practice, Catholic University Leuven (KUL), Belgium.

patient related factors, doctor related factors, practice organisation, context and intimacy, medical technical factors, health care organisation and economic factors.

Conclusion: *Many factors influence the request and performance of home visits by GPs in Belgium. The practice organisation, the contextual information and patient related factors were the most frequently mentioned reasons to perform home visits, whereas doctor related factors, in this research, seemed less important.*

Keywords

Belgium, family practice, home visits.

Introduction

In most European countries home visits form part of the general practitioners' (GP) normal routine. However, the home visiting rate varies from 0% to 45% of all encounters (1, 2). In the UK and the Netherlands, the average number of home visits by a GP is 20 per week, whereas in Portugal it is 2 per week. In France the number is much higher, 27 per week, and Belgium has the highest rate of 44 home visits per week. About 45 percent of all doctor-patient contacts in general practice in Belgium are home visits.

There is debate about the value of home visits and the appropriate rate. During home visits, it is more difficult to carry out diagnostic and therapeutic interventions and there may be problems with other people being present, bad lighting or noise. The medical records may not be readily available. In countries with a low home visit rate, there are fears that people are not receiving the home care they need, whereas in countries with a high rate, the quality and high cost of home visits are questioned. However, a home visit may be a powerful tool for achieving quality of care for patients that – either because of their health problem or other functional limitations – cannot go to the doctor's office. For some conditions, such as dementia, planning integrated care may only be possible if patients are seen at home (3).

There may be many factors influencing the home visits rate: the patients' health problem or dependence level, practice organisation, the health care system, and social and cultural factors. Few studies have examined reasons for home visits, but one study undertaken in Belgium demonstrated that the absolute number of home visits between 1975 and 1992 was stable and independent of the number of GPs and the financial contribution of the patient (4). Morbidity was less of an explanatory factor than a number of GP characteristics.

To understand more about home visits, an explorative, qualitative study was performed, with the following research questions:

- What is the added value, the disadvantage and/or benefit of a home visit compared to an office encounter as perceived by general practitioners, patients and health insurance companies?
- What factors determine the request and performance of home visits?
- What strategy can be used to reduce the rate of home visits, yet meet the needs of patients?

Methods

Focus groups were used to explore the research questions. In these focus groups, participants discuss questions about a well-defined topic (5). The advantage of focus groups to individual interviews or questionnaires is that the group process encourages exchange of individual perceptions, with interactions and positive and negative reactions stimulating further discussion. Focus groups also enable information on the background of opinions to be collected.

The number of focus groups was determined by data saturation, i.e. when no new data was being gathered. Five focus groups, which were made up of individuals from different groups, were withheld: group 1 consisted of male health insurance company representatives, groups 2 and 3 were made up out of female and male GPs, respectively, and groups 4 and 5 represented the patients.

To enable the free exchange of views, the composition of the groups was homogeneous for gender and age group (Table 1). Purposeful sampling ensured people from a diversity of age groups and vulnerable groups, such as the elderly and parents of young children, were included. Participants were contacted in the following ways:

TABLE 1
Composition of focus groups according to number invited, number of participants, age range and gender

	Group 1 Health insurance companies representatives	Group 2 GPs	Group 3 GPs	Group 4 Patients	Group 5 Patients	**Total**
Number invited	7	13	17	7	12	**56**
Participants	7	9	9	4	8	**37**
Age range	–	30-45 yrs	45-60 yrs	30-40 yrs	60-70 yrs	
Gender	Male	Female	Male	Female	Male	

– The two researchers (VRP, DLJ) each contacted by telephone a purposeful sample of twenty-five GPs from the Antwerp area of Belgium, chosen to give diversity of gender, practice characteristics and general practice experience. Thirty GPs willing to participate then received a written invitation. Eighteen GPs finally participated.
– A local health insurance company contacted (by telephone) a random sample of their members within the defined age groups. Those willing to participate received a written invitation and were phoned again one week before the focus group session in order to confirm their participation.
– Representatives of health insurance companies were invited by means of a personal letter.

The focus groups followed a standard procedure (5, 6) with the same professional moderator (Eylenbosh Karin). An observer was present, making notes about interactions and non-verbal reactions. Afterwards the observer conferred with the moderator to evaluate the discussion process. The moderator used the following open questions:

– What is the value or disadvantage of home visits to you?
– What are your views about the patient's request for a home visit?
– What is your opinion about the influence of the health care system, the practice organisation and the doctor him/herself on the home visit rate?

The discussions within the groups were tape-recorded and transcribed.

The texts were analysed by two researchers (i.e. VRP and DLJ), independently and in accordance with the principles of "qualitative content analysis" (7). At a workshop of the Flemish Scientific Society in

November 1997, the initial analysis was presented. Six groups of general practitioners, different from those in the focus groups, discussed the research questions and the initial analysis. The discussion was recorded and analysed but revealed no new elements. It was concluded that content saturation of data was reached after the discussions among the first five focus groups.

The transcripts were coded with the assistance of QSR NUD*IST software for relevant and recurrent themes (8). Through reflection and interpretation of the coded text, we identified relationships between the various codes and developed a theoretical framework. The codes were also sorted by frequency within the different categories of the framework.

Results

Between March and June 1997, 37 participants met in five focus groups (Table 1). Content analysis of transcribed texts was undertaken and 77 items or "codes", related to the number and performance of home visits by general practitioners, were identified. These codes were then classified into the eight categories of the theoretical framework: patient groups/illnesses, patient related factors, doctor related factors, practice organisation, context and intimacy, medical technical factors, health care organisation and economic factors.

Patient groups/illnesses and patient-related factors

Table 2 lists the patient groups/illnesses and patient-related factors identified. Table 3 gives extracts from the data illustrating the views expressed. Both patients and GPs stated that home visits are frequently requested for young children, the elderly and the very ill. One patient stated that the elderly request a home visit, because they can "have a good chat" with their GP at home (Table 3: 6). Physicians also find home visits to the elderly useful because in that way they can better assess their way of life, activities of daily living, hygienic conditions and medication use (Table 3: 5).

Patient-related factors included convenience for the patient (Table 3: 7-8). GPs said they tried to educate the patient about their attitude to general practice on home visits (Table 3: 9-10). Previous experience of disease and social class were also mentioned as influencing factors.

TABLE 2
Theoretical framework of items/codes concerning the value and reason of a home visit, sorted by frequency

Category	Frequency of found codes within the category
Practice organisation	**55**
– Waiting times	
– Practice population: young vs. old	
– Organisation: walk in (no appointment)/appointment system	
– Decision urgent/non-urgent	
– Who answers telephone	
– Routine visit/visit chronic patient,	
– Knowledge patients concerning practice organisation	
– Structure of practice/solo, duo, group practice	
– Distance home-practice	
– Doctor living at same place as practice	
– Pharmaceutical delegates	
– Visits during epidemics	
– Time (of day) of request for home visit	
– Availability of consultation room	
Patient related factors	**45**
– Comfort	
– Ease of patient	
– "education" of patient	
– Attitude towards doctor/GP specialist	
– Illness experience	
– Social class	
– Possibilities of patient	
– Pressure of patient	
– Administrative reasons	
– Attending practice is burden on the family	
– Women working outside the home	
– Patient assertiveness	
Context/intimacy	**42**
– Intimacy	
– Observation of interaction at home	
– Contextual information	
– Fear of technology in consultation room	
– City vs. Rural	
– Immigrant versus native population	
– Cultural factors	
– Personal attention	
– Consultation: more time pressure	
– At home: doctor as guest	
– Home visit: taking patient seriously	
– Home visit: good social talk	
– Terminology "huis"arts (the Dutch word for GP literally means "home" physician)	

TABLE 2 (continued)
Theoretical framework of items/codes concerning the value and reason of a home visit, sorted by frequency

Category	Frequency of found codes within the category
Patient groups/illnesses	**39**
– Paediatrics	
– Geriatrics	
– Very ill patients	
– Palliative care	
– Acute illness	
– Mobility problems	
– Psychosomatic conditions	
– Medical problems at night	
– Fever	
– Urgent problems	
Doctor related factors	**21**
– Encouragement of home visit by GP	
– Attitude of doctor/GP decides	
– Age of doctor/gender of doctor	
– Home visit is satisfying experience for doctor	
– Home visit scheduled by doctor	
– Whether GP is prepared to question request for home visit	
– Workload for doctor	
– Fear of missing serious condition	
Economical factors	**20**
– Cost for patient/financial earnings for doctor	
– Time load for doctor/time load for patient	
Medical technical factors	**19**
– Consultation higher quality at technical level	
– Home visit higher quality at human level	
– Consultation more structured	
– Patient's files available at practice	
– Home visit is an essential element of GP's task	
– Instruments available in the surgery	
– Drugs available at home	
Health care organisation	**16**
– Patient registration	
– Excess of doctors in the locality	
– Fee for service system	
– Competition between doctors	
– Health care organisation	

Doctor-related factors and practice organisation

The doctor characteristics (attitude of the GP, age, and own convenience) influence home visit frequency (Table 3: 11-12). GPs with a more defensive attitude perform more home visits. Some GPs recognise that although home visits increase workload for the GP, they are also a pleasant experience for the doctor.

They also state that the length of time spent in the waiting room keeps patients from attending the surgery, which is also recognised by patients and representatives of health insurance companies (Table 3: 13-15). An appointment system for consultations was seen as important in decreasing the rate of home visits (Table 3: 16-17).

Context, intimacy and medical-technical factors

Patients mentioned that the intimacy of a home visit was important when talking about family, their socio-economic and life situation and life events. A home visit creates a closer relationship (Table 3: 19-20).

Where it is necessary to have an in-depth understanding of the patient including contextual information, home visits are important to GPs (Table 3: 22-23). However, during a home visit it is more difficult to undertake diagnostic and therapeutic interventions. There may also be problems such as bad lighting and noise. The performance of the GP may be of lower quality than in the practice (Table 3: 24-25).

Health care organisation and economic factors

Cost can encourage patients to go to the surgery. However in Belgium, if patients request a home visit instead of going to the surgery, they only pay between 0.33 and 2.61 Euro more, depending on their status in the social security system. For many patients this additional cost is set-off by the advantages of not having to travel to the practice and spend time in the waiting room (Table 3: 28-30).

The structure and process of the health care organisation can also influence the rate of home visits. These comments were almost exclusively made by representatives of health insurance companies (Table 3: 26-27).

TABLE 3
Representative extracts of the different focus groups

Patient groups – Paediatrics

(1) RI: You do not take a child with 40° fever to a paediatrician, you go to the GP.
(2) RI: A home visit is something important if you have children with an acute illness or for the elderly.
(3) Female P: If you have a young child with high fever, it's better to think: I would rather stay in.

Patient groups – Geriatrics

(4) Female GP: When I started practice, my point of view was "Not too many home visits. The people should be flexible." But I came into conflict with the elderly.
(5) Female GP: I don't mind visiting the elderly, it's a good way to check on their medication intake. You can see the boxes and the hygienic conditions, and so on.
(6) Female P: The elderly ask for a home visit, so they can have a good chat with their GP.

Patient factors – Ease/comfort

(7) Female GP: Many older people are a bit lazy. They are able to go to the baker, to the butcher, but not to their GP.
(8) Female P: Quite a number of people phone the GP even if they can easily come to the practice – wantonly.

Patient factors – Education of patient

(9) RI: At the end it takes education on both sides: patients as well as GPs should review how we grant a patient's request.
(10) Male GP: You should work on it every home visit. So the next time the patient realises: "last time the doctor said: it's better to come to the practice."

Doctor's factors – attitude of GP

(11) Female GP: As a doctor one should proceed at the beginning (of establishing your practice) with a certain attitude and then negotiate.
(12) Male P: The patient asks for the doctor – all the rest is up to the doctor. If he knows you well and it's urgent, the doctor will be there quickly.

Practice organisation – waiting times/free consultation

(13) RI: As well as the number of kilometres, I consider the number of minutes and hours spent in the waiting-room to be important – and if you can go by appointment.
(14) Male GP: The waiting itself is an obstacle for many people.
(15) Female P: When my children are ill, I don't think it's reasonable to wait for over one hour and a half with them in the GP's waiting room, when there are other people too.

Practice organisation – appointment possibility

(16) Female GP: We work on an appointment basis, besides and moreover we have 3 consultations every day. If a patient is unable to come to the practice, then we are obliged to do a home visit.
(17) Male GP: I do it in a subtle way. I will never say I do not want to make a home visit, but I would say: I will come but I don't know when exactly. But maybe you could come to the practice at 11 a.m., then you are sure that the pharmacy is still open and a half hour later it's done.

TABLE 3 (continued)
Representative extracts of the different focus groups

Intimacy
(18) Male GP: In my opinion, visiting people is a matter of trust. They allow you to go further than the front door. You can come into their living-room, their bedroom.
(19) Female P: A home visit creates a closer relationship towards your doctor.

Contextual information
(20) Female P: I also notice that at a home visit, people talk more freely about family, material matters, the things happening in their lives.
(21) RI: As a medical officer, I do not make any home visits. When a social assistant makes them, sometimes you are surprised what those people have found there.
(22) Male GP: I think that a home visit has an important background effect, so you can also look behind the scenes.
(23) Male GP: It's important to have a total picture of the patient.

Medical-technical aspects
(24) Female GP: In my personal opinion, the quality of a medical examination at home is often not so good.
(25) Male GP: At home visits, the lighting is often not so good. Most of the time there is a floor lamp. It is never good to examine on a table or a bed. There is a huge quality difference.

Health care organisation
(26) RI: I think that a better organisation of health care is of serious account. One cannot look at it from an isolated point of view.
(27) RI: If you want to look whether or not the number of home visits abroad is higher: one should examine also how the medical care offered by GPs is organised.

Economical factors
(28) Female P: It is more expensive (for a home visit) because you recover less. That is for me a good reason to go to the doctor myself.
(29) Male GP: The benefit and comfort for the patient is considerable. The patient pays little extra for a home visit and he doesn't need to move nor wait.
(30) RI: "The difference in cost between a home visit and a consultation is too small". I do not agree. You can also stimulate the GPs to have more consultations by making the price of a consultation higher.

(P = patient, GP = general practitioner, RI = representative of health insurance company)

The analysis shows that patient-related elements, practice organisation and the need for contextual information are the most frequently mentioned influencing factors for performance of a home visit. Doctor-related elements, organisation and cost of health care play a less important role.

Discussion

Methods

Qualitative methods are appropriate for open research questions of immediate relevance, which are otherwise difficult to investigate (9). Within the European General Practice Research Workshop, the different rates of home visits in European countries have been regularly discussed. A quantitative investigation of the reasons for those differences would need a complicated data registration process. The authors therefore looked for another less complicated and perhaps more relevant approach. A qualitative approach is appropriate for studying the various issues and the nature of this subject area.

Focus groups also provide an opportunity to observe group interaction during discussion, which affords a better view of ideas and opinions than in-depth interviews. Focus group research yields data more quickly than participant observation.

In order to have a broad range of data, for each group a purposeful sample was invited. For the group of 30-40 year old women, it was difficult to find enough volunteers, because of work and household duties. Only four of the seven invited actually attended, but this focus group nevertheless provided many data.

The settings and groups studied within this research may be relevant only to the particular context and time period, i.e. patients and GPs from the Antwerp region in Belgium in the year 1997. Judging the transferability of findings to other settings, this context should be taken into account. We ensured reliability of the analysis through the use of two independent researchers and the triangulation with the discussion groups of Flemish GPs. The feedback from presenting the results orally to Flemish and European GPs and researchers confirmed our interpretation of the texts (10, 11). The results were also compared to previous research and opinion papers on home visits.

Results

This focus group research explored different reasons and appropriate indications for home visits in general practice. The reason for a home visit request has its origins not simply in the convenience of the patient

or the attitude of the GP. A large number of factors play a part in the request and performance of home visits. Participants stated that home visits are frequently requested for aged persons and young children. All previous registration studies confirm that elderly people are most likely to receive home visits by their GPs (12-15). In several European countries, home visiting rates are also high for young children (12, 13, 15). The practice organisation, the contextual information and patient-related factors were the most frequently mentioned reasons for performing home visits, whereas doctor-related factors seemed less important (Table 2). The additional value of home visits has been previously reported as the understanding gained from meeting the patients on their own territory and the observation of the home situation (16, 17).

In order to change the rate of home visits it would be necessary to change practice organisation, for example providing the possibility of making appointments and reducing waiting times, and change how both patients and health care providers look at home visits.

Table 3 demonstrates that a child having fever can result in the parents requesting a home visit or a consultation. Research has shown that older GPs do more home visits (2, 18), others think that young GPs are more willing to do them (15). Some GPs find home visits satisfying, but others find them a great burden. This research describes the factors that influence the rate of home visits in one direction or the other. The extension of this description is the strength of this research. However, in other settings, some factors may become more important. For instance, distance from practice was not a problem in this research but may be important in rural areas. The complexity of influences on home visits demonstrated by our research, indicates that simple solutions such as increasing the cost of home visits for the patient might not effect the rate of home visits. It is clear that the GP can negotiate with the patient, but there are limitations to this. A female GP said “if a patient is unable to come to the practice, then we are obliged to do a home visit”. In Belgium and the Netherlands, a GP refusing a request for a home visit is one of the most frequent reasons for patients to make a complaint (19).

In previous research doctor-related factors, and to a lesser degree the patient morbidity, were explanatory factors for the high number of home visits in Belgium (4). The relatively high number of home visits in Belgium is probably linked to health care organisation, a factor that may have been overlooked in other studies that were quantitative in nature (2, 4). This study demonstrates that other factors are also important, such as practice organisation, patient behaviour and attitudes. Qualitative research

is more appropriate for exploring the subjective opinions and experiences of physicians and patients.

A strategy to reduce the number of home visits calls for interventions at the level of practice organisation, for example an easily accessible appointment system or repeatedly asking patients to come to the surgery. A well-established and well-staffed practice is more likely to be able to offer this than a solo-practice with no reception staff.

The Belgian health care system is a fee-for-service open-access organisation with no patient list system. Patients can go directly to any GP or to any specialist with their medical problem. There are limited possibilities for GPs to negotiate with their patients, as was shown in this research. In other health care systems, with a patient list system and payment by capitation, there are fewer home visits (2). This indicated a need for policy and organisational changes at national level.

Conclusions

Many factors influence the request and performance of home visits in Belgium. This study suggests that the major factors are practice organisation and the patient views and attitudes.

Focus group research was an appropriate method for gathering data about this topic, in order to develop new hypotheses and to formulate new research aims. Future research could seek to:

- assess the benefits and appropriateness of home visits through prospectively registering data on visits and consultations;
- survey GP and patient expectations concerning the benefits of home visits;
- evaluate the effect of organisational changes in GP practice on the rate and benefit of home visits.

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