



# Models of patient enrolment

## Authors

Libby Kalucy

Rachel Katterl

Eleanor Jackson-Bowers

Ann-Louise Hordacre

Primary Health Care Research & Information Service  
(PHC RIS)

May 2009





Models of patient enrolment

© Primary Health Care Research Information Service 2009

ISBN 978-0-9808191-6-8

**May 2009**

**Suggested citation:**

Kalucy L, Katterl R, Jackson-Bowers E, Hordacre A-L. (2009). *Models of patient enrolment. PHC RIS Policy Issue Review*. Adelaide: Primary Health Care Research & Information Service.



# Table of contents

Method .....	1
1 Designing a patient list system .....	2
2 International patient enrolment models.....	3
2.1 United Kingdom – England.....	3
2.2 Netherlands.....	4
2.3 Norway.....	4
2.4 Denmark.....	6
2.5 New Zealand .....	6
2.6 Canada.....	8
2.7 USA .....	10
2.7.1 Indian Health Service .....	11
3 Choice, competition and innovation .....	11
3.1 Informed choice .....	12
3.2 Informed choice in the Netherlands.....	12
3.3 Informed choice in the UK .....	12
3.4 Level of registration.....	13
3.5 Should registration be compulsory?.....	13
3.6 Ability to refuse or deregister patients.....	14
3.6.1 Equity .....	14
3.7 Changing practices .....	15
4 Enrolment and continuity of care.....	15
4.1 Benefits from continuity of care.....	16
4.2 Disadvantages to enrolment .....	16
4.2.1 Do patients want continuity of care? .....	17
5 Accountability and enrolment .....	17
5.1 Financial accountability .....	18
5.2 Quality and continuous improvement .....	19
5.2.1 Through peer review .....	19
5.2.2 Through registration bodies.....	19
5.2.3 Through population health targets and clinical indicators .....	20
5.2.4 Through market competition.....	20
5.3 State and organisational legislation.....	20
5.4 Accountability to the public.....	21
5.4.1 Through complaints mechanisms.....	21
5.4.2 Through Patients Rights Act.....	22
5.4.3 Through public transparency .....	22
5.4.4 Through choice and competition.....	23
5.4.5 Patient satisfaction survey.....	23
5.5 Identified issues in the development of accountability structures.....	23
References .....	25
Appendix A: Primary health care strategy submissions.....	31



Choice .....	31
Access and equity for marginalised groups and Indigenous people .....	31
Preventive care .....	32
Chronic disease .....	32
Continuity and coordination of care .....	32
Administration of registers and data management .....	33
eHealth will make it unnecessary .....	33
Considerations .....	33
Concerns.....	34

## Method

This Policy Issue Review was undertaken to address the following questions:

*How do models of patient enrolment operate internationally (eg. voluntary vs. mandatory enrolment)? At what organisational level does patient enrolment take place? What are the impacts of different types and levels of patient enrolment, including an assessment of key strengths and weaknesses?*

This report is not intended to be a systematic review of the literature on Australian and international models of primary health care enrolment. A systematic review was not possible due to time constraints. Nevertheless, it is an overview of enrolment models relevant to Australian primary health care. A predetermined report structure was designed, reflecting the dimensions of the study questions and searching was targeted, seeking information sources to answer specific, predetermined questions. Google, Google Scholar and Pub Med were used to locate information sources and supplemented by existing PHC RIS resources and bibliographic references.

Authoritative sources were sought. In most cases this included grey literature from government or organisational sources, evaluation reports and organisational web sites as well as articles from the published literature. Where possible the information was triangulated in order to confirm sources. We sought to provide information on primary health care enrolment models internationally.

A final decision was made to include the following countries and organisations in the report: Australia, Denmark, Norway, Netherlands, Finland, Spain, the United Kingdom (England), Canada (the province of Ontario), New Zealand, and within the United States, the Indian Health Service, Veterans Affairs, and Kaiser Permanente. The review of the UK was restricted, for brevity, to England and in Canada to the province of Ontario and services for Indigenous people

## Models of Patient Enrolment

*For people and communities, formal links with an identifiable source of care enhance the likelihood that long-term relationships will develop; that services are encouraged to pay more attention to the defining features of primary care; and that lines of communication are more intelligible. At the same time, coordination linkages can be formalized with other levels of care – specialists, hospitals or other technical services – and with social services.<sup>1</sup>*

*With respect to coordination and continuity of care, a system in which patients are registered with a GP appears favourable in that it offers a greater likelihood that medical information will be stored in one place, than do systems without patient lists. A patient list system is not sufficient [for coordination and continuity], however. Individual GPs need to keep comprehensive medical records and maintain good working relations with other health professionals in primary and secondary care.<sup>2</sup>*

*In Australia, the relationships between service providers and between providers and patients are affected by the absence of registration of patients with general practices. Although most patients get their chronic disease care from a single practice, the lack of a formal relationship leaves GPs uncertain about the extent of their responsibility for ongoing care and care coordination, particularly in the area of psychosocial care.*



*Attempts to structure relations between service providers and between providers and patients are further hampered by discontinuities between general practice, community health and non-government organisations, who work from different locations, in different sectors of the health care system, often with conflicting boundaries and without shared lines of accountability. This provides a weak base for the teamwork and multidisciplinary care required for complex and chronic disease care.<sup>3</sup>*

Australia is the only country examined which does not have patient registration in any region. Advantages of this situation include patient choice, constrained only by issues of access and information. Disadvantages include a lack of formalised continuity of care, although this may occur through patient loyalty. An indication of this in Australian general practice from a market research survey undertaken by Brisbane North Division of General Practice in 2000<sup>4</sup> showed that in the Brisbane North area 88% of people indicate that they use the same practice every time they go to a GP, with patient loyalty highest in the older age groups, those not in the workforce and low income households.

Patient enrolment models feature nationally in UK, Netherlands, Norway, Denmark, NZ, Spain, Portugal and Italy, and for specific populations and/or provinces in Canada and USA. Formal patient links with an identifiable source of care are variously known as registration, enrolment and personal lists. Enrolment is mandatory only in the UK (England) and the Netherlands. In the USA, registration with an insurance provider is necessary to receive medical services. Despite enrolment being voluntary elsewhere, high proportions of the population are enrolled because of the high cost of health care without enrolment.

Patient enrolment may take place with a provider, practice, primary care organisation, insurance company or local government. Usually patients are registered with a practice or GP, who may then be part of another organisational layer such as a primary health organisation. Patients can change providers but this option may be limited to several changes per year.

Denmark and England restrict patients to choose a GP or practice within a specific zone. Zoning implies the availability of a GP within that zone able to accept patient registrations. In the UK a Primary Health Trust is able to intervene when a patient is unable to find a practice willing to accept their registration. Zoning has advantages in allocating and controlling budgets if teamed with capitation funding, which also provides for GP attention to prevention and to population health within a defined area. Research, epidemiology and health service planning is also facilitated due to the availability of longitudinal patient data sets.

While national rhetoric usually promotes patient choice, the extent to which patients actually have choice of provider is influenced by availability and distribution of providers, access, zoning limitations, and having adequate information on which to make a valid choice.

## 1 Designing a patient list system

If policy restricts patients to one practice or GP, issues to consider are:

- ⇒ Providing informed choice in selecting a practice and/or GP, such as information to patients about qualifications, accreditations, language spoken, gender and special interests of GPs.
- ⇒ Making provision for alternate care and informational continuity if the nominated GP is unavailable or no appointment is available within a reasonable time; in emergency treatment; if the patient is travelling or commuting; or prefers to see a GP close to their workplace.
- ⇒ Procedure for changing GPs.

- ⇒ Having an incentive for practices to build up a list, so that they compete for patients as in Scandinavia where there is a patient shortage. Where there is a GP shortage other approaches may be needed.
- ⇒ Considering the consequences for patients and providers when linking enrolment to payment systems. In a pay for performance system, do 'non-compliant' patients get included in outcome measurement?
- ⇒ Having systems of accountability for maintaining quality in the practice in access, continuity, and patient outcomes, as well as for population health and case coordination.
- ⇒ Establishing mechanisms to redress perceived deficiencies in care if the patient does not have confidence in their nominated GP.

**Table 1 Strengths and weaknesses of a patient enrolment system**

Strengths
<ul style="list-style-type: none"> <li>• Enhances continuity of care</li> <li>• Comprehensive care including prevention and health promotion</li> <li>• Keeps patient information in one place</li> <li>• Coordination of care within primary care and between primary and secondary care providers</li> <li>• Compatible with gatekeeping role for primary care</li> <li>• Strengths depend on payment systems, other structural elements, accountability mechanisms, demand for and supply of providers</li> <li>• Allows population health planning</li> </ul>
Weaknesses
<ul style="list-style-type: none"> <li>• Constrains patient choice</li> <li>• Does not meet patient needs when travelling, commuting, seeking second opinion</li> <li>• May increase bureaucracy and therefore costs</li> <li>• Record transfer delays when patients change providers</li> <li>• May decrease equity if there are incentives for providers to avoid enrolling high need patients</li> <li>• GP shortages limit competition between providers</li> </ul>

## 2 International patient enrolment models

### 2.1 United Kingdom – England

Patients in England are required to enrol with a medical centre within their area of residence to obtain a National Health Service (NHS) number. If a patient wishes to change practices they can register at a new practice without notifying the previous one. The new practice has the responsibility of obtaining medical records from the previous practice but the process is speeded up if the previous practice is notified of the move. Under the Data Protection Act, 1998 patients have the right to access their medical records. They submit a request in writing by recorded mail delivery. The surgery or hospital has up to 40 days to respond. Charges (£10-50) are levied for viewing or providing copies of records.<sup>5</sup>

In the UK (England) it is the statutory responsibility of Primary Care Trusts to maintain patient lists<sup>6</sup>. A PCT or more usually a group of PCTs in a region may delegate some of their functions to an agency.<sup>7</sup> A patient enrolls on the list at their GP practice of choice within their zone or at a Family Health Service Agency (FHSA) which may provide a shopfront. A FHSA, also called a Primary Care Agency or Primary Care Support Service<sup>8</sup> is a delegated agency which undertakes management of patient lists as well as practitioner lists, organises the payment of GPs and

undertakes patient screening services on behalf of several primary care trusts (PCTs). An agency appears to be formed through a 'coming together' of 'family health service providers' (ie. GPs, dentists, optometrists and pharmacists)<sup>7,9</sup>. Family Health Service Agencies are established in Dorset and Northumberland. North East Family Health Services Agency<sup>7</sup> does the above plus information support for NHS choices. Kent Primary Care Agency<sup>10</sup> appears to serve the same functions under a similar structure.

GP patient registration data for each GP practice are collated in Family Health Services (FHS) registers. A recent document<sup>11</sup> on the technical process of harvesting GP list data for research shows that data are not available from the trusts/PCOs, but are gathered from Family Health Service Agencies and collated by the NHS Information Authority. The data have inaccuracies as the combined total population of GP practices exceeds the UK population census data, and require considerable reconciliation and weighting before they are useful in research.

GP lists can become artificially inflated due to the movement of patients or administrative errors. A UK study found a 7% discrepancy between English population estimates based on census figures and those based on the registered lists of GPs. An exercise to verify the numbers of 20-24 year old patients resulted in 33.5% being delisted.<sup>12</sup>

## 2.2 Netherlands

Insurance funds require that individuals are enrolled with a GP to receive care. Doctors can only be reimbursed if the individual is registered. The *Health Insurance Act* enacted in 2006 changed the way GPs were recompensed for their patients. Prior to the new Act, GPs received either a fixed amount per annum (from those insured by the sickness funds) or a payment per service (for the privately insured). Under the new system, GPs were paid through a mixed funding model (eg. €54 for enrolled patients and an additional €9 per consultation).<sup>13</sup>

Patients can be enrolled with only one GP. However if the GP is together in a centre with others they are allowed to 'try out' others with the possibility of changing to another<sup>14</sup>. Enrolment is electronic, with patients' personal details entered into the computer at the doctor's office, to be used in part for financial administration.<sup>15</sup> Providers (GPs) must be registered on the BIG register<sup>a</sup> to receive money from the insurance companies, and more generally to use their powers as a health professional. People on this register are checked every 5 years to ensure their knowledge and expertise still meet the minimum required level. A failure to meet these standards results in de-registration.<sup>16</sup>

## 2.3 Norway

Patients in Norway enrol with an individual GP (not a practice), registering for the scheme with a social security office. The providers of primary health care services for enrolled patients are GPs and related primary health care services provided by the County. Reforms introduced in the Regular Practitioners Scheme in 2001 aimed to improve the quality of the local medical services, to improve continuity of care and ensure a more personal patient–physician relationship. This reform also provided a new model for employing GPs, based on contracted physicians in private practice where capitation, fee-for-service and out-of-pocket payments form the income of GPs.<sup>17</sup>

---

<sup>a</sup> The BIG register was set up in pursuance of the Individual Health Care Professions Act (BIG Act) (Bulletin of Acts, Orders and Decrees, 1993, 655) for the purpose of registering the so-called article 3 professions. It is an up to date register of pharmacists, doctors, physiotherapists, health care psychologists, psychotherapists, dentists, midwives and nurses that also records any limitations to their powers. Only those listed in the register may use the appropriate professional title and make use of the powers (reserved procedures) associated with that title.



All citizens listed in the National Population Register are eligible. All population groups in Norway are treated in the mainstream health care system.<sup>17</sup> In Norway the patient list system requires each municipality to provide a named GP for every citizen.<sup>17</sup> Patients can choose their own GP and they are not restricted by region. This accommodates patients who wish to see a GP near to their place of work rather than their home. Though enrolment is voluntary, 99.5% of the population are enrolled and the unenrolled pay full costs.

A GP is required to give priority to patients on his/her list. Patients may change GPs no more than twice a year. This restriction to one GP is balanced by safeguards enshrined in the 1999 Act on Patients' Rights: the right to a second opinion, access to their records, the right to complain and to have their case reviewed within 30 days, and for those with long term conditions, the right to an individual treatment plan.<sup>17</sup>

Patients are able to have their case reviewed by a County Medical Officer and the central Norwegian Board of Health if they believe that they have received poor quality health care services. The authority can check on the quality of the treatment received and overturn decisions where necessary. The Patients' Rights Act ensures that every county has a Patients' Ombudsman whose purpose is to safeguard patients' rights, interests and legal rights in relation to specialist health care, and improve the quality of the health service. There seems to be general agreement that such a control system contributes to raising the quality of health services.<sup>17</sup> (p26)

The Regular GP scheme has been evaluated by several research projects commissioned by the Ministry of Health and Care Services. According to the Ministry, "the GP scheme is functioning well, with 98% of the population having a regular GP. The share of 'very satisfied' patients has risen from 32% in 2000 to 44% in 2004. Two thirds of the GPs are satisfied with the scheme, and 35% are more satisfied with their working conditions now than before the introduction of the scheme... 99.5% of the population participates in the regular GP scheme, while 21 000 persons (0.5%) have chosen to remain outside".<sup>17</sup> (p94)

An interview study with Norwegian GPs has shown a decreased interest in a gatekeeper role since the introduction of the Regular GP Scheme.<sup>18</sup> GPs are now more concerned with providing better services and keep patients satisfied due to competition for patients. A patient shortage may contribute to this.<sup>19</sup> This concern with patient satisfaction may have led to fewer hospital admissions as one study found a statistically significant negative relationship between patient satisfaction with GPs and the number of hospital admissions.<sup>18</sup>

An evaluation by the Research Council of Norway of the Regular GP Scheme also found that patients had become more demanding after the introduction of the scheme and GPs were anxious about losing their patients. This resulted in unnecessary referrals. A patient is most likely to change his or her regular GP if the doctor is not a specialist in general practice, does not have a Norwegian citizenship, is male, has few patients on his list or works in central areas. Many people change from a male to a female GP each year and would prefer to wait for a female GP than go to a male one.<sup>20</sup>

A study<sup>21</sup> was undertaken using large national datasets to determine whether two perverse incentives were occurring: building a long patient list in order to ensure high unearned income and rationing consultations, or maintaining a short list and increasing services. The study found that fears were ungrounded, that long lists did not lead to rationing, and short lists did not increase service production per consultation.

## 2.4 Denmark

Patient enrolment is voluntary for the whole population of Denmark, without a focus on any special group. Danish patients enrol with their GP of choice within 10km of home or 5km in Copenhagen. Children are registered separately from their parents, being considered independent subjects. The incentive for patients to enrol is free access to general preventive, diagnostic and curative services. Patients may consult an ear, nose and throat specialist or an ophthalmologist without referral, but they must be referred by their general practitioner to gain access to all other specialist and hospital treatment.<sup>22</sup> Patients are obliged to attend the GP with which they are enrolled for a six month period but after this time they are entitled to change.

Enrolment is voluntary. Individuals who do not register are free to visit any general practitioner and any specialist without referral, but they must pay for all services except hospital treatment. Very few people choose this second option (only 1.7% of the population), partly due to general satisfaction with the referral system and partly because it is more expensive than the first option.<sup>23</sup> Denmark has the highest public satisfaction with health care (of the countries assessed in the Commonwealth fund survey in 2002, reflecting the value placed on accessibility of primary care.<sup>24</sup>

*Physicians are responsible for providing services quickly, typically same-day appointments. An organized off-hours service ensures accessible care 24 h a day, 7 days a week.<sup>24</sup>*

The number of patients registered with each general practitioner is limited and fixed through negotiations between the Organization of General Practitioners, which is part of the Danish Medical Association, and the National Health Security System Committee.<sup>23</sup> Cost containment is a key policy objective in Denmark. Counties limit the number of GPs in order to contain costs. In order to buy a general practice, one must have authorisation as a general practitioner from the National Board of Health and a license from the National Health Security System (NHSS), which is run by an Association of County Councils, with representation from different professional organisations.<sup>23</sup> Mooney considered the strength of the Danish health service is its equity, but prevention is not a priority. It scored well in terms of its ability to contain costs.

*The question however that hangs over the system is whether it has in a sense contained costs too well and not allowed the demand (or need) side to drive the system to a greater extent.<sup>25</sup>*

Accountability appears to be focused on cost containment with priority setting decisions focusing on which services should be remunerated by fees and which should be capitated. Giving priority to an activity by associating it with a fee appears to be a more effective incentive. An example of this is a newly introduced fee for preventive consultations, which are supposed to encourage general practitioners to offer longer consultations focusing on broader health and preventive activities such as education regarding smoking or dietary habits, weight control etc. Previously this type of activity was not paid for by the NHSS.<sup>23</sup>

## 2.5 New Zealand

All patients in New Zealand, including Maori and Pacific Islander populations<sup>26</sup> have the option to enrol with either a provider (GP) who is part of a primary health organisation (PHO) or directly with the PHO<sup>26</sup>. GPs are called the 'First Level Service', as primary health care providers, as well as gatekeepers<sup>26</sup>. Children under 16 are able to be enrolled by a custodian.

Enrolment is voluntary. It is estimated that as of January 2009, almost 98% of the population was enrolled with a PHO.<sup>27</sup> The incentives for patients include consistency and continuity of care, and greater access to services due to greater funding with enrolled population. Enrolled patients are also entitled to discounts in medication, multidisciplinary care, and generally lower health costs. Providers receive financial incentives, being funded in part by capitation models.<sup>28</sup>

From 1 April 2004, all people enrolled with access PHOs as well as all six to 17-year-olds enrolled with interim PHOs were required to pay no more than NZ\$3 co-payment per item for prescription drugs on the national pharmaceutical schedule. This same benefit accrued to all enrolled persons over 65 from 1 July 2004. Previously the maximum co-payment was NZ\$15 per item.

Enrolment means that the patient agrees to use the PHO or provider as their preferred service provider, and they are only allowed to enrol in one provider at a time.<sup>28</sup> They are allowed to un-enrol, and if their provider leaves then they are also able to leave.

Providers are not allowed to deny enrolment to an individual based on anticipated needs for health services.<sup>28</sup> PHOs are required to provide or provide access to primary health services 24 hour a day, 7 day a week.<sup>29</sup> If this cannot occur, justification should be provided as to why. If this is expected to be occurring as an ongoing issue, alternative arrangements should be negotiated with their District Health Board (DHB).

PHOs have a contract with their district health boards regarding funding.<sup>28</sup> Specific targets (for example, immunisation covering 95% of enrolled children) are negotiated with the District Health Board and PHOs are expected to meet these targets annually. Beyond this, it is at the discretion of the PHOs and providers within it to negotiate services appropriate to community needs. PHOs need to manage referral services, and monitor and review enrolment services. They are also required to engage in and provide evidence about continuous improvement processes.

Individuals who were with a provider who then became a PHO provider are informed about the move, the benefits and implications of being enrolled, and if they are happy to be enrolled their information is aggregated to the PHO records as an enrollee.

New patients must indicate that they wish to become enrolled and use the provider on a regular basis, and are then provided with benefits and implications of enrolment. They must authorise in writing for their information to be shared with other service providers/Ministry of health, and provide any additional details to allow inclusion on the enrolment register.

In New Zealand, patients enrol with their GP or practice of choice and the data are aggregated at the Primary Care Organisation level. The District Health Board monitors the data collection process to ensure quality and accuracy. Data collected include ethnicity information which is self identified and asked according to a standardised question used in the Statistics New Zealand census 2001.<sup>28</sup> On enrolment, the PHO allocates the patient a National Health Index number, which is validated by the NZ Ministry of Health Sector Services. It is encrypted in the records to enable de-identified data transmission.<sup>30</sup> The NHI number enables the Ministry of Health to determine whether people are enrolled at more than one PHO. Removing duplication occurs both at PHO and Ministry level.<sup>28</sup> Those who enrol with a second PHO will have their first registration cancelled by the ministry.

The NZ Ministry of Health Sector Services (formerly known as Health PAC) provides PHO enrolment, claim, payment and clinical data to the New Zealand Health Information Services for

loading into the national data warehouse<sup>b</sup>. The PHO Enrolment Collection, which is administered by the New Zealand Health Information Service is used to monitor and report on patient enrolment and to provide data for population health research<sup>c</sup>.

## 2.6 Canada

The federal government has constitutional authority and responsibility for a number of specialised areas of health care (eg. drug prescription and regulation) and the delivery of federally administered PHC services to special access groups such as Canadian mounted police force, First Nations, Inuit, and Aboriginal groups. Provinces are responsible for the delivery of primary health care services, and some such as Ontario have established primary health care structures based on voluntary patient enrolment.

Ontario's new care models all involve patient enrolment, with varying mechanisms of physician compensation. As well as straight fee for service, there has been a rapid increase in a blended fee for service model in the Comprehensive Care Model and the newer Family Health Groups. Blended capitation models include Family Health Networks, Family Health Teams, Primary Care Networks, Health Service Organisations and Group Health Centres. Ontario also has salaried models such as Community Health Centres and Aboriginal Health Access Centres.<sup>31</sup>

Family Health Teams (FHTs), first implemented in 2005<sup>32</sup> are different from other enrolment models in Ontario in that they support inter-professional team members. There are now more than 150 FHTs<sup>d</sup> which are much like the proposed Australian 'superclinics': multidisciplinary teams of health professionals ranging from GPs (who tend to be the coordinators) through to nurse practitioners, nurses, pharmacists, social workers, dieticians, etc. The FHTs work collaboratively to provide comprehensive, accessible and coordinated family health care services to a defined population, the majority of which do not currently have a primary health care provider. In addition to providing direct health care services, FHTs focus on chronic disease management, disease prevention and health promotion, in conjunction with other community-based health care organisations such as public health units.

Team composition is determined by the needs of the population. The number of patients is not specified but the largest is Hamilton Family Health Team, which serves 250 000 patients, through 119 GPs, 101 PN, 20 dieticians, 77 mental health counsellors, 21 psychiatrists and 7 pharmacists.<sup>33</sup>

The main incentive for patients to enrol is having access to services not previously available, including:

- ⇒ Guaranteed access to general practitioner and other health professionals
- ⇒ Access to the after hours services, either through extended office hours or through a 24-hrs telephone based service.
- ⇒ A one-window, well integrated access point to the health system.<sup>32</sup>

Enrolment is voluntary. Patients are not required to enrol to continue receiving services, nor will they be refused enrolment due to their health status or need for services. All patients in the practice of a FHT physician must be invited to enrol if eligible. This is to occur regardless of their

---

<sup>b</sup> <http://www.moh.govt.nz/moh.nsf/indexmh/sectorservices-about>

<sup>c</sup> <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-pho-enrolment>

<sup>d</sup> Another 50 were planned but have been delayed due to financial cutbacks

health status. Incentives are offered to physicians to enrol new patients who do not have a family physician. Physicians are responsible for the health of whoever is in their list and must monitor according to this.<sup>32</sup>

Patients who enrol commit to seeking treatment from their enrolled group first, unless travelling or in an emergency situation; and allowing the ministry to provide their doctor or the FHT with information about services they received from different family doctors outside the FHT and some preventive care services. They cannot switch their FHT more than two times in a year. Patients remain enrolled unless they choose to cancel their enrolment, are no longer eligible for the Ontario Health Insurance Program, move outside the geographic area covered by the FHT, enrol with another FHT, the physician leaves the FHT, or become a resident of a nursing home or chronic care facility. If the patient fails to abide by the obligations set out in the Patient Commitment terms on their enrolment form, the doctor may terminate their enrolment.

All FHTs provide services within a comprehensive care framework, including health assessments, diagnosis and treatment, primary reproductive care, primary mental health care, primary palliative care, patient education and preventive care, and Telephone Health Advisory Service (THAS). Other services can be negotiated with the ministry depending on the size of the organisation, the area it covers, and the needs of the local community.<sup>32</sup>

Funding is derived from the Ontario Health Insurance Plan, some fee-for-service gap payments, and the Canadian Health Transfer (money paid from the Canadian government which consists of cash and tax revenues, calculated on a per capita basis). Funding is provided to workers individually within the FHTs. Family physicians in Family Health Teams are compensated via one of the following funding models:

- ⇒ Blended Capitation Models: Family Health Networks (FHN) or Family Health Organizations (FHO);
- ⇒ Blended Complement Model: Rural and Northern Physician Group Agreements (RNPGA); or
- ⇒ Blended Salary Model (BSM).

All of the models encourage the delivery of comprehensive primary health care to patients by offering physicians the ability to earn incentives, premiums and special payments in addition to their capitation/complement payment or salaries for providing targeted services.<sup>34</sup>

Other health professionals receive salaried funding with the possible addition of sessional funding and funding for targeted programs. Specialists may also be funded (if they are in the team) by a per-session funding model. Funding is also provided for administration, overheads, and infrastructure. Each FHT is supported by an Ontario Ministry of Health and Long Term Care coordinator, and an IT team to convert paper records to electronic versions.

FHTs may establish themselves as community-based, provider-based or a mix of community- and provider-based groups. Organisations have the option of becoming registered non-profit organisations, with a board of directors which includes community representation (i.e. *community groups* structure), a provider group, which can be incorporated, a professional association or a health partnership, or a mix of both. Funding is affected by this.

All residents of Ontario have a health card which entitles them to free treatment in Ontario. The health card number is provided to the GP on enrolment. The patient fills out an enrolment form and a consent form for the release of information (name, address, phone number, health number) which is posted to MHLTC. The ministry maintains records of enrolments and changes of address must be communicated to the ministry by the patient or GP.<sup>35,36</sup> The Registration and Claims

Branch of the Ministry maintains a Registered Persons Database containing details of all persons who hold a Health Card and records are retrieved by Health Card number.<sup>37</sup> The Health Services Division, Registration & Claims Branch also maintains a Client Agency Program Enrolment (CAPE) data base, updated daily. This is a “repository of the association of a registered person with a specific physician at a specific agency in a formally recognized program”.<sup>38</sup> (p157)

The Ministry of Health and Long Term Care (MOHLTC) notes that in keeping with its ‘commitment to flexibility’ it will negotiate the accountability and performance structure of the FHTs. Guiding principles for the FHT groups are synonymous with the national regulations of universality, public administration, comprehensiveness, portability and accessibility.<sup>39</sup>

One challenge for Ontario is how to mandate implementation of clinical standards given current payment structures. It is up to individual providers to determine the model they want to be funded through. Local Health Integration Networks (LHINs) are not yet true commissioners of health services, but are planning bodies flowing funding to health service providers. They are responsible for negotiating service accountability agreements only with Community Health Centres, and have no jurisdiction over fee-for-service physicians or FHTs. Likewise, LHINs have no authority to report on the performance of health service providers in the primary care sector – eg. fee for service physicians, Family Health Teams – and public health initiatives.<sup>40</sup>

## 2.7 USA

The USA, famously, has no universal health system. Services are provided for specific groups such as Medicare for eligible pensioners and the disabled, Medicaid for the eligible poor, the Indian Health Service for native Americans who live on or near reservations, and Veterans Health Service for those who have given military service. While these services are provided by the USA government, they are provided under specific conditions and have strict eligibility requirements, including means tests to restrain costs.<sup>41,42</sup>

For other populations, managed care services in USA such as Kaiser Permanente<sup>43</sup> provide a comprehensive system of managed care for registered patients. Personal physicians, specialists and surgeons and other medical and allied health providers are employed by Kaiser Permanente in their services and hospitals. While patients register with Kaiser Permanente and are eligible for all their services, during the enrolment process patients nominate a preferred personal physician from those who work within the Kaiser Permanente system. They are assisted in choosing a personal physician by a database of physicians detailing their qualifications, special interests, gender, language spoken and location. Kaiser Permanente also provides collated data on the clinical indicators achieved by each medical centre as an aid to choice.

Another system featuring competition in the private health market is the Concierge health system which has arisen in USA in the last decade. According to Wikipedia,<sup>44</sup> Concierge medicine (politically correct term is ‘Direct Care’) is a term used to describe a relationship with a primary care physician in which the patient pays an annual fee or retainer. This may or may not be in addition to other charges. In exchange for the retainer, doctors provide enhanced care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design.

Concierge physicians care for fewer patients than in a conventional practice, ranging from 100 patients per doctor to 1 000, instead of the 3 000 to 4 000 that the average physician now sees every year. All generally claim to be accessible via cell phone or email at any time of day or night.

The annual fees vary widely, from US\$60 to US\$15 000 per year for an individual, with the lower annual fees being in addition to the usual fees for each service and the higher annual fees including most services. Some concierge practices do not accept insurance of any kind.<sup>44</sup> It should be noted that this annual fee is not a substitute for medical insurance, and generally does not cover consultations outside the practice, laboratory procedures, medicines, hospitalisations or emergency care from other providers. In 2004, the Government Accountability Office counted 146 such practices, mostly concentrated on the East and West Coasts. The American Medical Association does not track the number of concierge practices because the concept is still so new.<sup>44</sup>

### **2.7.1 Indian Health Service**

The USA through the Department of Health and Human Services has treaty obligations to provide health care for Native Americans and Alaska natives and to provide culturally appropriate services.<sup>45</sup> There is also an obligation to provide for Tribal Self Determination.<sup>46</sup>

The Indian Health Service is provided by the US government for members of recognised Native American tribes. Most users live on or near reservations but some funds have been provided for urban programs. Enrolment is voluntary. Patients do not appear to be formally enrolled with the service however they are eligible for services if they are enrolled members of a recognised Native American tribe and live on or near a reservation. Some urban residents who fulfil these criteria are also able to obtain services through specialised programs.

The eligibility for IHS medical care seems to be relatively loose<sup>47,48</sup> but to receive contract health services (ie services provided by mainstream health services but paid for by the IHS) the requirements are much stricter. Tribes are federally registered and there is a list of recognised tribes who are eligible to receive services.<sup>49</sup> In addition, one must be a registered member of a tribe. How this is done varies according to the tribe but is a formal registration process.<sup>47,48,50</sup> To receive contract health services the tribal registration or demonstrating descent and living in the reservation is required.

*The eligibility requirement for Contract Health Services (CHS) delivered by referral to a non-tribal facility or provider is stricter than for direct healthcare. To be eligible for CHS, an individual must reside within a CHS Delivery Area (CHSDA) and be a member of a federally recognized tribe or descendant of an Indian who was living in California on June 1, 1852 and living on or near the established CHSDA.<sup>48</sup>*

## **3 Choice, competition and innovation**

The facilitation of patient choice in healthcare is a feature of all the health systems examined for this review and is an ongoing tradition in Australia. Choice stimulates innovation through competition for patients and/or the capitation funding that they bring. The concept of free choice underpins the reliance on market mechanisms for delivering health services.

Patient choice balances supply and demand in a geographical area or between areas and thus is necessary for ensuring good access to services as patients gravitate to where there is least wait for services.<sup>51,52</sup> Patient choice also leads to service improvement as patients select practices where desired services are provided, such as home visits or out of hours appointments, where they have experienced or heard about high-quality care or the good interpersonal skills of practitioners.<sup>53</sup>

### 3.1 Informed choice

While all the countries examined in this review provide patients with choice of their primary health care provider, in practice, there is variation in the extent to which patient choice is a reality. Choice may be limited through zoning, through GPs and practices having full lists, through the patient's ability to pay (in the USA), and by the adequacy of information on which to base a valid choice. The literature suggests that patients, particularly in Europe, are very poorly informed.<sup>54,55,56</sup> If choice is to be a true driver for reform, then patients must have access to appropriate information to enable informed choice of GP or practice.

*...While patient choice features prominently in primary care policy, there is little evidence that it is happening in practice. Of course, some patients have good reasons not to shop around for a general practice — for example, people with chronic conditions who value continuity of care and a stable GP relationship. Nevertheless, far more attention has been paid to developing competition in primary care than to building an infrastructure to support patient choice. PCTs raised concerns about low public awareness of the right to choose a GP and the shortage of reliable public information about the availability and quality of local services. Unless this changes, the potential benefits of a more plural provider market may not be realised.<sup>57</sup>*

### 3.2 Informed choice in the Netherlands

The Netherlands Ministry of Health, Welfare and Sport<sup>58</sup> has designed their insurance based system to be competitive in nature. This means that both the insurance companies and the service providers must compete on the cost and quality of care, whilst still maintaining a service standard.

In the Netherlands individuals are free to choose their insurance provider as well as their health care provider. Consumers are able to change their insurance providers annually to create greater competition between insurance companies.<sup>59</sup> Insurers purchase the services of general practitioners and other health providers. This competitive system is designed to stimulate the service providers and the health insurance companies to offer higher levels of care.<sup>60</sup>

If individuals are unhappy with the nature and type of services received from the insurance fund, they are able to make changes annually. In the Netherlands, choice is somewhat constrained due to the fact that only providers who are registered with the insurance agency (via the BIG register) are able to be chosen. The Netherlands has developed a system to inform the public about the efficacy of particular health providers.<sup>v</sup>

### 3.3 Informed choice in the UK

In the UK where patient choice is emphasised as a policy priority the ability to see their GP of choice is a measure in the yearly survey by the English Department of Health of patient experience in general practice.<sup>61</sup> Patient experience statistics are provided publicly down to the practice level allowing people to choose practices informed by the experience of previous patients. Statistics for England as a whole show that in 2006-7, 88% of the people who desired to do so were able to get an appointment with their preferred GP within a practice.<sup>61</sup> Ability to access their choice of practice was not addressed by the survey. Participation by practices in the patient experience survey is optional but it triggers payments to reward practices according to performance on their patients' waiting times for GP services and choice of hospital services.

---

<sup>v</sup> Only available in Dutch <http://www.kiesbeter.nl/algemeen/default.aspx>



Baker et al.,<sup>62</sup> in a survey of 1 437 people from 22 general practices in London found that consulting someone known and trusted was important to 62.6% of responders and 13.7% of these had not experienced it at their last consultation. Another UK study<sup>63</sup> of 25 994 adults from 53 practices found that patients in the five practices with personal list systems were more likely to be seeing their usual doctor, as were older patients, those with longstanding physical problems or with psychological problems. List sizes over approximately 6 000-6 500 were associated with marked reductions in personal continuity.

A number of UK studies looking at what patients want found that individuals balanced their preference for seeing their GP of choice with the likelihood of obtaining a timely appointment. They preferred quick access to an available GP for minor or temporary conditions, but would prefer to wait to see a familiar medical practitioner who was well informed about their case when they had a problem causing uncertainty, had chronic, complex or emotional problems or needed a routine check-up.<sup>63,64,65,66</sup>

### 3.4 Level of registration

The review found several different options for patient registration which relate to the payment systems and structures of the countries examined. Patients register with an individual GP or practice in Denmark, Norway and in Family Health Teams in Ontario, Canada. In New Zealand and England, patients register with a GP or practice who is part of a regional organisation. The New Zealand Primary Health Care Strategy is based on regional meso-level organisations, the Primary Health Organisations (PHO).<sup>67</sup> People enrol with a GP or practice of their choice and the GP lists are aggregated to form a PHO register. PHOs are not able to refuse patients' registration. Enrolled citizens receive population health and preventive care through the PHO.

Registration with an insurance provider or service takes place in the USA Veterans' Health Service, Kaiser Permanente, and the Netherlands which requires citizens to enrol with one of the insurance companies, which compete with each other on the level of services provided. In the Netherlands, patients can be registered with only one GP but they are allowed to 'try out' other GPs in the same centre if contemplating change.<sup>14</sup> Patients of the USA Veterans' Health Service nominate a home medical centre and patients of Kaiser Permanente nominate a personal GP, but are able to visit any other facility of the same service while travelling.<sup>41,43</sup>

Patients in the UK can register at a FHSA, in Norway at a social security office and in New Zealand at a PHO.

### 3.5 Should registration be compulsory?

Considerations of whether to make registration mandatory depend on the requirements of the funding system. Where enrolment is optional those who choose not to enrol may pay full costs or a co-payment, not receive population health or preventative care, and may not be provided with medical services within the public system.

Where registration is voluntary it is taken up by very high percentages of the population. In Denmark and Norway enrolment is voluntary; those who do not enrol are able to see any GP but must pay full costs and a GP is required to give priority to patients on his/her list. In practice, enrolment levels are very high (99.5% of the population in Norway).<sup>17</sup> In NZ enrolment is not compulsory, but almost 98% of the population were estimated to be enrolled with a PHO<sup>27</sup> as of January 2009. Registration is mandatory to receive medical services in the UK. In the USA and

Netherlands it is mandatory to be enrolled with one of the insurance providers in order receive medical services.

## 3.6 Ability to refuse or deregister patients

Funding and GP remuneration methods may result in the registering organisation managing their lists so as to maximise profitability. New Zealand has established an audit procedure to ensure that patients are not refused enrolment on the basis of their healthcare needs.<sup>28</sup> In California, outcome measurement using clinical indicators for assessment of quality may have led to deregistering of non-compliant patients as these patients could not be excluded from the assessment.<sup>68</sup> Similarly, a study of patients removed from lists at GP request during successive waves of fundholding conducted in Northern Ireland found a small increase in the removal of patients from the lists of practices which became fundholding practices during the preparatory year.<sup>69</sup>

*A patient's demographics and utilization are associated with the probability that the patient will switch PCPs [primary care providers]. Capitated PCP payment was associated with higher rates of switching among high users of health care resources. These findings raise concerns about the continuity and quality of care experienced by vulnerable patients in an era of changing financial incentives.<sup>70</sup>*

Having a circumscribed defined number of patients registered to a GP or a practice can be a way of managing workload and the quality of care that can be provided to patients. It can also, as in Denmark, be a way of governments controlling health care costs by controlling the numbers of GPs practising in a zone and their list size. A consequence of this is that at times patients are constrained in their choice through not being able to register at a practice with a full list.

In the UK general practices should accept a new patient if they live in the prescribed catchment area, but are able to refuse if they are not accepting new patients at the time. They may also refuse a patient if they live outside the area but may not discriminate on any other basis. A Primary Care Trust can intervene if a patient cannot get onto a GP list in their zone. If a particular medical centre has a full list, they can be compelled by the Primary Care Trust to accept a patient in their area.

In New Zealand, Primary Care Organisations are not allowed to deny enrolment to an individual based on anticipated needs for health services.<sup>28</sup> PHOs are required to provide or provide access to primary health services 24 hours a day, 7 days a week.<sup>29</sup> If this requirement cannot be met, PHOs must justify why and negotiate alternative arrangements with their District Health Board if lack of 24/7 access is expected to be an ongoing issue. PHOs are able to deregister patients if their relationship with their provider is severely compromised or if fee for service records show that the patient is regularly receiving services from another provider. Patients are automatically deregistered if they do not have contact with the health service for three years and have not indicated a desire to remain enrolled.<sup>28</sup>

### 3.6.1 Equity

There are two dimensions of equity in health care: equal access to health care (for equal health needs) and equal payment for health care (whether through premiums or taxes) based on income or wealth. Equal access to health care (for equal need) implies that the resources of the health care plan should be distributed only in accordance with health care needs. An equal payment for equal income or wealth implies that financing should be according to ability to pay rather than level of sickness.

Even if 'open enrolment' is stipulated (under which a plan or a practice must, in principle, accept all applicants), Newhouse<sup>71</sup> showed how plans can effectively deter high-risk applicants or encourage high-risk members to leave the plan. With risk-adjusted capitation, plans may still have an incentive to scrutinise potential members to assess whether their expected annual costs exceed their capitation payments and to reject those for whom this is the case. However, the potential gains are considerably reduced.<sup>72</sup> If left unattended, 'cream skimming' would lead to increasing inequalities in premium rates and profit levels between plans that practise it and those that do not. In the extreme, it might lead to certain sections of the population being unable to find insurance, and a breakdown in the health care insurance market.

### 3.7 Changing practices

Patients were permitted to change GPs in all the countries studied, though Canada, Denmark and Norway limit changes to twice in a year. The UK has a cumbersome procedure for changing practices. A patient can register at a new practice without notifying the previous one. In addition to the time and trouble involved in changing registrations, switching to another GP imposes costs in the form of a lower initial level of care.<sup>53</sup>

Medical records are transferred with a significant delay. The new practice has the responsibility of obtaining medical records from the previous practice but the process is speeded up if the previous practice is notified of the move. Procedures to access medical records can be time consuming. Under the *Data Protection Act* 1998 patients have the right to access their medical records. They submit a request in writing by recorded mail delivery. The surgery or hospital has up to 40 days to respond. Charges (£10-50) are levied for viewing or providing copies of records.<sup>5</sup>

## 4 Enrolment and continuity of care

Many international health care reform processes have identified continuity as a key variable to the reforms' success. Reforms consider patient enrolment and lists as the optimal way for primary health care providers to track patient progress over time.<sup>73</sup> In Norway, the Regular Practitioners Scheme aimed to achieve personal continuity of care.<sup>17</sup>(pxv) The ability for GPs to provide continuity is significantly affected by the number of people of their lists. In the UK, whilst patient enrolment was significantly associated with continuity of care, those with list sizes of 6 000 to 6 500 were associated with a marked reduction in continuity.<sup>63</sup>

Continuity refers to care administered over time by a single individual or team, and to the continuous effective communication of health-relevant information between the patient and the team<sup>74</sup>. A number of different forms of continuity are relevant to PHC, including:

- ⇒ Relational continuity where health care is delivered by the same health care provider. This includes knowledge of the patient's preferences, trust and good expectations due to positive past experiences. This is held in the memory of the practitioner rather than being formally documented.
- ⇒ Informational continuity, or formally recorded information that is usually complemented by the clinician's tacit knowledge of patient preferences;
- ⇒ Management or team continuity which is the shared management/care protocols and plans, with explicit roles and responsibilities by those administering the care. This can extend beyond the primary care setting into secondary care<sup>75,76</sup>

Sustained continuity of care encourages communication, so clinicians gain more familiarity with the patient over time. This enables the GP to treat chronic conditions more effectively.<sup>74</sup>

The recent focus on accessibility and treatment with multidisciplinary teams has reduced the ability of systems and practitioners to provide continuity<sup>77</sup>, despite the value placed on it by patients, clinicians, and researchers who find that it is an important aspect of care especially for those with complex, chronic and multiple conditions<sup>78</sup>. Indeed, a balance of access, provision of care by multidisciplinary teams, and continuity of care is only possible in a system where the supply of health care exceeds the demand. This is not the case for Australia.

A 2002 Commonwealth Fund survey found that Australians were at a high risk for care coordination communication failures and medical care errors. A systematic review by APHCRI found continuity of care via a structured relationship between patient and provider (patient enrolment) was a way in which this issue could be overcome or circumvented. Positive health outcomes were reported in 19 of 29 studies, and patient satisfaction rose conclusively in 8 of 12 studies.<sup>79</sup>

Australia is increasingly facing an issue with the treatment of chronic disease, together with the complexity of treating multiple diseases (on average, 2-3 per person). Continuity is considered very important by those with chronic illnesses, because of the development of trust with the practitioner, the confidence to express their needs, and the time-saving factors for both the patient and the GP.

## 4.1 Benefits from continuity of care

Enrolment may tie individuals to a particular provider, thereby emphasising explicitly and formally a relationship between the two individuals. Higher continuity is associated with a higher level of trust between a patient and a physician. Efforts to improve the relationship between patients and physicians may improve the quality and outcomes of care.<sup>80</sup>

Continuity of care has been associated with lower annual health care expenditures.<sup>74</sup> This is potentially attributable to the reduction in costly hospital admissions. Numerous studies have found that increases in continuity of care are associated with decreases in Emergency Department usage.<sup>74,81,82</sup> Similar phenomena have been found in paediatric populations.<sup>81,83,84</sup> In a group of men with heart and respiratory diseases, increased continuity led to fewer hospital days (by almost half), fewer intensive care days (a third), shorter lengths of hospital stays (by ten days, cited by Harding).<sup>74</sup> Continuity also influences medication compliance, with significant increases linked with continuity increases.<sup>85</sup>

Personal, continuous care is linked with patient satisfaction. If patient satisfaction is accepted as an integral part of quality health care, reinforcing personal care may be one way of increasing this quality.<sup>86</sup> It tends to give the patient the impression that the physician is able to treat them, and may also make talking about their condition easier.<sup>74</sup> It appears that continuity increases quality of care, especially for those with a chronic condition. Since the longest of the experiments spans two years, it is quite possible that the full extent of the effect of continuity of care for those with chronic conditions are not known.<sup>74</sup>

## 4.2 Disadvantages to enrolment

A number of disadvantages have been noted in studies that take a case-study and focus group approach. Enrolment may disadvantage patients who want a second opinion in a different practice

and patients who do not wish to discuss a particular problem, for example an embarrassing one, with their own GP or another one in the same practice.

The main disadvantage identified was potentially missing slow change, such as a patient developing hypothyroidism. A few GPs said that too close a relationship risked doctors' being unable to be objective about a patient's problems, and could make patients less self-reliant and inappropriately dependent on the doctor.<sup>78</sup> There was some speculation that GPs could become complacent if one was treated by them for too long, and individuals still wished to be able to gain a second opinion.

The range of available services may be reduced for patients enrolled in organisations too small to provide population based services and manage budgets for referred services, which is relevant to regional, rural and remote areas.

Trials of patient registration programmes show job satisfaction among GPs is variable. Whilst it allows GPs to know their patient better, and build a rapport with them, they likewise can suffer from increased stress due to their responsibility<sup>87</sup> This is particularly pronounced when they cannot control their list size.<sup>88</sup> Enrolment and the financial systems involved (likely some degree of capitation remuneration) may also create financial incentives for providers to avoid high-need, high-utilising patients.<sup>70</sup> However, this may be possible under the current system in Australia already.

#### **4.2.1 Do patients want continuity of care?**

A plethora of research shows that increases in continuity are associated with increased patient satisfaction.<sup>53,66,86</sup> If there is provision for speedy access to care when needed, then an emphasis on continuity is advantageous for long-term care provision. In the UK where there were walk-in centres provided for people who did not wish to wait for care from their normal provider, patients valued continuity with their providers above speedy access to care.<sup>78</sup>

## **5 Accountability and enrolment**

Internationally, reform and strengthening efforts have adopted similar approaches to getting health systems to perform better: downsizing, privatisation, competition in service delivery, performance measurement and indicators, and citizen participation. All these approaches converge in emphasising accountability as a core element in implementing health reform and improving system performance.<sup>89</sup>

Accountability has become a major issue in health care.<sup>90</sup> It involves a justification for health expenditure, care-related responsibilities, and provides the core element for improving system performance. There are three broad purposes of accountability for health systems and providers<sup>89</sup>:

- ⇒ To control the abuse of public resources, particularly in the area of finances
- ⇒ To provide assurance that the resources are being used according to specific legal and professional standards, and
- ⇒ To support improved service provision and management via feedback mechanisms from the obtained performance data.

Three critical components to health accountability are specification of the accountable body or group and their relationship to the second party; areas in which this group is accountable; and formal and informal procedures of accountability.

In the context of enrolment, the focus is on the providers as the accountable individuals/ groups. Providers may be health organisations such as Primary Health Organisations in New Zealand, or single GP providers such as in Norway. Providers may be accountable to national health boards or sub-divisions such as adverse events reporting bodies.

A move towards the centrality of accountability represents the movement from professional, provider-centred care to more economic and politically accountable models where the citizen-user is a consumer. This shift is important in a number of ways with regards to accountability. The domains of accountability shift with this change in model. Traditionally accountability was primarily focused on professional competence, as well as legal and ethical standards. A focus on the patient as a consumer shifts accountability to include financial performance, as well as topics which are deemed to be politically important by the public.

It likewise reflects a change in accountability relationships. Previously this relationship rested on physicians/ providers' accountability to their provider representative bodies with little or no input from the public or funding bodies. Patient centred models emphasise interactions between physician/ providers and consumers, with regulatory mechanisms by the government overseeing the process. It also includes the compulsory representation of citizens and interest groups on important regulatory boards.

As will be seen, this is reflected in the modes of accountability internationally today, in which health care reforms are placing less importance on accreditation and licensing. Increasingly, accountability mechanisms include:

- ⇒ National or district health service fundholding
- ⇒ Legal regulatory policies and acts which protect consumers
- ⇒ Standardisation of price for physicians services
- ⇒ Budgetary accountability for finances
- ⇒ Public provision of quality-of-care and performance information about GPs
- ⇒ Citizens' opportunity to change providers if their performance is inadequate
- ⇒ Reserved citizen board membership for health related matters.<sup>89</sup>

A survey in the USA<sup>91</sup> indicated unanimous agreement among researchers, clinicians, purchasers, accreditation bodies and government representatives on the importance of provider accountability in primary health care service provision. The greatest level of variation in health outcomes was at the level of clinicians rather than health networks, insurance plans or hospitals in which GPs are based. This indicates that users of the health are likely to seek out information on individual providers to select their physician of choice.

The key areas of accountability which will be examined are financial, performance or quality. The means by which accountability is assessed include negotiated contractual agreements with state or federal bodies, registration/ accreditation bodies as well as public accountability and transparency processes.

## 5.1 Financial accountability

Most enrolment providers are individuals (GPs), the majority of whom are paid on a combination of capitation and fee-for-service arrangements. There is no need for financial accountability beyond the fact that the patient is enrolled with them and attended the consultation. Financial accountability in Denmark is characterised by a focus on cost containment with priority setting decisions focusing on which services should be remunerated by fees and which should be

capitated.<sup>23</sup> There are still auditing systems in place for unexpected fee-for-service deviations. In Denmark, each GP's activity is monitored by a committee representing both GPs in the county and the county health authorities. Deviation by more than 25% in expenditure per patient, or by more than 40% in services, leads to an investigation and, if the explanation is unsatisfactory, a sanction can be applied<sup>92</sup>.

There is more scope for funding accountability for Ontario's Family Health Teams (Canada) and the Primary Health Organisations in New Zealand, as funding is not necessarily based on a per-patient, per-consultation fee for the direct services provided. In Ontario, the Ministry of Health and Long Term Planning requires a three stage financial planning and accountability process. The exact details depend on the outcomes of negotiations with the Department and on the structure of the Family Health Team (not-for-profit, incorporated, or a mixture). The Teams are required to submit budgets which specify projected cost and timeframe for activities undertaken by the team. An internal control system is required to document the ongoing revenue and expenditure of the organisation, which must also submit audited financial statements and other financial documents to the Ministry for inspection. In New Zealand, the Primary Health Organisations receive funding for administration as well as the services provided. They must report on their financial activity via budgets and annual reports, and make these available to the public.

## **5.2 Quality and continuous improvement**

### **5.2.1 Through peer review**

In 1976, the Netherlands implemented a national program for peer review in response to expressions by physician groups that they needed assistance in the development, establishment and management of quality assurance (QA) processes.<sup>93</sup> The groups are linked to the professional medical associations (comparable to the Royal Australian College of General Practice) who assist them in standard setting. This program was directed primarily at hospital-based GPs, was entered into voluntarily on a hospital-by-hospital basis, and was developed with a long-term focus. Committees of staff members from different hospitals travel to individual hospitals giving assistance and advice.

### **5.2.2 Through registration bodies**

Australia currently engages in quality assurance for GPs via accreditation by AGPAL and other bodies. These bodies assess general practitioners against quality standards developed by the Royal Australian College of General Practice. The Australian Government offers financial incentives for practices to become accredited. GPs in Australia are registered with state Medical Boards, soon to become a national Board. GPs who are fellows of the RACGP or ACRRM must earn sufficient continuing professional development and quality assurance points each triennium to maintain their membership.

The Netherlands likewise uses GP registration as a way of maintaining quality. In order to practice providers in the Netherlands must be on the 'BIG register' which is maintained by the Health Care Insurance Board with representatives appointed by the federal government. Providers must be on this register in order to receive payment for their services, as well as to act as a health professional generally. Individuals on this list are audited every 5 years to ensure they are meeting an adequate standard of care. A failure to meet these standards results in de-registration.<sup>16</sup> The Dutch college of general practitioners has, since 1989, developed 77 standards to serve as the core of quality-improvement efforts in general practice across the Netherlands.<sup>94</sup>

### **5.2.3 Through population health targets and clinical indicators**

In the USA, the Indian Health Service utilises a two-fold measure of performance indicators. The first relates to public transparency. The Indian Health Service has developed seven performance measures based on the indicators of diabetes management, and the appropriateness of care for other chronic conditions, to allow the public access to information the quality of care provided by each health service in their local area. This method of accountability was meant to ensure that patients had choice of provider if they were unhappy with their current one, however this falls short due to low provider numbers generally. The Indian Health Service also reports on population health targets to Congress and Office of Management and Budget (OMB). These again are based on chronic disease management, oral health, immunisations, and behavioural health measures, and are less specific performance measures than the transparency measures.<sup>95</sup>

In New Zealand, specific national health priorities are developed by the federal government, with the expectation that they will be rolled out by individual practitioners within primary health organisations. These national priorities, together with other strategies such as the Maori Health Plan and immunisation programs are developed into specific targets for the PHO population within a *Negotiated Service Agreement*. PHOs are accountable to the district health boards as well as the Ministry of Health on their ability to meet these targets.<sup>27</sup>

The USA Department of Veteran Affairs has developed a performance framework for the health care standards of SVA health centres.<sup>96</sup> Each fiscal year, published information derived from the reports is available to the public. Each item in the framework has a preface explaining its public benefit and emphasises measures to ensure accuracy in providing health and other benefits to the correct people with the correct amount and in containing costs. These surveys are analysed on a provider-by-provider basis.

### **5.2.4 Through market competition**

Explicit government-regulated market competition exists in the Netherlands, Switzerland and through private health insurer systems such as Kaiser Permanente in the US. Public accountability exists in these models via the ability of the patient-consumer to choose their health fund, and change it if services are not satisfactory. There is an implicit requirement for the attractive services to be provided, and for services to maintain higher and more competitive standards in order to attract customer-patients. Information regarding provider performance is normally easily available. Any system which permits users to un-enrol from their providers includes a degree of market competition (including Australia currently). Dissemination of information regarding the performance of the provider is a critical factor in making the system competitive.

## **5.3 State and organisational legislation**

GPs within enrolment systems work within national legislative requirements, which vary in specification from a prescription of services to be provided by enrolment groups, to guiding principles for individual providers. GPs tend to be accountable via negotiated contractual agreements with intermediary bodies such as state, province or county governments, or health insurance organisations.

The NZ government has developed a specific set of national health priorities against which provider groups must be accountable via district health boards who fund them. Primary Health Organisations enter into specific contracts with the district health boards. The annual negotiations have specific targets which are formulated from the national health priorities. The targets include



continuous improvement processes, health promotion activities, access to healthcare for high needs groups, and referral management.

The Danish Ministry of Health is responsible for formulating goals for health care policy, developing legislative frameworks for the provision of care and setting standards against which reporting should occur.<sup>92,97</sup> GPs in Denmark work within agreements negotiated by their counties with the National Health Board, based on the idea that the counties are better able to respond to local need.<sup>25</sup> As county guidelines are vague, it is thought that national priority setting could be utilised more readily.

UK practitioners work within National Service Frameworks for chronic conditions such as heart disease and diabetes. These frameworks are monitored via a series of audits by the provider organisation as well as Primary Care Trusts, and a national system of monitoring and inspection by the department of Health.<sup>98</sup> Financial incentives are also offered to meet national targets under the Quality and Outcomes Framework, as an adjunct to other quality improvement initiatives. Allowing exception reporting, on the grounds that evidence-based guidelines were never intended to apply to every patient, has made it easier to align managerial with professional incentives, and to avoid inappropriate distortions of care.<sup>99</sup>

The Ministry of Health and Long Term Care in Ontario, Canada is focused on flexibility and responsiveness of the primary health care sector to local needs. The Ministry engages in individualised accountability and performance structures negotiated together with the Family Health Teams with which the patients are enrolled. It has developed guiding principles that must be covered by the Teams. The principles specify the types of services to be provided (including after hours, and telephone services), the delivery of patient-centred care, assisting patients in the navigation of the health care system, a focus on chronic disease prevention and management, and the integration of the service with local community representative and organisations.<sup>39</sup>

One challenge for Ontario is how to mandate implementation of clinical standards given current payment structures. It is up to individual providers to determine the model they want to be funded through. LHINs are not yet true commissioners of health services, but are planning bodies flowing funding to health service providers. They are only responsible for negotiating service accountability agreements with Community Health Centres; they have no jurisdiction over fee-for-service physicians or FHTs. Likewise, LHINs have no authority to report on the performance of health service providers in the primary care sector, such as fee for service physicians, Family Health Teams, and public health initiatives.<sup>40</sup>

## **5.4 Accountability to the public**

### **5.4.1 Through complaints mechanisms**

Most countries have patient complaints mechanisms to encourage GP accountability for services provided by them. This becomes especially pertinent when enrolment precludes the ability for consumers to change easily to another provider.

Australia currently has complaint mechanisms managed by independent ombudsmen on a state-by-state basis. Individuals are generally required to follow up any disputes with the provider, and if their response is unsatisfactory to refer the case to the ombudsmen. The ombudsman may act as a mediator, or refer the issue to regulatory bodies and other government departments if the issues are of a serious nature. State Medical Boards provide another avenue for complaint against individual medical practitioners.

Similarly, Norway entitles patients to have their case reviewed by a County Medical Officer and the central Norwegian Board of Health if they believe that they have received poor quality health care services. The authority can check on the quality of the treatment received and overturn decisions where necessary. Mechanisms include a patient rights system with access to a second opinion, an ombudsman, and investigation of concerns/complaints. In Norway the restriction to one GP is balanced by safeguards enshrined in the 1999 *Patients' Rights Act*: the right to a second opinion, access to their records, the right to complain and to have their case reviewed within 30 days, and for those with long term conditions, the right to an individual treatment plan.<sup>17</sup> Kaiser Permanente also has a patient complaints facility on their website.

In 1994, NZ developed a system with an independent health and disability commissioner. The Commissioner is responsible for ensuring compliance of providers with relation to the rights of health consumers. These rights are legislatively set by the federal government.<sup>100</sup> Consumers of the NHS in England have the right to take their complaint to the independent Parliamentary and Health Service Ombudsman if they are not satisfied with the way the NHS has dealt with it.<sup>vi</sup>

#### **5.4.2 Through Patients Rights Act**

Australia currently utilises patient rights charters. The responsibility for developing and responding to patient rights charters and codes is devolved to state and territory governments. The USA Veterans Affairs and NZ have charters similar in nature, which cover quality of care, choice and the provision of information enabling choice and freedom from discrimination.

Norway has a more specific policy for GP accountability via their 1999 *Patients' Rights Act*<sup>17</sup> which specifies enrolment conditions such as GP requirements to prioritise patients on their list, though it also specifies patient responsibilities. It includes a patient's right to a second opinion, access to their records, to complain and to have their case reviewed within 30 days, and for those with long term conditions, the right to an individual treatment plan.<sup>17</sup> The *Patients' Rights Act* ensures that every county has a Patients' Ombudsman whose purpose is to safeguard patients' rights, interests and legal rights in relation to specialist health care, and improve the quality of the health service. There seems to be general agreement that such a control system contributes to raising the quality of health services.<sup>17</sup>

The English Patient's Charter implemented in 1991 was abolished as part of changes to the NHS implemented in the year 2000 under the 10-year "NHS plan". The Patient's Charter was replaced in 2001 by *Your Guide to the NHS: getting the most from your National Health Service* which each local NHS organisation is required to publish annually.<sup>101</sup>

#### **5.4.3 Through public transparency**

Public transparency tends to occur through one of two mechanisms: the availability of financial and quality indicator reports, and the provision of information on quality statistics and waiting lists via websites. It appears that the greater the orientation towards market competition, the more the emphasis is on publicly available information.

Governments have launched a number of initiatives to provide web-based information for consumers on quality of care and wait time. Providing such information is expected to lead patient-

---

<sup>vi</sup> <http://www.nhs.uk/aboutNHSChoices/pages/Howtocomplaincompliment.aspx>

consumers to choose the provider who statistically provides the best care, thus creating market-based competition, with quality improvement and speedier services the target of competition.

Primary Health Organisations in New Zealand report annually on their budgets and annual reports. While it is a nationally mandated requirement that these be made available to the public, only vague information was available on relevant websites when this document was prepared, and the expected reports were not available

The National Health System in the UK provides a search function which allows patients to find services in their local area, or according to their health care need or chronic illness. There is information on the practices' ability to meet targets within the Quality and Outcomes Framework about managing chronic disease, waiting times and organisation level, as well as information derived from patient satisfaction surveys.

In an effort to reduce waiting times for emergency care and surgery and diagnostic imaging, the Canadian Ministry of Health and Long Term Care developed a website mapping optimal waiting time targets to districts and hospitals.<sup>102</sup> They show changes in waiting times since the targets were introduced, and provide this information on either a province or hospital-by-hospital basis.

The Netherlands has instituted a similar program, but more focused on the primary health care arena. *Kies Beter* is a public website which provides quality of care information about healthcare providers, including general practitioners. Patients may search their local area for a specialist or general doctor, with the option of changing practitioners (provided they are registered with their Insurance Plan).<sup>vii</sup>

#### **5.4.4 Through choice and competition**

The ability of health clinic users to hold clinics accountable by exercising their exit option creates incentives for responsiveness and service quality improvement. To a certain degree, all health systems provide users with the ability to exercise choice, and make practitioners accountable via this means. However, it assumes that prerequisites are in place for individuals to make an informed choice (such as the provision of accessible information on a specific GPs quality of care) and have the means to exercise this choice (such as financial ability to travel to another location). This can dampen the effectiveness of exit for accountability.<sup>89</sup> It also assumes the availability of alternative providers.

#### **5.4.5 Patient satisfaction survey**

The UK Department of Health undertakes a yearly survey of patient experience in general practice.<sup>61</sup> The survey assesses the performance of a practice against standards set out in the "Improved Access Scheme" and "Choice and Booking" Directed Enhanced Services (DES). These surveys assess the degree of accessibility and waiting times, and the results are posted on the National Health System website. Participation in this program is optional, however financial incentives are offered to those GP practices that choose to be involved.

## **5.5 Identified issues in the development of accountability structures**

⇒ The development of performance measures such as National Performance Indicators represents an underlying assumption that any health outcomes are entirely the responsibility

---

<sup>vii</sup> <http://www.kiesbeter.nl/algemeen/default.aspx>

of the provider and neglects any responsibility from the patient. Rigid performance measures may also neglect demographic differences such as high needs populations (eg. the elderly) whose health status may be unavoidably different to 'the optimal'.

- ⇒ The development of national performance indicators has met a number of barriers in the USA<sup>103</sup>. The development of appropriate and valid indicators was found to be unexpectedly difficult, as were the development of easily accessible data systems with which to assess them. There was also speculation that the data entered into these systems were not accurate or complete. Linked with this issue is the growing level of public concern that this form of accountability is entirely self-reported by the health care providers rather than being audited by an independent, external body.
- ⇒ The focus on provider accountability overlooks the difficulty of certain patients, or that some patients may not manage their conditions as prescribed by their health practitioner.
- ⇒ The ideas of public transparency are good in theory, however information needs to be easily accessible by all individuals (not just those with computing skills). The NHS has provided a telephone line for individuals which would prevent this problem. In NZ where there is a significant emphasis on public transparency, the reports which are supposed to be published on the PHO websites are not available.
- ⇒ For market competition to be a mechanism of accountability, patients must have a choice between providers ie. there must be a surplus of provider time when compared to demand.
- ⇒ Regulation by professional bodies detracts from the emphasis on patient centred care. Individual patients are often not aware of what accreditation with regulatory bodies (such as the AGPAL) actually means.
- ⇒ Health services are characterized by strong asymmetries among service providers, users and oversight bodies in terms of information, expertise and access to services. This asymmetry is in part responsiveness to the unique condition of communities and the individual patient list. As such, central bodies who oversee accountability mechanisms can experience difficulties in monitoring provider performance since providers often control the necessary information.<sup>89</sup>
- ⇒ There is often divergence between public and private interests and incentives, which can constrain efforts to increase accountability.
- ⇒ Institutional capacity gaps often constrain or undermine efforts to increase accountability for all three purposes. The inability of health facilities to track and report on budgets, collection of fees, pharmaceutical purchases and supply inventories, vehicles and equipment, and so on, limits possibilities for accountability for control and assurance purposes. It results in waste in the health system and can create fertile ground for corruption. Further, weak capacity to exercise oversight of facility and practitioner performance hampers efforts at accountability for the purpose of performance improvement. This capacity gap is aggravated by the difficulty in isolating the contributions of various health system actors to achieving performance goals.<sup>89</sup>
- ⇒ Disparities between the sanctions that exist 'on paper' and capacity to enforce them pose equally serious accountability problems. Facilities that lack the ability to identify who works there, where they are at a given time, and what they are doing cannot take the first steps toward holding staff accountable for performance.<sup>89</sup>



## References

- 1 World Health Organization. (2008). *Now more than ever*. WHO, [http://www.who.int/whr/2008/whr08\\_en.pdf](http://www.who.int/whr/2008/whr08_en.pdf).
- 2 Saltman, R. B., Rico, A. a., & Boerma, W. G. W. (2006). *Primary care in the driver's seat? Organizational reform in European primary care: World Health Organization 2006 on behalf of the European Observatory on Health Systems and Policies*. [http://www.euro.who.int/observatory/Publications/20060117\\_1](http://www.euro.who.int/observatory/Publications/20060117_1)
- 3 Powell Davies, G., Williams, A. M., Larsen, K., Perkins, D., Roland, M., & Harris, M. F. (2008). Coordinating primary health care: an analysis of the outcomes of a systematic review. *Med J Aust*, 188(8 Suppl), S65-68. [http://www.mja.com.au/public/issues/188\\_08\\_210408/pow11099\\_fm.pdf](http://www.mja.com.au/public/issues/188_08_210408/pow11099_fm.pdf)
- 4 Marketshare. (2000). *Consumer Market Research: Perceptions and attitudes towards general practice*. Brisbane: Brisbane North Division of General Practice. [http://www.gppartners.com.au/content/Document/report\\_marketresearch.pdf](http://www.gppartners.com.au/content/Document/report_marketresearch.pdf)
- 5 NHS. (209). NHS Choices website: How do I access my health records? . 2009, from <http://www.nhs.uk/chq/Pages/1309.aspx?CategoryID=68&SubCategoryID=160>
- 6 Department of Health. (2004). *Directions to PCTs concerning patient lists (Personal Medical Services) (Transitional Agreements) 2004*. London: England: Department of Health, [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH\\_4\\_083028](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4_083028)
- 7 NHS North of Tyne. (2007). *North East Family Health Services Authority: Governance Arrangements: Joint meeting of the boards of Newcastle Primary Care Trust, North Tyneside Primary Care Trust and Northumberland Care Trust 25th September 2007*, <http://www.northoftyne.nhs.uk/about-us/the-board-the-pec/board-papers/september-2007-joint-meeting-of-the-boards/delegation-of-powers-to-family-health-services/item14.pdf>
- 8 Primary Care Support Service. (2009). Primary Care Support Service Website,. Retrieved May 2009, from <http://www.pcss.nhs.uk/index.htm>
- 9 County Durham Primary Care Trust. (2007). *Governance arrangements for the newly formed North East Family Health Services Agency: County Durham PCT Board Tuesday 18 September 2007*, <http://www.countydurham.nhs.uk/Files/Board/CD0795.pdf>
- 10 Kent Primary Care Agency. (2009). Kent Primary Care Agency Website. Retrieved May 2009, from <http://www.kentandmedway.nhs.uk/welcome/nhs-organisations/primary-care-agency/>
- 11 NHS The Information Centre. (2009). *Attribution dataset GP registered populations 2008: ADS 2008 Technical note Jan 2009*: NHS The Information Centre, <http://www.ic.nhs.uk/statistics-and-data-collections/population-and-geography/population/attribution-dataset-gp-registered-populations-2008>
- 12 Ashworth, M., Jenkins, M., Burgess, K., Keynes, H., Wallace, M., Roberts, D., et al. (2005). Which general practices have higher list inflation? An exploratory study. *Fam Pract*, 22(5), 529-531, <http://fampra.oxfordjournals.org/cgi/content/full/22/5/529>
- 13 van Ginneken, E. (2006). Health Insurance Reform in the Netherlands. *Health Policy Monitor*(March), [http://www.hpm.org/en/Downloads/Half-Yearly\\_Reports.html](http://www.hpm.org/en/Downloads/Half-Yearly_Reports.html)
- 14 van den Bosch, W. J. H. M., & Freeman, G. K. (2005). Coordination and continuity of care. In C. Silagy, R. Jones, N. Britten, L. Culpepper, D. Gass, D. Mant & R. Grol (Eds.), *Oxford textbook of primary medical care*. Oxford: Oxford University Press.
- 15 Hart, H. E., van der Wouden, J. C., Hoppener, P., van Schendel, G. J., & Knottnerus, J. A. (1999). General practice registration networks in the Netherlands: a brief report. *J Am Med Inform Assoc*, 6(2), 173-175, <http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=10094070>



- 16 Poorter, J. (2005). *Primary health care in the Netherlands: The nature, structure, financing, regulation, supply, and training and demand for primary health care in the Netherlands*. Retrieved. from <http://www.minvws.nl/en/folders/cz/2005/primary-health-care.asp>
- 17 Johnsen, J. (2006). *Health Systems in Transition: Norway*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, [http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/95144/E88821.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/95144/E88821.pdf)
- 18 Carlsen, B., & Norheim, O. F. (2003). Introduction of the patient-list system in general practice. Changes in Norwegian physicians' perception of their gatekeeper role. *Scand J Prim Health Care*, 21(4), 209-213.
- 19 Godager, G., & Luras, H. (2008). Dual job holding general practitioners: the effect of patient shortage. *Health Econ*, <http://www3.interscience.wiley.com/journal/121494058/abstract?CRETRY=1&SRETRY=0>
- 20 Bjørnæs, I. (2006). Norwegians Prefer Female Doctors. Retrieved from <http://www.forskningsradet.no/en/News/Norwegians+Prefer+Female+Doctors/1142297131920>
- 21 Grytten, J., & Sørensen, R. (2007). Primary physician services-List size and primary physicians' service production. *Journal of Health Economics*, 26(4), 721-741, <http://www.scopus.com/scopus/inward/record.url?eid=2-s2.0-34249023045&partnerID=40>
- 22 Bech, M. (2004). Choice in the Danish health care system. *European Observer*, 6(4), 5-6.
- 23 Vallgård, S., Krasnik, A., & Vrangbæk, K. (2001). *Health Care Systems in Transition: Denmark* European Observatory on Health Care Systems <http://www.euro.who.int/document/e72967.pdf>
- 24 Davis, K. (2002). The Danish health system through an American lens. *Health Policy*, 59(2), 119-132.
- 25 Mooney, G. (2002). The Danish health care system: it ain't broke... so don't fix it *Health Policy*, 59(2), 161-171, [http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6V8X-44R1BNY-5&\\_user=1272615&\\_origUdi=B6V8X-44R1BNY-4&\\_fmt=high&\\_coverDate=01%2F31%2F2002&\\_rdoc=1&\\_orig=article&\\_acct=C000052175&\\_version=1&\\_urlVersion=0&\\_userid=1272615&md5=eb87930800523daa44015903d7b32c3a](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8X-44R1BNY-5&_user=1272615&_origUdi=B6V8X-44R1BNY-4&_fmt=high&_coverDate=01%2F31%2F2002&_rdoc=1&_orig=article&_acct=C000052175&_version=1&_urlVersion=0&_userid=1272615&md5=eb87930800523daa44015903d7b32c3a)
- 26 MOH. (2002). *Establishment service specifications for essential primary health care services provided by primary health organisations*. Retrieved. from [http://www.moh.govt.nz/moh.nsf/82f4780aa066f8d7cc2570bb006b5d4d/fe7a9fb4171c7cc256c3e001333d4/\\$FILE/establishment-service-specifications.pdf](http://www.moh.govt.nz/moh.nsf/82f4780aa066f8d7cc2570bb006b5d4d/fe7a9fb4171c7cc256c3e001333d4/$FILE/establishment-service-specifications.pdf)
- 27 Ministry of Health. (2009). *Health targets: Moving towards healthier futures 2007/08 - The Results*. Retrieved. from. <http://www.moh.govt.nz/moh.nsf/indexmh/health-targets-200708-results-oct08>
- 28 Ministry of Health. (2004). *Enrolment requirements for Primary Health Organisations*. Retrieved. from [www.moh.govt.nz/moh.nsf/0/D5806528C4B265CECC256BC900065ECA/\\$File/PHOEnrolmentReqV2-2.doc](http://www.moh.govt.nz/moh.nsf/0/D5806528C4B265CECC256BC900065ECA/$File/PHOEnrolmentReqV2-2.doc)
- 29 Ministry of Health. (2002). *Establishment service specifications for essential primary health care services provided by primary health organisations*. Retrieved. from [http://www.moh.govt.nz/moh.nsf/82f4780aa066f8d7cc2570bb006b5d4d/fe7a9fb4171c7cc256c3e001333d4/\\$FILE/establishment-service-specifications.pdf](http://www.moh.govt.nz/moh.nsf/82f4780aa066f8d7cc2570bb006b5d4d/fe7a9fb4171c7cc256c3e001333d4/$FILE/establishment-service-specifications.pdf)
- 30 New Zealand Ministry of Health. (2005). *Primary Health Organisation Datamart Data Dictionary Version 1.1*: New Zealand Health Information Service, [http://www.nzhis.govt.nz/moh.nsf/pagesns/240/\\$File/pho-dictionary.pdf](http://www.nzhis.govt.nz/moh.nsf/pagesns/240/$File/pho-dictionary.pdf)
- 31 Glazier, R. (2007). Balancing Equity Issues in Health Systems: Perspectives of Primary Healthcare. . *HealthcarePapers. New Models for the new Healthcare*, 8(Special Issue 2007).



- 32 OMHLTC. (2009). *An introduction to Family Health Teams*. Retrieved. from <http://www.ontla.on.ca/library/repository/mon/11000/254471.pdf>
- 33 HFHT. (2009). The Hamilton Family Health Team. Retrieved from <http://www.hamiltonfht.ca/detail.aspx?menu=46&app=205&cat1=633&tp=2&lk=no>
- 34 Canadian Ministry of Health and Long-Term Care. (2009). *Family Health Teams: Advancing Primary Health Care: Guide to Physician Compensation. Updated May 2009. Version 2.0*: Canadian Ministry of Health and Long-Term Care, [http://www.health.gov.on.ca/transformation/fht/guides/fht\\_compensation.pdf](http://www.health.gov.on.ca/transformation/fht/guides/fht_compensation.pdf)
- 35 Canadian Ministry of Health and Long-Term Care. (2005). *Processing Enrolment/Consent Forms Reference Manual For Primary Care Groups. March 2005* Canadian Ministry of Health and Long-Term Care, [http://www.health.gov.on.ca/english/providers/pub/primarycare/proces\\_enrolment/proces\\_enrolment\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/primarycare/proces_enrolment/proces_enrolment_mn.html)
- 36 Ontario Ministry of Health and Long term Care. (2005). *Processing Enrolment/Consent Forms Reference Manual For Primary Care Groups*: Ontario Ministry of Health and Long Term Care, [http://www.health.gov.on.ca/english/providers/pub/primarycare/proces\\_enrolment/proces\\_enrolment\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/primarycare/proces_enrolment/proces_enrolment_mn.html)
- 37 Ontario Ministry of Health and Long term Care. (2006). *Ontario Health Planning Data Guide: Release 3.0 28th February 2006*: Ontario Ministry of Health and Long term Care, [http://www.health.gov.on.ca/transformation/providers/information/resources/healthplan\\_guide.pdf](http://www.health.gov.on.ca/transformation/providers/information/resources/healthplan_guide.pdf)
- 38 Gosden, T., Williams, J., Petchey, R., Leese, B., & Sibbald, B. (2002). Salaried contracts in UK general practice: a study of job satisfaction and stress. *J Health Serv Res Policy*, 7(1), 26-33.
- 39 Ontario Ministry of Health and Long Term Care. (n.d.). *Family health teams: InfoKit*. Retrieved from. [http://www.health.gov.on.ca/transformation/fht/fht\\_mn.html](http://www.health.gov.on.ca/transformation/fht/fht_mn.html)
- 40 The Change Foundation. (2009). *Integrated Care in England - the challenge for Ontario*. 2009 Toronto: The Change Foundation,, <http://www.changefoundation.ca/docs/IntegratedHealthCareinEngland.pdf>
- 41 United States Department of Veterans' Affairs Website. (2009). VA Health Care Eligibility & Enrollment: Department of Veterans' Affairs, <http://www.va.gov/healtheligibility/>
- 42 Indian Health Service Website. (2009). IHS Fact Sheets: Indian Health Service, <http://info.ihs.gov/>
- 43 Kaiser Permanente. (2009). Kaiser Permanente Website. Retrieved April 2009 from <https://www.kaiserpermanente.org/>
- 44 Concierge medicine. (2009). Retrieved 28 May, from [http://en.wikipedia.org/wiki/Concierge\\_medicine#cite\\_note-0#cite\\_note-0](http://en.wikipedia.org/wiki/Concierge_medicine#cite_note-0#cite_note-0)
- 45 Indian Health Service Website. (2009). IHS Fact Sheets: Federal Basis for Health Services: Indian Health Service, <http://info.ihs.gov/BasisHlthSvcs.asp>
- 46 Indian Health Service. (2009). Tribal Self Determination. Retrieved May 2009, from <http://info.ihs.gov/TrblSlfDtrm.asp>
- 47 Indian Health Service. (2009). *Eligibility Requirements for Health Services From the Indian Health Service*: Indian Health Service, <http://www.ihs.gov/GeneralWeb/HelpCenter/CustomServices/elig.asp>
- 48 Indian Health Service. (2009). Eligibility Statement for Indian Health Service Indian Health Service, <http://www.ihs.gov/FacilitiesServices/areaOffices/California/UploadedFiles/EligibilityUpdatesforIHS.pdf> or <http://www.ihs.gov/FacilitiesServices/areaOffices/California/Universal/PageMain.cfm?p=70>



- 49 United States Bureau of Indian Affairs (2009). Federally Recognized Indian Tribes: Federal Register: July 12, 2002 (Volume 67, Number 134). Retrieved May 2009, from <http://www.artnatam.com/tribes.html>
- 50 United States Department of the Interior. (2009). Indian Ancestry - Enrollment in a Federally Recognized Tribe from <http://www.doi.gov/enrollment.html>
- 51 Besley, T., & Ghatak, M. (2003). Reforming public service delivery. *Journal of African Economies*, 16(1), 127-156, [http://jae.oxfordjournals.org/cgi/content/full/16/suppl\\_1/127](http://jae.oxfordjournals.org/cgi/content/full/16/suppl_1/127).
- 52 Grytten, J., Fredrik, C., & Irene, S. (2009). Services production and patient satisfaction in primary care. *Health Policy*, 89(3), 312-321, [http://www.biomedexperts.com/Abstract.bme/18656276/Services\\_production\\_and\\_patient\\_satisfaction\\_in\\_primary\\_care](http://www.biomedexperts.com/Abstract.bme/18656276/Services_production_and_patient_satisfaction_in_primary_care)
- 53 Gravelle, H., & Masiero, G. (2000). Quality incentives with imperfect information and switching costs in a regulated environment. *Journal of Health Economics*, 19(6), 1067-1088, <http://ideas.repec.org/p/yor/yorken/00-18.html>
- 54 Beusekom, I., Tonshoff, S., de Vries, H., Spreng, C., & Keeler, E. B. (2004). *Possibility or utopia? Consumer choice in health care: A literature review*: RAND Europe.
- 55 Coulter, A., & Jenkinson, C. (2005). European patients' views on the responsiveness of health systems and health care providers. *Health Services Research*, 15(4), 355-360.
- 56 Fotaki, M., & Boyd, A. (2005). From plan to market: A comparison of health and old age care policies in the UK and Sweden. *Public Money & Management*, 25(4), 237-243, [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=771714](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=771714)
- 57 Ellins, J., Ham, C., & Parker, H. (2009). Opening up the primary medical care market. *BMJ*, 338(31 March 2009), 1127, [http://www.bmj.com/cgi/content/full/338/mar31\\_1/b1127](http://www.bmj.com/cgi/content/full/338/mar31_1/b1127)
- 58 MHWS. (2006). *The new care system in the Netherlands: durability, solidarity, choice, quality, efficiency*. Den Haag: Ministry for Health, Welfare and Sport.
- 59 Figueras, J., Robinson, R., & Jakubowski, E. (Eds.). (2005). *Purchasing to improve health systems performance*. Berkshire, England: Open University Press.
- 60 Ham, C., & Brommels, M. (1991). Health care reform in the Netherlands, Sweeden, and the UK. *Health Affairs*, 106-119.
- 61 Ipsos MORI. (2007). *GP Patient Survey 2006-7*. London: Department of Health, England., <http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm>
- 62 Baker, R., Boulton, M., Windridge, K., Tarrant, C., Bankart, J., & Freeman, G. K. (2007). Interpersonal continuity of care: a cross-sectional survey of primary care patients' preferences and their experiences. *Br J Gen Pract*, 57(537), 283-289.
- 63 Guthrie, B. (2002). Continuity in UK general practice: a multilevel model of patient, doctor and practice factors associated with patients seeing their usual doctor. *Fam Pract*, 19(5), 496-499.
- 64 Cheraghi-Sohi, S., Hole, A. R., Mead, N., McDonald, R., Whalley, D., Bower, P., et al. (2008). What patients want from primary care consultations: a discrete choice experiment to identify patients' priorities. *Ann Fam Med*, 6(2), 107-115.
- 65 Robertson, R., Dixon, A., & Le Grand, J. (2008). Patient choice in general practice: the implications of patient satisfaction surveys. *J Health Serv Res Policy*, 13(2), 67-72.
- 66 Turner, D., Tarrant, C., Windridge, K., Bryan, S., Boulton, M., Freeman, G., et al. (2007). Do patients value continuity of care in general practice? An investigation using stated preference discrete choice experiments. *J Health Serv Res Policy*, 12(3), 132-137.
- 67 Howell, B. (2005). Restructuring primary health care markets in New Zealand: from welfare benefits to insurance markets. *Aust New Zealand Health Policy*, 2, 20, <http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=16144544>





- 68 McDonald, R., & Roland, M. (2009). Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences. *Annals of Family Medicine*, 7, 121-127, <http://www.annfammed.org/cgi/content/full/7/2/121>
- 69 O' Reilly, M. (1998). Ontario's attempt at primary care reform hits another snag. *Cmaj*, 159(11), 1398-1400.
- 70 Sorbero, M. E., Dick, A. W., Zwanziger, J., Mukamel, D., & Weyl, N. (2003). The effect of capitation on switching primary care physicians. *Health Serv Res*, 38(1 Pt 1), 191-209, <http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=12650388>
- 71 Newhouse, J. P. (1994). Patients at risk: Health reform and risk adjustment. *Health Affairs*, 13(1), 132-146, <http://content.healthaffairs.org/cgi/content/abstract/13/1/132>
- 72 van Barneveld, E. M., Lamers, L. M., van Vliet, R. C. J. A., & van de Ven, W. P. M. M. (2000). Ignoring small predictable profits and losses: a new approach for measuring incentives for cream skimming. *Health Care Management Science*, 3, 131-140.
- 73 Macinko, J., Starfield, B., & Shi, L. (2003). The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970-1998. *Health Services Research*, 38(3), 831-865, <http://www3.interscience.wiley.com/cgi-bin/fulltext/118868226/PDFSTART>
- 74 Cabana, M. D., & Jee, S. H. (2004). Does continuity of care improve patient outcomes? *J Fam Pract*, 53(12), 974-980.
- 75 Guthrie, B., Saultz, J. W., Freeman, G. K., & Haggerty, J. L. (2008). Continuity of care matters. *Bmj*, 337, a867.
- 76 Alazri, M. H., Heywood, P., Neal, R. D., & Leese, B. (2007). UK GPs' and practice nurses' views of continuity of care for patients with type 2 diabetes. *Fam Pract*, 24(2), 128-137.
- 77 Gray, D. P., Evans, P., Sweeney, K., Lings, P., Seamark, D., Seamark, C., et al. (2003). Towards a theory of continuity of care. *J R Soc Med*, 96(4), 160-166.
- 78 Guthrie, B., & Wyke, S. (2006). Personal continuity and access in UK general practice: a qualitative study of general practitioners' and patients' perceptions of when and how they matter. *BMC Fam Pract*, 7, 11.
- 79 Wranik, D. W., & Durier-Copp, M. (2009). Physician Remuneration Methods for Family Physicians in Canada: Expected Outcomes and Lessons Learned. *Health Care Anal*, <http://www.springerlink.com/content/xj51131030268638/fulltext.pdf>
- 80 Manious, A. G., Baker, R., Love, M., Pereira, G. D. J., & Gill, J. M. (2001). Continuity of care and trust in one's physician: evicence from primary care in the US and UK. *Family Medicine*, 33(3), 22-27, <http://www.ncbi.nlm.nih.gov/pubmed/11199905?dopt=Abstract>
- 81 Christakis, D. A., Mell, L., Koepsell, T. D., Zimmerman, F. J., & Connell, F. A. (2001). Association of lower continuity of care with greater risk of emergency department use and hospitalisation in children. *Pediatrics*, 107(3), 524-529, <http://www.ncbi.nlm.nih.gov/pubmed/11230593>
- 82 Davidson, S. M., Manheim, L. M., Werner, S. M., Hohlen, M. M., Yudkowsky, B. K., & Fleming, G. V. (1992). Prepayment with office based phsycians in publicly funded programs: results from the children's Medicaid program. *Pediatrics*, 89(4), 761-767, <http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002215/frame.html>
- 83 Christakis, D. A., Kazak, A. E., Wright, J. A., Zimmerman, F. J., Bassett, A. L., & Connell, F. A. (2004). What factors are associated with achieving high continuity of care? *Fam Med*, 36(1), 55-60.
- 84 Christakis, D. A., Wright, J. A., Zimmerman, F. J., Bassett, A. L., & Connell, F. A. (2003). Continuity of care is associated with well-coordinated care. *Ambul Pediatr*, 3(2), 82-86.
- 85 Kerse, N., Beutow, S., Manious, A. G., Young, G., Coster, G., & Aroll, B. (2004). Physician-patient relationship and medication compliance: A primary care investigation. *Annals of Family Medicine*, 2(455-461).



- 86 Hjortdahl, P., & Laerum, E. (1992). Continuity of care in general practice. *British Medical Journal*, 304, 1287-1290, <http://www.bmj.com/cgi/content/abstract/304/6837/1287>
- 87 Buetow, S. (1999). Patient enrollment with co-payments: implications for patient choice in general practice. *N Z Med J*, 112(1101), 473-474.
- 88 Branthwaite, A., & Ross, A. (1988). Satisfaction and Job Stress in General Practice *Family Practice* 5(2), 83-93, <http://fampra.oxfordjournals.org/cgi/content/abstract/5/2/83>
- 89 Brinkerhoff, D. W. (2004). Accountability and health systems: Towards conceptual clarity and policy relevance. *Health Policy and Planning*, 19(6), 371-379, <http://heapol.oxfordjournals.org/cgi/reprint/19/6/371>
- 90 Emanuel, E. J., & Emanuel, L. L. (1996). What is accountability in health care? *Annals of Internal Medicine*, 124(2), 229-239, <http://www.annals.org/cgi/content/full/124/2/229>
- 91 Nerenz, D. R. (1998). Accountability for health outcomes and the proper unit for analysis: what do the experts think? *International Journal for Quality in Health Care*, 10(6), 539-546, <http://intqhc.oxfordjournals.org/cgi/reprint/10/6/539>
- 92 Christiansen, T. (2008). Modernisation of general practice in Denmark. *Health Policy Monitor*(April), [www.hpm.org/en/Downloads/Half-Yearly\\_Reports.html](http://www.hpm.org/en/Downloads/Half-Yearly_Reports.html)
- 93 Reerink, E. (1990). Improving the quality of hospital services in The Netherlands. The role of CBO--The National Organization for Quality Assurance in The Netherlands. *Quality Assurance in Health Care*, 2(1), 13-19.
- 94 Klazinga, N., Lombarts, K., & van Everdingen, J. (1998). Quality Management in medical specialties: The use of channels and dikes in improving health care in the Netherlands. *The Joint Commission Journal on Quality Improvement*, 54(5), 240-250.
- 95 Indian Health Service. (2008). Indian Health Service: Reporting Quality for GPRA. Retrieved May 25, 2009, from [http://www.ihs.gov/NonMedicalPrograms/quality/index.cfm?module=gpra\\_list](http://www.ihs.gov/NonMedicalPrograms/quality/index.cfm?module=gpra_list)
- 96 United States Department of Veterans' Affairs. (2008). *Fiscal Year 2008 Performance and Accountability Report*: Department of Veterans Affairs, US, [http://www.va.gov/budget/report/2008/PartI/Performance\\_Summaries\\_by\\_Strategic\\_Goal.pdf](http://www.va.gov/budget/report/2008/PartI/Performance_Summaries_by_Strategic_Goal.pdf)
- 97 Christiansen, T. (2002). Organization and financing of the Danish health care system. *Health Policy*, 59(2), 107-118.
- 98 Campbell, S. M., Robison, J., Steiner, A., Webb, D., & Roland, M. O. (2004). Improving the quality of mental health services in Personal Medical Services pilots: A longitudinal qualitative study. *Quality and Safety in Health Care*, 13(2), 115-120, <http://www.scopus.com/scopus/inward/record.url?eid=2-s2.0-1942521735&partnerID=40>
- 99 Roland, M. (2007). The Quality and Outcomes Framework: too early for a final verdict. *British Journal of General Practice*, 57(540), 535-537.
- 100 Paterson, R. (2002). The patients' complaints system in New Zealand. *Health Affairs*, 21, 70-79.
- 101 NHS. (2001). *Your Guide to the NHS: getting the most from your National Health Service* National Health Service, [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4007349](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007349)
- 102 Ministry of Health and Long Term Care. (2009). Ontario Wait Times. Retrieved March 25, 2009, from [http://www.health.gov.on.ca/transformation/wait\\_times/wait\\_mn.html](http://www.health.gov.on.ca/transformation/wait_times/wait_mn.html)
- 103 Roper, W. L., & Cultler, C. M. (1998). Health care accountability and reporting: Issues from the field. *Health Affairs*, 17(2), 152-155, <http://content.healthaffairs.org/cgi/reprint/17/2/152.pdf>

## Appendix A:

# Primary health care strategy submissions

In order to provide context to this review we examined a purposive sample of submissions to the Primary Health Strategy consultation provided by the Department. The sample included major stakeholder groups, government, members of the Divisions Network, medical organisations, Indigenous groups, consumer organisations, allied health organisations, research groups and a random selection of submissions from individuals, and GPs. In all, 35 submissions were analysed. The following addresses the major issues raised in the submissions, which are discussed in light of the international experience.

### Choice

There was no support for mandatory enrolment but voluntary enrolment has moderate support.<sup>viii</sup> A number of submissions mentions choice as an issue for consumers. Choice of GP and practice is valued as is the ability to access a second opinion<sup>ix</sup>, to go to a second clinic if they cannot access a convenient appointment or to visit different GPs for different purposes, such as a female GP for women's health concerns. <sup>x</sup> An enrolment system needs to take into account the varying skills, special training and accreditation of GPs (eg Better outcome in Mental Health or Veterans Affairs) and the desire for consumers to see the best GP for their problem. It is suggested that GPs lacking skills in some areas could refer to GPs having those skills and report back to the regular GP.<sup>xi</sup>

### Access and equity for marginalised groups and Indigenous people

Ensuring that any enrolment scheme does not create inequities was a major theme of the submissions. Any enrolment scheme needs to ensure that:

- ⇒ disadvantaged communities have adequate resources to provide services<sup>xii</sup>
- ⇒ people with complex co-morbidity are not selectively omitted from enrolment schemes<sup>xiii</sup>
- ⇒ there is adequate monitoring of lists to monitor for reach across disadvantaged groups<sup>xiv</sup>
- ⇒ consumers are not discriminated against if they choose not to enrol, resulting in different levels of care for those who enrol and those who do not.<sup>xv</sup>

There was concern that the scheme does not fail to recognise or cater for those with transient lifestyles or personal circumstances that make such enrolment impractical or impossible as those most likely not to enrol include some of our most disadvantaged individuals and population groups, such as the homeless, Indigenous populations, those with mental health issues and those with limited incomes. Conversely, it was anticipated that those most likely to enrol are those who already enjoy high levels of care.<sup>xvi</sup>

---

<sup>viii</sup> Sub 198 GPDV; Sub 95 Aust Commission on Quality and Safety in Health Care; Sub 141 AGPN; Sub 173 RACGP; Sub 253 RACP; Sub 208 GP NSW; Sub 161 Monash DGP; Sub 198 GPDV.

<sup>ix</sup> Sub 169 Consumers Health Forum of Aust

<sup>x</sup> Sub 233 Southern GPN; Sub 141 AGPN; Sub 169 Consumers Health Forum of Aust

<sup>xi</sup> Sub 174 Alzheimers Assn; Sub 21 Cochrane collab; Sub 84 Ipswich and West Moreton DGP

<sup>xii</sup> Sub 057 Health Inequalities Research Collaboration

<sup>xiii</sup> Sub 057 Health Inequalities Research Collaboration

<sup>xiv</sup> Sub 057 Health Inequalities Research Collaboration

<sup>xv</sup> Sub 161 Monash DGP; Sub 198 GPDV

<sup>xvi</sup> Sub 169 Consumers Health Forum of Aust; Sub 198 GPDV

NACCHO believes that Aboriginal people will be affected in this way and do not support an enrolment system, as Aboriginal peoples are highly dispersed and mobile populations and “the creation of another bureaucratic layer to health services delivery, with the aim of rationing and accounting for health services expenditure, may in fact worsen Aboriginal people’s access to health care”.<sup>xvii</sup>

NACCHO also has concerns about leakage of Indigenous-specific program resources to non-Aboriginal patients and stresses the importance of being able to identify Aboriginality. The ACCHSs sector requires users to establish descent, self identification and community recognition as Aboriginal in order to receive services.<sup>xviii</sup>

## Preventive care

Many see the strength of a patient enrolment scheme as its potential to enable general practices to take a population approach and to have clear responsibility for the delivery of PHC services to a population. Other advantages include the identification and follow up of patients at risk.<sup>xix</sup>

## Chronic disease

Many respondents see benefits in a registration system for chronic disease care as it will enable practices to identify those patients from whom they are responsible and facilitate improved continuity of care.<sup>xx</sup> Some submissions expressed the hope that patients would be encouraged to “own their problems” and that the enrolment process would clarify the mutual responsibilities and expectations of providers and patients and remove the fear that active follow up would be seen to be soliciting for business.<sup>i,xxi</sup>

## Continuity and coordination of care

Several respondents saw opportunities in patient enrolment for better coordinated systems of care, including better follow up and reminder systems and better models of remuneration of GPs for the time spent in coordinating care,<sup>xxii</sup> and in providing case management for complex care.<sup>xxiii</sup> Enrolment at one practice has the advantage of continuity of care and a strengthened relationship between GP and patient. It would also ensure that individual preferences are known and respected, provide ongoing opportunities for preventative health care, provide for more accurate prescribing and reduce duplication of tests and conflicting advice.<sup>xxiv</sup> It also avoids fragmentation of the medical record as patients do not always tell their usual GP if they have seen somebody else and important information may be missing from the record. The importance of this continuity is particularly noted for young people.<sup>xxv</sup> It is however acknowledged by several submissions that a

---

<sup>xvii</sup> Sub 140 NACCHO

<sup>xviii</sup> Sub 140 NACCHO

<sup>xix</sup> Sub 198 GPDV; Sub 141 AGPN

<sup>xx</sup> Sub 199 WA GP Network; Sub 141 AGPN; Sub 144 Health Issues Centre; Sub 43 SA Dept of Health; Sub 145 GP Tasmania; Sub 145 GP Tasmania; Sub 168 Centre PHC & Equity

<sup>xxi</sup> Sub 145 GP Tasmania; Sub 168 Centre PHC & Equity

<sup>xxii</sup> Sub 168 Centre PHC & Equity; Sub 173 RACGP

<sup>xxiii</sup> Sub 95 Aust Commission on Quality and Safety in Health Care

<sup>xxiv</sup> Sub 173 RACGP; Sub 253 RAC Physicians; Sub 145 GP Tasmania; Sub 95 Aust Commission on Quality and Safety in Health Care; Sub 084 Ipswich and West Moreton DGP

<sup>xxv</sup> Sub 52 Youth Health Research Group

de facto enrolment system operates as patients with chronic disease often see the same doctor over a long period of time.<sup>xxvi</sup> The concept of a “medical home” is mentioned which encompasses these ideas.<sup>xxvii</sup>

## Administration of registers and data management

The requirements for establishing and maintaining accurate patient enrolment registers must not be underestimated and is mentioned by a number of respondents. Integrated data and information management is suggested, as well as well supported, easy to use reliable systems. If data collection is incomplete or not reliable it will become invalid. Significant capital and expertise will be required for development.

The need for good population data was emphasised in order to provide a basis for planning health care for the population, to provide enhanced information about access to services, to underpin a needs based funding mechanism and to support planning and resource allocation.<sup>xxviii</sup>

The resources required to incentivize and promote enrolment must also be considered.<sup>xxix</sup> One suggestion is to provide a higher MBS rebate for enrollees<sup>xxx</sup>, however this may lead to inequities as described above.

## eHealth will make it unnecessary

While the importance of good data and IT structures to support patient enrolment was stressed, others suggest strongly that, due to the unique health care identifiers currently being developed by the National E-Health Transition Authority (NEHTA) and a developed eHealth record, patient enrolment will become unnecessary.<sup>xxxi</sup> One submission says that eHealth would be the “greatest thing since the stethoscope”.<sup>xxxii</sup>

## Considerations

A number of points were made in the submissions regarding aspects of enrolment:

- ⇒ There needs to be consideration of how enrolment would work in areas of GP shortage and how it would affect access.<sup>xxxiii</sup>
- ⇒ It is important that an enrolment system makes allowances for people who are travelling.<sup>xxxiv</sup>
- ⇒ Patient enrolment need not be restricted to enrolment with GPs and there are calls for enrolment to cover access to nurses, nurse practitioners and culturally specific health workers.<sup>xxxv</sup>
- ⇒ There also needs to be safeguards against gaming the system. One respondent suggested that if certain MBS item numbers can only be paid to the enrolled practice there needs to be a

---

<sup>xxvi</sup> Sub 121 G Miller (Family Medicine Research Centre)

<sup>xxvii</sup> Aust Commission on Quality and Safety in Health Care

<sup>xxviii</sup> Sub 226 APHCRI

<sup>xxix</sup> Sub 208 GP NSW; Sub 146 GPSA

<sup>xxx</sup> Sub 145 GP Tasmania

<sup>xxxi</sup> Sub 169 Consumers Health Forum of Aust; Sub 165 Northern Sydney DGP; Sub 084 Ipswich and West Moreton DGP; Sub 188 Capricornia DGP; Sub 226 APHCRI; Sub 146 GPSA; Sub 21 Cochrane collaboration

<sup>xxxii</sup> Sub 084 Ipswich and West Moreton DGP

<sup>xxxiii</sup> Sub 84 Ipswich and West Moreton DGP

<sup>xxxiv</sup> Sub 21 Cochrane collab; Sub 141 AGPN

<sup>xxxv</sup> Sub 104 Aust College of Nurse Practitioners; Sub 078 PHCRED WA



mechanism to avoid a GP who sees the patient once claiming the item, preventing the regular GP from doing so.<sup>xxxvi</sup>

- ⇒ There needs to be a safeguard against GPs selecting patients with less problems and more motivation, particularly if reporting is linked to positive or negative incentives for GPs or practices.<sup>xxxvii</sup>
- ⇒ The enrolment system needs to maintain the rights of patients in the health system as set out in the Australian Charter of Healthcare Rights in 2008.<sup>xxxviii</sup>

## Concerns

Other concerns about patient enrolment related to:

- ⇒ fears the it would lead to rationing of care on the basis of cost rather than need,<sup>xxxix</sup>
- ⇒ concerns about patient enrolment on the basis of a specific condition, rather than 'whole person' will undermine holistic patient care<sup>xl</sup>
- ⇒ Concerns over patient control and the removal of choice<sup>xli</sup>
- ⇒ Concerns that enrolment/ eHealth may not uphold the privacy of teenage children.<sup>xlii</sup>

---

<sup>xxxvi</sup> Sub 84 Ipswich and West Moreton DGP

<sup>xxxvii</sup> Sub 84 Ipswich and West Moreton DGP

<sup>xxxviii</sup> Sub 95 Aust Commission on Quality and Safety in Health Care

<sup>xxxix</sup> Sub 161 Monash DGP

<sup>xl</sup> Sub 198 DPDV; Sub 161 Monash DGP; Sub 173 RACGP; Sub 21 Cochrane collaboration

<sup>xli</sup> Sub 21 Cochrane collab.

<sup>xlii</sup> Sub 21 Cochrane collab.