



# Patient enrolment in Australian primary health care

Keep up to date with new Australian primary health care research

ISSN 1839-6348

Issue 36  
June 2014

J Oliver-Baxter

**Patient enrolment in general practice is an important consideration for health systems, administrators, service providers and consumers across the world.**

**This RESEARCH ROUNDup reviews patient enrolment in the Australian context, including both strengths and weaknesses of the approach, the policy context and examples of programs currently being implemented nationally.**

Patient enrolment refers to a formal affiliation that a patient has with a general practitioner (GP) and/or their general practice; enrolment can be described as full or partial.<sup>1</sup> Patient enrolment can be understood on a spectrum from voluntary to formal. Voluntary enrolment is where a patient chooses their own GP and is able to change GPs or practices as they please (e.g. Norway). This type of affiliation is also known as active registration or patient lists. At the other end of the spectrum is formal enrolment where patients are allocated by administrating organisations to a local GP and/or practice (e.g. Netherlands) based on a geographical criterion of proximity (e.g. 5km radius).

Health systems administering the services can align incentives and/or penalties for adherence to patient enrolment. For example, in Denmark patients are penalised financially if they attend GPs where they are not formally enrolled.<sup>2</sup> However, most systems permit patients to change GPs, although some are more prohibitive (e.g. only a certain number of changes per year) and cumbersome (e.g. medical records can be delayed) than others. Countries where primary health care financing is structured around capitation payments to doctors for their patient community inherently require patient enrolment. Patient-centred medical homes, being based on connection of a patient and an individual doctor, depend on patient enrolment.<sup>3</sup>

## Why enrolment?

The key components of primary care at the clinical level include access to and use of first-contact care; patient-focused (rather than disease-focused) care over time for a defined population; comprehensive and timely services; and coordination of care when patients need additional services elsewhere. Having a continuous relationship with a single primary care provider is considered to be one of the four critical features of primary care.<sup>3</sup> Studies have also found a strong relationship between patient affiliation with a physician and reduced health expenditure for the most ill patients, signalling that care provider continuity reduces total health costs.<sup>4-6</sup>

## Who enrolls in Australia?

McRae and colleagues explored characteristics that influenced affiliation with GPs in Australia.<sup>1</sup> The groups that are significantly more likely to be affiliated with a single GP were older, lived in major cities, were full-time students or retired, had private

health insurance, had excellent/very good/good self-assessed health, were non-smokers and were satisfied with their last visit to a GP. Additional exploration of affiliation with a GP impacting on prevention and promotion advice suggested there was only weak evidence for affiliation affecting advice on weight and diet, and no support for it having an impact on exercise, smoking and alcohol consumption. This study recommended developing policy for voluntary patient enrolment and focusing on providing continuity of care for those experiencing poor health.

Patient enrolment is restricted not only by patients' willingness to enrol, but also by the availability of services willing to participate in the program. The applicability of enrolment varies across health systems and depends on payment systems, other structural elements (e.g. provision of alternate care; shared records to ensure continuity if nominated GP is unavailable or no appointment is available within a reasonable time; options if the patient is travelling or commuting, or prefers to see a GP close to their workplace), accountability mechanisms, demand and supply of providers.<sup>2</sup> Kalucy et al. (2009) reviewed international models of patient enrolment and provided a summary of the strengths and weaknesses of the approach (Table 1).

## Australian policy context

In Australia, patients have largely been free to choose which general practice they attend without any penalty; however, there is a high level of voluntary affiliation with an individual GP or general practice. A cross-sectional survey<sup>1</sup> of Australian residents (N = 1 146) indicated 89% of respondents were fully or partially affiliated with a GP or a practice. Similar rates have been found in other studies.<sup>7-9</sup>

In 2009, Australia's first National Primary Health Care Strategy identified a key direction to better manage chronic conditions via programs linked to voluntary enrolment.<sup>10</sup> In 2010, the Australian National Health and Hospital Reform Commission proposed voluntary enrolment with a 'health care home' for specific groups of patients to enhance their continuity of care. These groups include people with chronic diseases and disabilities, families with young children, and Aboriginal and Torres Strait Islander people.<sup>11</sup> While such wide scale enrolment has not yet been implemented in Australia, a large scale project trialling the approach (Diabetes Care Project) has been implemented.

**Table 1 Strengths and weaknesses of international patient enrolment models (adapted from Kalucy et al. 2009)**

Strengths	Weaknesses
Enhanced continuity of care	Constrains patient choice
Comprehensive care including prevention and promotion	Does not meet patient needs when travelling, commuting, seeking second opinions
Patient information in one place	Record transfer delays when patients change providers
Coordination across and between primary and secondary, tertiary care providers	May decrease equity if there are incentives for providers to avoid enrolling high need patients (chronic disease, multimorbidity)
Compatible with gatekeeping role for primary care	GP shortages limit competition between providers
Allows for population planning	May increase bureaucracy and therefore costs

## Programs to watch

The **Diabetes Care Project (DCP)** began enrolling eligible practices and people with diabetes across seven sites, covering regions in Queensland, Victoria and South Australia, as part of the implementation phase in early 2012.<sup>12</sup> This program is trialling new technologies, funding models, facilitator roles and educational modules to improve health outcomes. After two years of implementing the new models of care, the project will formally begin its evaluation phase, when outcomes will be analysed and final reports created. The primary endpoint is the difference in the change in HbA1c (glycated haemoglobin—a measure of plasma glucose concentration) between groups; secondary outcomes include other clinical metrics (i.e. cholesterol, blood pressure, Body Mass Index).<sup>12</sup>

The **Coordinated Veterans Care (CVC) Program**, established in 2011, is a planned and coordinated health care model for eligible returned service personnel with one or more chronic conditions and at risk of hospitalisation. Care is an ongoing partnership between the CVC participant, their GP and a nurse coordinator. As at May 2013, over 17 000 eligible patients had enrolled in this program. An interim report has noted strong indicators that the CVC Program is achieving positive benefits for participating service providers and is improving quality of care for enrolled patients.<sup>13</sup> However, formal evaluation is not yet publicly available.

## Future directions

According to the National Health and Hospital Reform Commission, supporting voluntary enrolment in Australia requires the use of blended funding models, which involve fee-for-service payments, grant payments to support multidisciplinary clinical services and care coordination, outcomes payments to reward good performance, and episodic or bundled payments.<sup>11</sup> Approaches to organising health care services are unlikely to improve care unless they are based on recognition that care needs to be focused on the patient rather than on the disease.<sup>3</sup> An educational approach is required to inform users, health professionals and administrators of the strengths and weaknesses of patient enrolment.

**Acknowledgement:** thank you to expert reviewer Dr Ian McRae for his comments on a draft of this paper.

## References

- McRae I, et al. (2011). Patient affiliation with GPs in Australia—who is and who is not and does it matter? *Health Policy*, 103(1), 16–23.
- Kalucy L, et al. (2009). *Models of patient enrolment. PHCRIS Policy Issue Review*. Adelaide: Primary Health Care Research & Information Service.
- Starfield B. (2009). Toward international primary care reform. *Canadian Medical Association Journal*, 180(11), 1091–1092.
- De Maeseneer JM, et al. (2003). Provider continuity in family medicine: does it make a difference for total health care costs? *The Annals of Family Medicine*, 1(3), 144–148.
- Hollander MJ, et al. (2009). Increasing value for money in the Canadian healthcare system: new findings and the case for integrated care for seniors. *Healthcare Quarterly*, 12(1), 38–47.
- Hollander MJ, Liu G, Chappell NL. (2009). Who cares and how much? The imputed economic contribution to the Canadian healthcare system of middle-aged and older unpaid caregivers providing care to the elderly. *Healthcare Quarterly*, 12(2), 42–9.
- Schoen C, et al. (2009). In chronic condition: experiences of patients with complex health care needs, in eight countries, 2008. *Health Affairs*, 28(1), w1–w16.
- Schoen C, et al. (2007). Toward higher-performance health systems: adults' health care experiences in seven countries, 2007. *Health Affairs*, 26(6), w717–w734.
- Australian Primary Health Care Research Institute. (2008). *Submission to the National Health and Hospital Reform Commission: Primary Health Care Workforce*. Canberra: The Australian National University.
- Commonwealth of Australia. (2010). *Building a 21st Century Primary Health Care system. Australia's first national primary health care strategy*. Canberra: Australian Government Department of Health and Ageing.
- Commonwealth of Australia. (2010). *A National Health and Hospitals Network for Australia's future—Delivering better health and better hospitals for all Australians*. Canberra: Australian Government Department of Health and Ageing.
- Leach M, et al. (2013). The Diabetes Care Project: an Australian multicentre, cluster randomised controlled trial [study protocol]. *BMC Public Health*, 13(1), 1212.
- Australian Government Department of Veterans' Affairs. *Coordinated Veterans' Care Program*. Retrieved May 2014 from [dva.gov.au/health\\_and\\_wellbeing/health\\_programs/cvc/Pages/new.aspx](http://dva.gov.au/health_and_wellbeing/health_programs/cvc/Pages/new.aspx)