Introducing general practice enrolment in Australia: the devil is in the detail

Enrolment may strengthen the link between patients and their preferred primary care providers and needs to support flexible provision of high quality care

In the 2019-20 Federal Budget, $448m was allocated to introduce a system of voluntary general practice enrolment for Indigenous people over 50 and all Australians over 70 years of age from July 2020 [1]. Enrolment, also known as nomination or empanelment, allows patients to register with a specified general practitioner at their preferred general practice. At the end of June 2020, the federal government announced that the introduction of voluntary general practice enrolment would be delayed and that models to support universal enrolment would be explored as part of the development of a 10 year primary health care plan[2]. The exploration of population-wide enrolment was prompted by Australia's coronavirus disease 2019 (COVID-19) response, most notably the introduction of Medicare-funded telehealth (both telephone and video consultations) — a long-advocated reform currently available until 30 June 2021. In this article, we outline Australian and international experience with enrolment and suggest ways for Australia to introduce a system that benefits patients, health system funders and providers of comprehensive holistic general practice care.

What is enrolment?

Enrolment involves a patient nominating a preferred health provider, the provider agreeing to enrol the patient, and typically an agreement between the patient and provider regarding what care will be provided as part of enrolment. Enrolment is not an endpoint. The intention of enrolment is to identify and strengthen GP–patient links, and provide a mechanism supporting the delivery of evidence-based and high quality patient services that are not appropriately supported under the current health system.

Although most Australians identify a usual GP, multiple practice attendance is common,[3] and it can be unclear to GPs whether patients view them as their preferred doctor. Patient enrolment signals to the GP and practice that they are a patient's preferred provider for ongoing primary health care. This signal encourages shared responsibility for care such that practices feel empowered to provide comprehensive holistic care, and patients feel more engaged in their care. Introducing enrolment has the potential to address the issue of a patient having a preferred GP but GPs being unaware of this.

Enrolment is not a new concept in the Australian context and has been proposed by previous Australian health reform groups including the Primary Health Care Advisory Group,[4] and the Medicare Benefits Schedule Review Taskforce.[5] In addition to formal trials that included enrolment, such as the Diabetes Care Project [6] and the coordinated care trials [7] patients, including the implementation of patient registers, patient charters and membership fees. However, there has been no formal mechanism or funding to support the process for enrolment in mainstream general practice. Australia is an outlier in this, as most Organisation for Economic Co-operation and Development countries include enrolment as a feature of primary health care.[8]

Compulsory enrolment has long been a feature of general practice in the United Kingdom National Health Service. Patients are required to register with a practice in close proximity to their home residence, and practices receive capitation payments (regular practice payments for providing patient care which are unrelated to how often people attend a practice) based on the size of their enrolled patient population[9]. However, enrolment is not capitation, or any other specific payment model. Compulsory enrolment linked to geography and capitation is not proposed for the Australian system, and fee for service will remain the basis for government-funded patient services.

The benefits of enrolment

The potential benefits of enrolment include improved continuity of care, clearer identification of a practice's population, and improved services enabled by the enrolment process.

Continuity of care is the concept of seeing a doctor on multiple occasions, and has been associated with improved health outcomes, lower costs of care, and improved patient and GP satisfaction [10-12]. Continuity in this context goes beyond practitioner continuity for a

single condition, and refers to whole patient, long term (or even lifelong) care. Regarding continuity of primary care, most evidence refers to benefits associated with continuity with a single person (such as a GP), but there are also benefits related to continuity of care at a practice level. When both levels have been measured, most studies report benefits in having a regular GP in addition to having a regular practice,[13-16] although some have reported no difference.[17]

Enrolment permits clear identification of a practice's population and facilitates additional services and funding for enrolled patients and enrolling practices. Enhanced patient services might include education aimed at patient self-management, or the provision of non-face-to-face care such as telehealth or email services. Whole-of-practice services could include care coordination for patients entering or leaving hospital care, funded by additional practice payments calculated according to enrolled patient numbers. With broad support from patients, funders and professional groups, Medicare funded telehealth appears likely to stay beyond the pandemic. This is despite concerns regarding the potential impact on health spending. Enrolment provides a potential structure to support sustainable telehealth, with ongoing access to telehealth services being made available for enrolled patients.

Enrolment also has the potential to improve efficiency and reduce waste. GPs report variable communication of test results from hospital-based services and this has been highlighted during the pandemic [18]. Providing a clear link between a patient and GP which can be recognised by all providers within the health system will reduce this problem, improving safety and reducing duplication and costs.

The evidence for enrolment

International evidence will be important in understanding the potential impact of voluntary general practice enrolment in the Australian context. In Ontario, Canada, there have been mixed results from reforms including the introduction of voluntary patient enrolment. Some authors report positive findings such as lower rates of emergency department attendance for patients enrolled with a preferred practice,[19] while others report negative or no impact.[20,21].An observational study of the introduction of voluntary general practice enrolment linked to increased funding and provision of more comprehensive care in Germany was associated with significantly decreased hospitalisation rates in the enrolled population compared with unenrolled patients who received at least 50% of their care from one provider.[22]

UK research shows that allocating all patients aged over 75 years a specific GP in a population already enrolled with a practice has not improved GP-level continuity of care or reduced hospitalisation rates.[23] . Patients were allocated a GP rather than choosing their preferred GP, potentially reducing patient input into strengthening patient–GP relationships.

Overall assessment of the evidence remains fraught, due to contextual differences and the large time frames required to demonstrate reduced health system costs. Many of the international studies have introduced funding reform at the same time as enrolment, making it difficult to disentangle the impact of enrolment from the impact of funding changes. This problem is also likely to be an issue for the Australian program.

Learnings for Australia

Although delayed by the COVID-19 pandemic, the introduction of voluntary general practice enrolment remains on the health reform agenda. The MBS Review taskforce final report (released in December 2020) identifies general practice enrolment as a desirable feature of Australian primary health care reform [5]. The Primary Health Care 10-Year Plan (due for release mid-2021) is also expected to include enrolment as a feature [2] .

Choice remains an important principle of Medicare, and the voluntary nature of enrolment for patients and GPs must remain an important feature of the program. The benefits of continuity of care appear maximal with a person rather than with a location, and linking enrolment with a GP in a preferred practice aligns with current evidence. There may be situations where this is not possible — for example, in remote practices supported by locum services — but having a preferred person rather than location should be the default. This

identifies a single person responsible for overall care, although multiple providers will usually have clinical input.

The mixed evidence for enrolment suggests that understanding both the health system context in which voluntary general practice enrolment is introduced as well as the incentive design are important factors when assessing the likely impact of reforms. Incentives need to encourage better care, not just enrolments. The balance of incentives needs to be on provision of high quality, holistic, longitudinal general practice care, rather than the process of enrolment. Failure to get this balance right will lead to perverse behaviour (such as the chasing of enrolment fees without provision of care) which will not improve continuity of care nor health outcomes.

Enrolment allows patients to identify both a preferred provider of services and a default recipient of all their relevant health information. Enrolment also allows funding for services to be targeted to an enrolled population and will reduce costs compared with population-wide access. These cost savings need to be measured and can be reinvested in additional services for enrolled patients, or for better supporting the GPs who enrol them. Policy makers should ensure that enrolment remains a mechanism to provide funding to deliver high quality care and not used to limit access to or spending on existing services.

Conclusion

Improved primary care through a stronger clear link with patients and their primary care provider must continue to be the motivation for enrolment and its associated funding. This will improve continuity and comprehensiveness of care, and lead to health system savings. Improved targeting of health funding to enrolled populations should support more flexible provision of high quality primary care. It is unlikely that a program to introduce voluntary general practice enrolment will demonstrate improvements to health outcomes in the short term. It is even possible that it will fail to improve health outcomes altogether. The impact on patients, GPs, practices, the health system and funders will depend on the precise model implemented, and how patients and GPs respond to the incentives in the program. In any event, additional funding for general practice services is welcome at a time when many practices are struggling to maintain viability following the Medicare freeze and the COVID-19 pandemic. The program may support the short term sustainability of general practice, particularly for those practices with a focus on quality care, until more extensive health system reform occurs.

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