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Patient affiliation with GPs in Australia—Who is and who is not and does it matter?

Ian McRae[a,*], Laurann Yen[a,b], James Gillespie[c,d], Kirsty Douglas[a]

[a] Australian Primary Health Care Research Institute, The Australian National University, Canberra, ACT 0200, Australia
[b] The Menzies Centre for Health Policy, The Australian National University, Canberra, ACT 0200, Australia
[c] The Menzies Centre for Health Policy, The University of Sydney, NSW 2006, Australia
[d] Sydney School of Public Health, Sydney Medical School, The University of Sydney, NSW 2006, Australia

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ABSTRACT

Aims and rationale: Recent government reports have proposed voluntary enrolment with general practitioners for certain groups of patients to enhance their continuity of care.

We examine which groups of patients are presently "de facto" affiliated with GPs, and whether affiliated patients are more likely to receive advice from their GPs on primary preventative matters such as weight, exercise and smoking.

Methods: A nationally representative cross sectional survey of Australian residents aged 18 years or over was conducted via telephone in 2008. Data from 1146 participants were analysed in both tabular forms and with logistic regression.

Findings: Most Australian adults are affiliated, de facto, with an individual GP or a GP practice (11% often go to different GPs). Factors associated with affiliation were patient age, education, satisfaction with their GP and urban or rural location. Patients with poor or fair self assessed health are relatively unlikely to be affiliated with a GP. Weak support was found for the hypothesis that affiliated patients were more likely to receive primary preventative advice on weight and diet and no support found in relation to exercise, smoking or alcohol consumption.

Benefits to the community: The study suggests policy on voluntary patient enrolment should focus on providing continuity of care to those with poor health. If further studies confirm affiliation does not enhance preventive health advice, further policy interventions may be appropriate.

1. Introduction

Patients formally enrol with general practices under some health systems (e.g. the United Kingdom) while having free choice in others (e.g. Australia) and a constrained choice in other countries. The Australian National Health and Hospital Reform Commission (NHHRC) [1] has proposed:

> "...encouraging better continuity and co-ordinated care for people with complex health problems – including people with chronic diseases and disabilities, families with young children, and Aboriginal and Torres Strait Islander people – under voluntary enrolment with a "health care home" that can help co-ordinate, guide and navigate access to the right range of multidisciplinary health services..." (p. 6).

The NHHRC proposal [1] suggested financial incentives to practices to enrol patients, which

* Corresponding author at: Australian Primary Health Care Research Institute, Bldg 62, Mills Rd, The Australian National University, Canberra, ACT 0200, Australia. Tel.: +61 2 6125 8088; fax: +61 2 6125 2254.
E-mail addresses: ian.s.mcrae@anu.edu.au (I. McRae), laurann.yen@anu.edu.au (L. Yen), jimg@health.usyd.edu.au (J. Gillespie), kirsty.a.douglas@anu.edu.au (K. Douglas).

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were costed between $341 and $682 million per year.

The Draft National Primary Health Care Strategy [2] also supports voluntary enrolment "...with a health care provider based on clinical need...." (p. 20). Further, the Australian Government has now proposed a voluntary enrolment arrangement for people with diabetes to be introduced in 2012 [3].

There is considerable evidence of the benefits to patients of continuity or longitudinality of care [4] and the notion of the health care home referred to by the NHHRC has received considerable attention in the United States in recent years [5]. However, there has been little direct research in Australia into these issues. In particular there has been little research into the existing de-facto affiliation of patients with general practitioners (GPs) which may arise without the formality of enrolment, and little research into benefits of any existing informal affiliation.

Affiliation with a single primary care provider, with the associated continuity of care, is considered to be one of the four critical features of primary care [6–8]. Studies have also found a strong negative relationship between affiliation and health expenditure for the most ill patients, and have showed that provider continuity reduces total health costs [8,9].

Based on the existing evidence of the benefits of patient affiliation, the Royal Australian College of General Practitioners in their standards for general practitioners include as Criterion 1.5 that "Our practice provides continuity of care for its patients", with detailed requirements for achieving this [10].

While much of the benefit of continuity of provision of care comes in treating patients with identified conditions, there is also reason to consider whether stronger relationships between patients and primary health care providers should lead to greater efforts to prevent health problems arising from risk behaviours such as smoking and obesity. This question is addressed in this study.

1.1. How many patients attend multiple GPs?

This is a complex question. Most GPs work in group practices, when one is on leave or particularly busy patients will often be directed to a colleague within the practice. Even patients attending single doctor practices will find occasions when the practitioner is on leave and a locum is in attendance, and in some more remote areas doctors rotate through practices. While this may reduce continuity of care as the locum will not have a detailed personal knowledge of the patient, they will have access to all the clinical records and to information about management of the patient. As all aspects of continuity of care enhance the quality of care provided [11], attendance at a patient's regular practice will benefit the patient even if care is not provided by their regular doctor.

In the Australian context, Ward et al. showed that 69% of patients attending one of three general practices in Western Australia attended only one practice over a six month period (31% did attend elsewhere) [12]. Veale et al. found that 32% of their sample who had two or more GP visits in the previous year had seen more than one GP. The Health Insurance Commission Annual Report of 1992 showed that 82% of the population attended a GP at least once in the preceding year and that 56% saw two or more GPs [13]. The much higher degree of apparent mobility here than in the Ward and Veale studies is likely to be due to patients who attend a single practice being seen by different GPs in that practice. A different perspective on patient mobility based on larger and more recent surveys, but again implying relatively low mobility levels, provided estimates that only 7.3–9.7% of patient encounters in Australian general practices were with a patient not previously seen at that practice [14].

Comparing seven countries, a 2007 Commonwealth Fund survey also found low mobility levels. A very high proportion of Australians (88%) reported that they had a doctor or GP who they 'regularly see' [15]. A subsequent Commonwealth Fund survey of patients reporting complex chronic conditions found a similar proportion (89%) had a regular doctor [16]. Using a more exacting test, Australians (59%) were second only to New Zealanders (61%) in reporting that they had a "Medical home a regular doctor or place that is very/somewhat easy to contact by phone, always/often knows medical history, and always/often helps coordinate care". This contrasted with 47% of the Dutch and 50% of those surveyed in the United States. The survey revealed nothing about the characteristics of the patients who chose to attend one practice regularly and those who used multiple doctors [15].

Another multi-national study reported that 69.8% of UK patients but only 8.0% of US patients have had their regular physician for 6 years or more [17]. However, even in the United States, 31.6% of patients had been with a regular physician for more than 2 years, and 88.2% reported that there was a particular place they usually went if sick or in need of advice about their health compared with 98.1% in UK.

Under New Zealand arrangements, which unlike Australia provide incentives for patient enrolment, only 8.3% of patients reported no affiliation with a single primary care provider (defined as a "doctor, nurse or medical centre they usually go to") [7].

1.2. Which patients are most likely to affiliate with a single doctor or practice?

The most comprehensive analysis identifying those patients likely to be affiliated with a primary care provider was undertaken in New Zealand [7]. It concluded that people with high health care needs (elderly, women and those in poor health) had the highest rates of affiliation. Smokers and those with higher levels of education were less likely to affiliate. A small study of Australian patients found younger patients and better educated patients were more mobile, and women more likely than men to have seen more than one GP in the preceding year [13]. This study also found that dissatisfaction with the latest GP visit was a significant determinant of multiple GP usage [13].

These results are broadly consistent with a study of attitudes to continuity of care in the US which found that "...extremes of age, female gender, less education, Medicare and Medicaid insurance, number of chronic conditions