Health Reform - Note 5

October 2009

Voluntary enrolment with a primary care health service and performance based incentive payments

What is 'voluntary enrolment'?

The term 'voluntary enrolment' describes the situation in which a patient chooses to register with a single provider of primary care, perhaps a general practice or a multidisciplinary health facility, and agrees to have their primary care services coordinated by that provider.

Voluntary enrolment with a particular service provider would not prohibit the patient from seeing another provider, for example after hours or near work if required, or when a woman prefers to see a female practitioner for women's health screening or advice.

Many patients and practitioners prefer and already have *de facto* voluntary enrolment, in the sense that many people like to visit the same practice and the same doctor whenever possible. This preference is likely to be especially strong for people who need to see their doctor often, such as those with chronic or multiple conditions, recurring or episodic health conditions or with a range of family health needs.

So the proposal for voluntary enrolment may be interpreted to mean some greater formalisation of a situation which often already exists. Formalisation of a commitment by both patient and service provider about the provision of primary care services is potentially beneficial for both. For the patient, it can provide a clearer or firmer guarantee of continued care from a single, known source and help with referrals to other health services as required. This in turn is likely to lead to better health outcomes, all other things being equal, due to improved continuity of care. For the service provider, voluntary enrolment can give greater certainty in some aspects of clinical practice, given the provider's relationship with and knowledge of the patient's history and current health issues.

For these reasons, voluntary enrolment is seen in some quarters as a critical foundation for good primary care. The Australian General Practice Network (AGPN) suggests that voluntary enrolment "*assures Australians that a specific general practice will be responsible for coordinating their chronic health needs, undertaking proactive preventative healthcare, including monitoring their health, administering registers, recalls and reminders systems, and coordinating their access to additional health services.*"

The current proposal

The Health and Hospitals Reform Commission has recommended that young families, Aboriginal and Torres Strait Islander people and people with chronic and complex conditions

(including people with a disability or a long-term mental illness) should have the option of enrolling with a single primary care health service of their choice. The Draft National Primary Care Strategy Report supports the idea.

Australian governments have already decided to provide about $470 million in incentives and support for general practices to improve chronic disease management for Aboriginal and Torres Strait Islander patients who enrol with them under the Closing the Gap initiative.

The NHHRC report proposes some additional funding arrangements to complement Medicare payments so that when a patient enrols with a primary health care service, the service will be required to take more responsibility for coordinating their care across all their health service needs. The enrolled patient would also be able to get access to services that are not currently included under Medicare and which would help manage their conditions.

One specific proposal is that a medical service would receive $100 per enrolee per annum, intended to strengthen the continuity, coordination and range of multidisciplinary care available to address the health needs of those people who opt in. Assuming that over 50 per cent of those eligible to enrol do so, it has been estimated that this would translate to payments of $73,000 to $146,000 per annum for a general practice of 4.5 GPs, sufficient to employ 0.75 to 1.5 additional staff such as nursing or allied health professionals to provide a broader range of services.

The Commission also recommends, in the longer term, the development of performance payments across all of primary care, based on the development of sound patient outcomes data, including measures of prevention, timeliness and quality care. Such payments could apply to GPs' after hours care and asthma and diabetes management, and it has been estimated that this could add over $300 million to practice revenues. Such outcome incentive programs could also be applied to primary care services currently provided by the States.

Funding provided to health services meeting the needs of those who are voluntarily enrolled with them, and incentive payments to services that meet performance targets, could help staff and run the additional or augmented Comprehensive Primary Care Centres and Service envisaged elsewhere in the NHHRC's report.

The Alliance position so far

The Alliance strongly supports the principles underlying these recommendations: that primary care should be targeted to groups in greatest need and that there should be improvements in the coordination, level and range of care provided to people in those groups. There are likely to be substantial benefits for people in rural and remote Australia from the implementation of these principles.

Voluntary enrolment would be especially relevant in rural and remote areas, where a higher proportion of people are in the selected population groups. If enrolment delivered better health outcomes, there could also be substantial postponement and saving of health care costs. Avoidable hospitalisations are estimated at 74 per 1000 in remote areas. Rural Australia also includes the majority of low socio-economic areas, where avoidable hospitalisations are 42 per 1000, compared with 25 per 1000 in high socio-economic areas.

Voluntary enrolment would increase the extent to which the overall health system is governed and funded according to improvements in patient health outcomes and /or improvements in the application of evidence based practice. The additional funding it could attract to rural and remote areas would help to recruit and retain health professionals to those areas - where Medicare has proved insufficient to ensure reasonable access to primary care.

Voluntary enrolment may well be more acceptable to people in rural and remote communities than in the major cities, since many of them have no choice about a 'principal health care home' and always visit a particular primary care facility.

However, there would appear to be much development work to be done to achieve effective implementation in a way to support both health providers and patients, including in rural areas, and the Alliance would like to be involved in that work.

Your input is invited

It may well be challenging to encourage those most in need of health care to enrol. The proposal for patient enrolment may be seen by some as 'the thin end of the wedge' for US-style managed health care in which access to and choice of services could be limited by the managed care fund. Other people, such as those who have moved to Australia from authoritarian cultural backgrounds or Indigenous people for whom the notion of 'enrolment with the Government' is inherently unattractive, may have concerns about signing up for health care in this way.

It will therefore be critical to involve consumer and community groups in the development and communication of the proposal. The benefits of voluntary enrolment for the groups who are eligible will need to be clearly explained and concerns addressed, and communications strategies designed in ways that reach people with different levels of health literacy, including in particular in rural and remote areas.

The National Aboriginal Community Controlled Health Organisation (NACCHO) believes it is premature to say whether voluntary enrolment of Aboriginal patients with a primary care service of their choice could improve health service access to this population.

If voluntary enrolment is implemented, its relationship with the existing Chronic Disease Management MBS items would need to be clarified to ensure that people who are not enrolled but who currently qualify for access to allied health services, for example, are still able to access those services.

Improved coordination of care through voluntary enrolment may also identify the need for a broader range of services than is available locally, so that out-of-pocket costs such as travel and co-payments could increase or provide a disincentive for necessary care for rural people.

What do you see as the key benefits for voluntary enrolment for people in rural and remote communities and the concerns that would need to be addressed if this proposal goes ahead?

Do you have suggestions on how best to reach people in rural and remote communities about whether to participate in voluntary health programs?

Participation in a voluntary enrolment scheme would also be voluntary for general practices, which raises the question of whether smaller practices, especially in rural Australia, may be deterred from participation because of the additional reporting requirements.

Overall there could be a risk that the proposal for voluntary enrolment might be more enthusiastically embraced by those on the margins of needing enhanced care, especially in higher socio-economic areas and in larger practices.

The incentives proposed by the NHHRC, based on number of patients enrolled, may not be sufficient to attract new nursing or allied health staff, or manage the administration of an enrolment system - especially for smaller practices.

Health services in rural and remote areas face greater travel times, and higher costs in establishing and maintaining infrastructure and buying goods and services. These higher costs will need to be covered in incentives and payments for voluntary enrolment, if it proceeds.

What do you see as the key benefits for health professionals in rural and remote communities from voluntary enrolment and the concerns that would need to be addressed should it go ahead?

While voluntary enrolment shows potential for improving access to care for people with high health care needs in rural and remote Australia, it will need to be implemented in conjunction with other initiatives for improving access to multidisciplinary primary care.

What do you see as the particular opportunities and threats for rural communities if we were to move to voluntary enrolment for people with high health needs?

If you have a comment, let us know at nrha@ruralhealth.org.au or by mail to NRHA, PO Box 280, Deakin West, ACT 2600.