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Title: Primary and secondary health care use before and after introduction of a named GP for older English patients, 2012-2016.

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Introduction/Objectives:

In April 2014 a named accountable GP-scheme was introduced for patients aged 75+ to provide personalised care to keep them healthy and out of hospital. This study aimed to investigate whether this intervention 1) improved patients' continuity of primary care, 2) decreased patients' risk of emergency hospital admission (EHA).

Methods:

This cohort study obtained data on 27,500 patients from the Clinical Practice Research Datalink (CPRD) who were aged 65 to 84 in 2012, alive in 2016, and registered with their practice at least one year prior to 2012. The CPRD was linked with Hospital Episode Statistics (HES) data in England. Patients were followed between April 2012 and April 2016, comprising a two-year period before and a two-year period after the intervention. In both periods we determined a patient's continuity of primary care (Bice-Boxerman (BB) index, range 0-1), and whether they experienced an EHA. We used multilevel (ML) modeling including period (level-1), patients (level-2), and practices (level-3). To test the hypotheses that the named GP-policy resulted in improved continuity of care and reduced risk of EHA for patients aged 75+, we adjusted for gender, number of GP-consultations, number of chronic co-morbidities, deprivation level, number of GPs in practices, and urban/rural location of practice.

Results:

BB index-score for patients aged 75+ decreased by 0.031 over time, from 0.434 pre-intervention to 0.403 post-intervention. This decrease was bigger than for patients under 75, from 0.423 pre-intervention to 0.397 post-intervention: 0.026. An adjusted ML model for the BB index-score including a time-age interaction showed patients aged 75+ still had a stronger decrease in their continuity of care: an extra decrease of 0.014 (95%CI 0.007-0.021) for patients aged 75+ compared with those under 75.

7,105 patients (26%) had at least one EHA between 2012 and 2016. The probability of an EHA for patients aged 75+ increased over time by 4.8%-points (from 19.9% pre-intervention to 24.7% post-intervention). This increase was bigger than for patients under 75, namely 2.0%-points (from 12.4% pre-intervention to 14.4% post-intervention). An adjusted logistic ML model for EHA including a time-age interaction and quartiles of BB index-score, patients aged 75+ still showed an increase in their probability of an EHA: the ratio of odds ratios for patients aged 75+ was 1.77 (95%CI 1.65-1.90) compared with those under 75.

Conclusions:

The introduction of a named GP did not arrest the decline in continuity of care or the increase in probability of EHA for patients aged 75+.