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Patient Characteristics and Primary Care Enrolment: The Case of Australia's MyMedicare

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ABSTRACT

Research Question/Issue: This study examines the patient characteristics associated with enrolment in MyMedicare, Australia's first national voluntary primary care enrolment program, introduced in October 2023.

Research Findings/Insights: Enrolment is positively associated with each of the eight chronic condition groups examined, although the magnitude of association varies across conditions. Enrolment is also increasingly likely with greater multimorbidity. Females, older adults, patients living in relatively socioeconomically advantaged areas and those with greater pre-policy primary care use are also more likely to enrol.

Practitioner/Policy Implications: MyMedicare enrolment appears broadly aligned with clinical need, with greater uptake among patients with chronic conditions and particularly those with multimorbidity. However, enrolment is also more common among patients with stronger existing engagement with primary care. As additional benefits and service entitlements become linked to MyMedicare, policymakers should monitor whether patients with weaker existing primary care engagement are being reached.

Methods used: We analyse linked electronic health records from more than 1.3 million patients across 350 general practices using multivariable logistic regression models. The analysis examines associations between MyMedicare enrolment and clinical, sociodemographic and pre-policy healthcare use characteristics.

JEL Classification: I11, I14, I18

1 | Introduction

Across high-income health systems, formally enrolling patients with a usual general practice or primary care provider is increasingly used as a strategy to strengthen primary care, improve patient outcomes and support broader population-level health planning. The relevance of primary care enrolment has intensified as health systems face rising chronic disease,

population ageing, workforce shortages and growing pressure to shift care away from hospitals towards community-based primary care (OECD 2020). By formally identifying a usual provider or practice, patient enrolment can support prevention, chronic disease management, care coordination and continuity of care, although evidence that enrolment itself improves continuity of care remains mixed (Bates, Lin, et al. 2025).

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Emerging evidence suggests that enrolment into primary care is not socially equitable, although the existing literature is limited. In a recent systematic review and meta-analysis of 10 studies across four countries, Lin et al. (2025) reported that enrolment was less common among males, immigrants, residents of large metropolitan areas, socioeconomically disadvantaged groups and some ethnic minority populations. Evidence on the relationship between patient clinical characteristics and enrolment was thinner and geographically concentrated. Across five Canadian publications, lower enrolment was reported among people with mental illness, substance use disorders, intellectual and developmental disabilities, higher morbidity burden, and lower prevalence of hypertension, asthma and chronic obstructive pulmonary disease, while higher enrolment was reported among people with diabetes (Bayoumi et al. 2023; Strumpf et al. 2017; Batista et al. 2019; Lavergne et al. 2022; Ouellette-Kuntz et al. 2015). However, these results were mixed across programmes and jurisdictions, and only three out of five publications examined the associated clinical characteristics statistically (Strumpf et al. 2017; Batista et al. 2019; Lavergne et al. 2022).

These existing findings suggest that enrolment schemes may reproduce existing inequalities in primary care access unless their design and implementation are explicitly equity-sensitive. This matters especially when enrolment becomes the platform through which additional benefits, incentives or service entitlements are delivered (Bates, Wright, et al. 2025). At the same time, the relationship between patient clinical characteristics and enrolment remains underdeveloped. Existing evidence says little about whether enrolment varies systematically across different chronic condition groups, while evidence on multimorbidity remains limited to a single Canadian study (Lin et al. 2025). Chronic conditions may differ in the extent to which they require ongoing monitoring, medication management and coordination across providers, meaning the potential value of formal enrolment may plausibly vary across clinical groups.

Australia provides a strong setting in which to extend this literature. Prior to 2023, Australia was among the few OECD countries without a formal patient enrolment system in primary care (Bates, Wright, et al. 2025). MyMedicare was introduced in October 2023 as a voluntary patient registration model intended to formalise the relationship between patients, their usual general practice, general practitioner (GP), and primary care team, improve continuity of care, and provide a platform for future primary care funding reform (Australian Government Department of Health, Disability and Ageing 2026a). Because MyMedicare registration is increasingly tied to the delivery of new benefits, incentives and service entitlements (Bates, Wright, et al. 2025), understanding which patients enrol is important for assessing whether later reforms are likely to be distributed equitably and aligned with clinical need.

In this paper, we use linked electronic health records from more than 1.3 million Australians across 350 general practices to examine the clinical, service use and sociodemographic characteristics associated with enrolment in MyMedicare. Specifically, we ask whether enrolment varies across eight major chronic condition groups (cardiovascular, respiratory, musculoskeletal, neurological, autoimmune, mental illness, type 2 diabetes and

cancer), how it varies with multimorbidity, whether it is associated with pre-policy primary care use and whether its association with patient sociodemographic characteristics resembles the results thus far reported internationally. We provide, to our knowledge, the first quantitative Australian study on the patient characteristics associated with MyMedicare enrolment since the programme was introduced in October 2023. We likewise extend the limited international literature on how primary care enrolment can systematically vary across different types of chronic conditions and multimorbidity.

2 | Institutional Setting and Programme Overview

Australia's health system combines universal public insurance with a mixed public-private delivery model. Medicare subsidises a broad range of out-of-hospital services, including general practice, specialist care, diagnostic testing and allied health, while public hospitals provide treatment at no direct charge to public patients. General practice is typically the first point of contact with the health system and remains the central access point for most non-hospital care. However, unlike in many other OECD countries, Australia historically did not require patients to formally enrol with a general practice or family physician (Bates, Wright, et al. 2025). Instead, patients could attend multiple practices, while providers retained considerable discretion over billing, including whether to bulk bill or charge fees above the Medicare rebate (Australian Government Department of Health, Disability and Ageing 2026b). This structure has long offered patient choice, but it has also meant that continuity of care has depended more on patient and practice behaviour than on formal system design (Bates, Lin, et al. 2025).

Primary Health Networks (PHNs) are a key part of Australia's primary care architecture. Established by the Australian Government in 2015, PHNs are independent, regionally defined organisations funded to improve the efficiency and effectiveness of primary health care and to support better coordination across local services (Australian Government Department of Health, Disability and Ageing 2025a). Their core functions include assessing local population health needs, commissioning services to address gaps and supporting integration across general practice, community care, hospitals and other parts of the health system. The Eastern Melbourne PHN is one of six PHNs in Victoria and the second largest (third largest nationally) and provides the regional setting for the present study.

The policy rationale for MyMedicare emerged from a system that had long relied on geographically organised primary care coordination without a formal national patient-enrolment model. Australia's Primary Health Care 10 Year Plan proposed voluntary patient registration as a platform for reforming general practice funding and strengthening person-centred care (Australian Government Department of Health, Disability and Ageing 2022). The subsequent Strengthening Medicare Taskforce Report identified voluntary patient enrolment as a priority reform area, alongside multidisciplinary team-based care, data and digital reform, and more sustainable funding (Australian Government Department of Health, Disability and Ageing 2023). MyMedicare is the policy response to that agenda.

Practices were able to prepare for MyMedicare from 1 July 2023, and patients have been able to enrol since 1 October 2023. Eligible patients must hold a Medicare card or Department of Veterans' Affairs Veteran Card and must generally demonstrate an existing relationship with the practice through prior face-to-face attendance: one face-to-face Medicare Benefits Schedule (MBS) service in the previous 24 months for practices in remote locations, or two for practices in all other locations (Australian Government Department of Health, Disability and Ageing 2026a). Patients can enrol with one practice and nominate one preferred GP within that practice, although they may still receive care from other GPs in the same practice (Australian Government Department of Health, Disability and Ageing 2023). According to the government's monitoring report, by June 2025 MyMedicare included 6654 enrolled practices, 53,489 linked providers and 3,211,073 enrolled patients (approximately 11.6% of Australia's population; Australian Government Department of Health, Disability and Ageing 2025b).

Importantly, MyMedicare is also a platform to which additional funding streams and service entitlements are linked. Enrolled patients gain access to longer MBS-funded telehealth consultations with their nominated practice and GP, and further incentives were progressively linked to the platform over time (Australian Government Department of Health, Disability and Ageing 2023). As such, when enrolment becomes the gateway to specific services, claiming arrangements or incentive payments, it itself adds to the reform's impact on health equity.

3 | Methods

3.1 | Data

This study uses routinely collected individual-level electronic health record data from 350 general practices in the Eastern Melbourne PHN, accessed through the Population Level Analysis and Reporting (POLAR) platform. POLAR, developed by Outcome Health (Outcome Health n.d.), is a web-based clinical intelligence tool that autonomously extracts patient records from each practice's clinical information management system and combines them into a single de-identified dataset spanning all participating practices within the PHN. Encrypted linkage keys are used to assign each patient a unique de-identified identifier across the combined dataset (Pearce, McLeod, Patrick, et al. 2019; Pearce, McLeod, Rinehart, et al. 2019). Practices across the PHN may provide approval for de-identified data sharing, in line with RACGP Accreditation Standards. Patients may opt out of inclusion in POLAR, in which case their data are not collected; based on personal communication with the Eastern Melbourne PHN, the opt-out rate is negligible. The extract used in this study spans January 2022 to September 2025, covering 21 months before and 24 months after the national introduction of MyMedicare in October 2023, and was the most recent and complete POLAR extract available at the time of writing.

3.2 | Participants

Participants included all MyMedicare-enrolled and not-yet-enrolled patients in POLAR who received at least one face-to-

face or telehealth general practice consultation between October 2022 and September 2023; that is, in the 12 months prior to MyMedicare's national introduction. This criterion was specifically chosen to restrict the cohort to active patients in a clearly defined pre-policy period, ensuring that observed health characteristics were not yet influenced by MyMedicare. Registration dates were recorded in practice clinical information systems at the time the registration was entered and were converted to monthly values for analysis, available in POLAR once autonomously extracted. Patients could enrol online or in-practice.

The analytical sample comprised 178,821 active patients who enrolled between October 2023 and September 2025 and 1,125,375 patients who had not yet enrolled by September 2025.

3.3 | Patient Characteristics

We examined patient characteristics across chronic conditions, sociodemographics and healthcare utilisation as explanatory variables for MyMedicare registration.

Chronic condition categories included those of cardiovascular, respiratory, cancer, musculoskeletal, neurological, Type-2 Diabetes, autoimmune and mental illness. These conditions were classified in POLAR using the SNOMED-CT-based clinical hierarchy coding structure (SNOMED International n.d.). A detailed frequency table for the components of each condition category is provided in Supporting Information S1: Table A.8. A categorical measure of multimorbidity was created from these chronic condition categories, ranging from zero to four or more conditions. Granular analyses of specific components for different chronic condition categories were beyond the scope of this study.

Sociodemographic characteristics included baseline age as of September 2023, sex and area-level socioeconomic disadvantage, measured by the ABS Index of Relative Socioeconomic Disadvantage (IRSD) (Australian Bureau of Statistics 2023), linked to each patient's residential postcode. IRSD was operationalised as a binary indicator for above-median IRSD, with above-median values indicating that the patient lived in an area of relative socioeconomic advantage.

We additionally derived 12-month pre-policy healthcare-utilisation measures from October 2022 to September 2023 using POLAR records. GP face-to-face and telehealth consultations were identified using MBS item numbers listed in Supporting Information S1: Table A.1. We also measured total referrals to secondary and tertiary care and total prescription medicines issued, with prescriptions classified using ATC codes (World Health Organization n.d.).

3.4 | Statistical Analysis

We first calculated descriptive statistics separately for the enrolled and not-yet-enrolled groups, reporting means for continuous variables and proportions for categorical variables, each with 95% confidence intervals (CIs).

We then estimated two multivariable logistic regression models in which the outcome was whether the patient had ever enrolled into MyMedicare between October 2023 and September 2025. Let $Y_i = 1$ if patient i enrolled and $Y_i = 0$ if they did not enrol. The model was specified as

$$\log\left(\frac{\Pr(Y_i = 1)}{1 - \Pr(Y_i = 1)}\right) = \alpha + \mathbf{H}_i\phi + \mathbf{X}_i\beta,$$

where $\mathbf{H}_i$ denotes a vector of the health-condition variables of interest. In Model 1, $\mathbf{H}_i$ included indicator variables for eight chronic condition groups: cardiovascular, respiratory, cancer, musculoskeletal, mental illness, neurological, autoimmune and Type-2 diabetes. In Model 2, these indicators in $\mathbf{H}_i$ were replaced by categorical indicators for the number of condition groups: one, two, three and four or more conditions, with zero conditions as the reference category.

In both models, $\mathbf{X}_i$ denotes a covariate vector of patient socio-demographic and 12-month pre-policy healthcare use characteristics. Sociodemographic covariates included sex, baseline age group and above-median IRSD. Pre-policy healthcare use characteristics included total GP telehealth consultations, face-to-face GP consultations, prescription medicines issued and referrals to secondary and tertiary care.

For interpretability, we report average marginal effects (AMEs) from both logistic regression models. For binary and categorical variables, these represent the average percentage-point (pp) difference in predicted enrolment probability associated with belonging to the relevant category, relative to the reference category. For continuous variables, AMEs represent the average marginal change in predicted enrolment probability associated with a one-unit increase in the covariate.

Results are expressed as pp changes in the predicted probability of enrolment, with 95% confidence intervals. Odds ratios are retained in the Supporting Information for completeness. All analyses were conducted in Stata Version 18.

3.4.1 | Sensitivity Analysis

As a robustness check, we estimated an additional logistic regression model that controlled for general practice fixed effects, IRSD in quartiles and participation in the Eastern Melbourne PHN Right Care Better Health (RCBH) nurse-led care coordination programme for chronic disease patients (Fisher et al. 2025; Eastern Melbourne Primary Health Network n.d.) The RCBH program operated concurrently for 842 patients across 31 general practices in our sample between April 2024 and September 2025, with the goal of providing total wrap-around services and care coordination for programme participants.

3.4.2 | External Validity

To contextualise the study setting, we undertook a descriptive benchmarking exercise against Australia's greater capital city regions rather than against the full Australian population. This comparison was based on Greater Capital City Statistical Areas (GCCSAs), the Australian Bureau of Statistics' standard

geography for the functional extent of each capital city (Australian Bureau of Statistics 2021). We chose this approach because an inner-metropolitan PHN would not be expected to represent regional or remote Australia, where population composition, service environments and patterns of primary care access differ substantially. We compared the pooled study cohort with capital-city benchmarks for age, sex and population-weighted median IRSD, as detailed clinical information is not available.

4 | Results

4.1 | Main Results

Table 1 summarises baseline characteristics for the not-yet-enrolled and enrolled cohorts. The analytical sample comprised 1,125,375 not-yet-enrolled patients and 178,821 enrolled patients. On average, not-yet-enrolled patients were younger than enrollees (39.55 years vs. 49.80 years) and included a higher proportion of males (46.6% vs. 41.4%). The proportion of patients living in a relatively advantaged postcode was slightly lower in the not-yet-enrolled group (49.8% vs. 50.3%).

Enrolled patients had a higher burden of chronic illness than not-yet-enrolled patients. The average number of chronic condition groups was 1.82 among enrollees compared with 1.07 among those not-yet-enrolled. Among not-yet-enrolled patients, 45.6% had zero chronic condition groups, compared with 24.4% among enrollees. Conversely, 31.1% of enrollees had three or more chronic condition groups, compared with 14.3% of those not yet enrolled. Across both groups, the most common chronic condition categories were cardiovascular, mental illness, musculoskeletal and respiratory conditions. Neurological, autoimmune, cancer and Type-2 diabetes were comparatively less common.

Healthcare utilisation in the 12 months prior to MyMedicare's national introduction was consistently higher among enrollees than among patients not-yet-enrolled. Mean annual GP telehealth consultations, face-to-face GP consultations, prescriptions and referrals were all higher among enrollees (2.03 vs. 1.19; 6.25 vs. 3.79; 7.87 vs. 4.25; and 2.56 vs. 1.75, respectively). Given the very large sample, confidence intervals were estimated precisely.

Figure 1 presents AMEs from both multivariable logistic regression models. Figure 1A presents results from the specific-conditions model, while Figure 1B presents results from the multimorbidity model. Results are reported as pp changes in the predicted probability of MyMedicare enrolment. Full AME estimates are reported in Supporting Information S1: Tables A.2 and A.4. Corresponding odds ratios from the same logistic regression models are retained in Supporting Information S1: Tables A.3 and A.5 for completeness.

Figure 1A shows that all eight chronic condition groups were positively associated with enrolment, although the magnitude of association differed across conditions. Cardiovascular conditions had the strongest association, corresponding to a 4.14 pp higher predicted probability of enrolment (95% CI 3.97–4.31). This was followed by musculoskeletal conditions (3.71 pp; 95% CI 3.55–3.88), respiratory conditions (2.15 pp; 95% CI

TABLE 1 | Patient characteristics by MyMedicare enrolment status.

	Not yet enrolled Mean/Prop (95% CI)	Enrolled Mean/Prop (95% CI)
Number of patients	1,125,375	178,821
Male	46.6% (46.5%–46.7%)	41.4% (41.1%–41.6%)
Socioeconomic advantage ^a	49.8% (49.7%–49.9%)	50.3% (50.1%–50.5%)
Age ^b (years)	39.55 (39.51–39.60)	49.80 (49.69–49.91)
Age group (years)		
< 25	29.4% (29.3%–29.5%)	17.0% (16.8%–17.2%)
25–49	35.9% (35.8%–36%)	30.4% (30.1%–30.6%)
50–74	26.6% (26.5%–26.7%)	35.4% (35.2%–35.6%)
75+	8.1% (8.0%–8.1%)	17.2% (17.1%–17.4%)
Number of chronic conditions	1.07 (1.06%–1.07%)	1.82 (1.81%–1.83)
Number of chronic conditions (categories)		
Zero	45.6% (45.5%–45.7%)	24.4% (24.2%–24.6%)
One	25.2% (25.1%–25.3%)	23.4% (23.2%–23.6%)
Two	14.9% (14.8%–15.0%)	21.0% (20.9%–21.2%)
Three	8.3% (8.3%–8.4%)	15.9% (15.7%–16.1%)
Four or more	6.0% (6.0%–6.1%)	15.2% (15.1%–15.4%)
Specific chronic conditions		
Cardiovascular	25.5% (25.4%–25.5%)	45.1% (44.9%–45.3%)
Mental illness	19.6% (19.5%–19.6%)	29.2% (29.0%–29.4%)
Musculoskeletal	18.2% (18.2%–18.3%)	35.2% (35.0%–35.5%)
Respiratory	17.1% (17.0%–17.1%)	24.6% (24.5%–24.8%)
Neurological	8.9% (8.9%–9.0%)	15.3% (15.1%–15.4%)
Autoimmune	6.6% (6.5%–6.6%)	10.8% (10.7%–11.0%)
Cancer	5.7% (5.7%–5.8%)	11.2% (11.1%–11.4%)
Type-2 Diabetes	5.1% (5.0%–5.1%)	10.4% (10.3%–10.6%)
Healthcare utilisation ^c		
GP Telehealth consultations	1.19 (1.18–1.19)	2.03 (2.02–2.05)
GP Face-to-face consultations	3.79 (3.79–3.80)	6.25 (6.22–6.28)
Prescription medicines	4.25 (4.24–4.26)	7.87 (7.82–7.92)
Referrals	1.75 (1.74–1.75)	2.56 (2.54–2.58)

Abbreviation: CI = confidence interval.

^a'Above-median IRSD' has been labelled as 'socioeconomic advantage' for easier interpretation.^bAge calculated at baseline of September 2023 (month prior to MyMedicare introduction in October 2023).^cHealthcare utilisation was calculated across the 12 months prior to MyMedicare introduction (October 2022 – September 2023).

2.00–2.31), Type 2 diabetes (2.11 pp; 95% CI 1.87–2.34), mental illness (1.92 pp; 95% CI 1.77–2.07), cancer (1.56 pp; 95% CI 1.33–1.78), autoimmune conditions (1.48 pp; 95% CI 1.26–1.69) and neurological conditions (1.21 pp; 95% CI 1.02–1.39).

Figure 1B shows that multimorbidity was strongly associated with enrolment. Relative to patients with no recorded chronic condition groups, patients with one condition had a 4.22 pp higher predicted probability of enrolment (95% CI 4.08–4.37). This increased to 7.61 pp for patients with two conditions (95% CI 7.41–7.80), 9.93 pp for patients with three conditions (95% CI 9.68–10.18) and 11.13 pp for patients with four or more conditions (95% CI 10.83–11.43).

Sociodemographic patterns were similar across both model specifications. In the specific-conditions model, males had a

1.43 pp lower predicted probability of enrolment than females (95% CI –1.54 to –1.31). Older age groups were more likely to enrol than patients aged under 25 years, with AMEs of 2.12 pp for ages 25–49 years (95% CI 1.96–2.28), 3.22 pp for ages 50–74 years (95% CI 3.03–3.41) and 3.53 pp for ages 75 years and older (95% CI 3.26–3.79). Patients living in relatively socio-economically advantaged areas also had a slightly higher predicted probability of enrolment (0.29 pp; 95% CI 0.17–0.40). These patterns held across the multimorbidity model in Figure 1B.

Higher pre-policy healthcare use was also associated with greater predicted probability of enrolment. In the specific-conditions model, each additional GP telehealth consultation in the 12-month pre-policy period was associated with a 0.41 pp higher predicted probability of enrolment (95% CI 0.39–0.43),

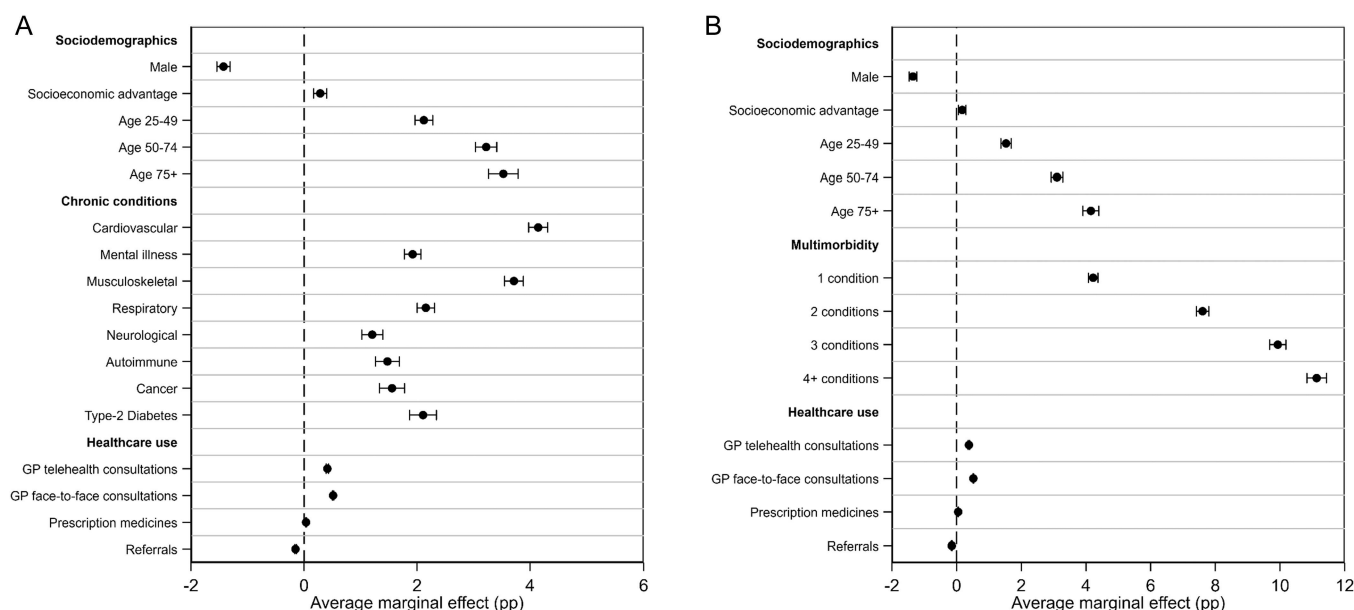


FIGURE 1 | (A) Average marginal effects on predicted enrolment probability, conditions model. (B) Average marginal effects on predicted enrolment probability, multimorbidity model. Points indicate average marginal effects, expressed as percentage-point changes in predicted enrolment probability. Horizontal lines indicate 95% confidence intervals. Multimorbidity results are relative to zero conditions. Age-group results are relative to age < 25 years. The patient characteristic ‘above-median IRSD’ has been labelled as ‘socioeconomic advantage’ for easier interpretation.

while each additional face-to-face GP consultation was associated with a 0.51 pp increase (95% CI 0.50–0.53). Each additional prescription medicine was associated with a smaller increase of 0.04 pp (95% CI 0.03–0.04). In contrast, each additional referral was associated with a 0.15 pp lower predicted probability of enrolment (95% CI –0.17 to –0.14). Healthcare-use patterns were similar in the multimorbidity model in Figure 1B.

4.2 | Sensitivity Analysis

Results were robust in the sensitivity model (Supporting Information S1: Table A.7). Notably, participation in the RCBH program was associated with a 9.66 pp higher predicted probability of MyMedicare enrolment (95% CI 7.33–12.00 pp).

4.3 | External Validity

Benchmarking against Australian capital-city regions indicated that the pooled Eastern Melbourne PHN cohort fell within the broad metropolitan range on age, sex and socioeconomic disadvantage, although it appeared slightly older, less male and relatively more advantaged than the capital-city average. The study cohort’s median age was 40.95 years compared with 36.98 across capital cities, 45.88% of the cohort was male compared with 49.63% across capital cities and the cohort’s population-weighted median postcode-linked IRSD score was 1036.84 compared with 1028.14 across capital cities. Full benchmarking results by city are reported in Supporting Information S1: Table A.6.

5 | Discussion

In this large general practice cohort of more than 1.3 million active patients in Eastern Melbourne, enrolment in MyMedicare

was more likely among patients with chronic conditions and multimorbidity, as well as among patients with greater primary care use before the programme began, females, older adults and those living in relatively socioeconomically advantaged areas. Overall, the findings suggest that enrolment into MyMedicare was associated with patient clinical and sociodemographic characteristics, as well as prior attachment to general practice.

All eight chronic condition groups examined in the paper were positively associated with enrolment, but the size of the associations differed across condition groups. These results suggest that enrolment was shaped not only by whether a patient possessed a chronic condition, but also by the type of condition they possessed. Patients with cardiovascular and musculoskeletal conditions had the largest AMEs, while conditions such as cancer, autoimmune and neurological conditions showed comparatively smaller AMEs. One plausible interpretation is that conditions more routinely managed through ongoing general-practice review, medication renewal, symptom monitoring and longitudinal care coordination may be more likely to translate into patient or practice motivation to enrol. Cancer, autoimmune and neurological conditions often involve more specialist-led treatment pathways, even though general practice still plays an important coordinating and supportive role in follow-up, comorbidity management, survivorship care and symptom control (Garpenhag et al. 2023; Oliver et al. 2022; Houssien and Scott 1998). The smaller AMEs for these groups should therefore not be interpreted as an absence of primary care need, but perhaps as consistent with more shared or specialist-centred models of care.

Mental illness was also positively associated with enrolment, although the association was moderate. This differs from some Canadian evidence reporting lower enrolment among people with severe mental illness (Lin et al. 2025), but the difference

may partly reflect programme design and case-mix: in our data the mental illness category is dominated by anxiety and depression, instead of severe mental illness.

Multimorbidity was strongly associated with enrolment, with predicted enrolment probability increasing steadily as the number of recorded condition groups rose from one to four or more. This finding suggests that enrolment was also shaped by the overall burden of illness, which contrasts with the previous study reported on multimorbidity (Lin et al. 2025). People living with multimorbidity often move across multiple clinicians and care settings, experience repeated referrals and provider transitions and face substantial treatment burden in managing appointments, medications and competing care demands (Prior et al. 2023; Lee et al. 2024). In that context, a formal relationship with a usual practice may become more valuable as illness burden increases, particularly where enrolment is linked to continuity-oriented funding and chronic condition management (Bates, Lin, et al. 2025). The multimorbidity result thus strengthens the interpretation that MyMedicare was taken up most strongly by patients for whom consolidation and coordination of care are likely to be especially beneficial.

Patients with higher pre-policy use of face-to-face GP care, telehealth and prescription medicines were also more likely to enrol. This is consistent with international evidence suggesting that voluntary enrolment often first consolidates care among patients who already have relatively strong attachment to primary care, instead of creating entirely new attachment among those with weak prior engagement (Bates, Lin, et al. 2025). This pattern is not necessarily undesirable. Patients with greater ongoing primary care need are plausibly among those most likely to benefit from continuity-oriented enrolment. This may be evident, for example, in the strong association observed for patients participating in the Eastern Melbourne PHN RCBH nurse-led care coordination programme. By contrast, the small negative AME for referrals may be counterintuitive. One plausible explanation is that, conditional on diagnosed conditions and prior GP use, patients with more referral activity may have more specialist-centred care pathways or care spread across providers outside a single general practice, reducing the salience of practice enrolment. Furthermore, we cannot observe whether referrals were actually attended. This result should therefore be interpreted cautiously.

The sociodemographic gradients were likewise consistent with international evidence (Lin et al. 2025). Older adults and females were more likely to enrol, while enrolment was also marginally higher among patients living in relatively socioeconomically advantaged areas. The robustness model using IRSD quartiles suggested a non-monotonic socioeconomic pattern, with stronger associations for the middle quartiles than for the highest quartile relative to the most disadvantaged quartile. This suggests that socioeconomic differences in enrolment may not follow a simple linear gradient. These findings suggest that barriers to enrolment may persist even within a universal public insurance system like Australia's.

This study has several limitations. First, it uses routinely collected data from practices within a single metropolitan PHN and is not nationally representative. We therefore benchmarked

the pooled cohort against Australian capital-city regions and found the study population to be broadly comparable on age, sex and socioeconomic status, albeit slightly older and less male than the pooled metropolitan benchmark. Given that the analytical sample was restricted to active general-practice users, this is not unexpected and is consistent with broader socio-demographic gradients in primary care use (Dobbertin et al. 2015). This also means that the analysis compares more and less engaged general-practice users, rather than comparing patients who engage with general practice with those who do not. Second, pre-policy healthcare use was observed only within participating practices in the Eastern Melbourne PHN and therefore captures recorded engagement with the study network rather than complete use of care across the whole healthcare system. This means that utilisation was likely underestimated for some patients, particularly those whose care was spread across multiple providers or sectors. This may be relevant for conditions with greater specialist involvement, although even for specialist-managed conditions primary care in Australia usually remains involved in coordination, follow-up and ongoing support (Royal Australian College of General Practitioners 2023). Third, the analysis cannot directly observe determinants of enrolment such as patient awareness, digital access, practice-level outreach, administrative workflows or clinician encouragement. Finally, the logistic regression models are descriptive and should not be interpreted causally.

Despite these limitations, this study provides, to our knowledge, the first large-scale quantitative evidence on the types of patients who enrol in MyMedicare, Australia's first voluntary primary care enrolment programme. It also provides, to our knowledge, the first granular evidence on how enrolment varies across different chronic condition groups, extending a literature that remains thus far concentrated on sociodemographic characteristics as correlates of primary care enrolment (Lin et al. 2025). Future research into MyMedicare should examine whether these enrolment relationships persist as the programme matures and whether enrolment into MyMedicare and similar international programmes ultimately translates into measurable improvements in continuity, quality and equity of care.

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Ethics Statement

The Office of Research Ethics and Integrity at the University of Melbourne has approved this study (Project ID: 32718).

Data Availability Statement

Data are available upon request to the Eastern Melbourne Primary Health Network.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supporting File: aere70068-sup-0001-appendix_resubmit.docx.