NAMDS National Association for Medical Deputising Services (Australia)

TWG Questions concerning After Hours and Medicare Locals from NAMDS

1 Can DoHA please advise what the estimated after hours budget will be for Medicare Locals on a per capita basis for both face-to-face after hours home visited patients and for patients attending extended hours clinics?

Is the payment to vary among MLs or is the payment intended to be uniform throughout Australia?

NOTE: AH PIP presently amounts to $56 Million + the after hours grant monies of circa $14 Million PA. Combined, and on a per capita basis, this is $2.61 per head of population (see point 2 below). NAMDS calculates that the per person payment per Medicare Local will need to be in the order of $6.25 to maintain existing after hours services (extended hours clinics, MDS and GP cooperatives) and to introduce new services to provide services where non-presently exist.

2 The after hours component of the PIP has not been indexed since inception. Taking into account inflation during the period, NAMDS estimates that the $56 Million paid via the AH PIP to practices would need to rise to $87 Million being paid to Medicare Locals to maintain the true value of the responsibility being transferred. What gross payment to Australian Medicare Locals is intended?

3 In providing face-to-face patient service budget to MLs, will these funds exclude administrative on-costs i.e. will MLs be block funded for their administrative costs and separately funded for their patient care responsibilities?

4 GP and MDS Face-to-face after hours care in Australia is carried out thus:

(i) 5,000,000 extended hours GP attendances PA
(ii) 600,000 MDS metropolitan attendances PA
(iii) 250,000 GP home visits (primarily in regional, rural and remote Australia) PA.
(iv) 1,200,000 after hours category 4 and 5 attendances and Emergency Departments PA.

Is DoHA intending to allocate funds to each Australian Medicare Local for each of these face-to-face service types (other than State funded ED Attendances) via tied funding? Alternatively, is it intended that the Medicare Local funding will not be tied and instead be block funding?

5 General Practitioners in Australia are presently held responsible and accountable for 24/7 patient care coordination via the RACGP Standards for General

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Practice. In return, practices receive AH PIP funding to assist with this onerous responsibility (approximately $56 Million).

Does DoHA expect that GPs will remain responsible for 24/7 patient care when their practices (and Doctors) are no longer remunerated for this health care responsibility (i.e. after the AH PIP is abolished in July 2013)?

6 Remote, Rural and Sub-Regional GPs are necessarily on 24/7 call as they are without alternative patient care cover from nearby colleagues.

Are Medicare Locals required to ensure that these doctors and practices are no worse off under the Medicare Locals reforms? Is tied funding proposed for these remote area Medicare Locals? If not, what system is proposed?

7 Can DoHA please confirm that Medicare Locals will be prohibited from becoming direct after hours service providers (i.e. that MLs will not be able to simultaneously become fund holders and service providers for after hours care)?

8 Presently, Australian Medical Deputising Services hold crucial and highly confidential health information and management guidelines on patients on behalf of General Practitioners (eg drug seeking patients, doctor shoppers, patients who present a security risk to both day time and after hours doctors, palliative care patients, patients who are expected to die and require and whose family will require a life extinct certificate etc). This confidential information is freely shared between MDS and regular GPs and securely stored. The information is crucially important in protecting both patients and doctors.

How is it proposed that this information will be shared, retained and deployed when Medicare Locals take over responsibility for after hours care from General Practitioners? Will MLs need to gain consent from GPs, patients and 3rd party after hours providers before sharing this vital information between the various healthcare providers?

9 Are Medicare Locals going to be funded to continue to support extended hours GP practices (5,000,000 patient attendances after hours each year)?

Will the tied/block funding be the same as existing funding (excluding MLs administration)?

If extended hours GP practices are not to be remunerated via the PIP (or by MLs) does DoHA expect that the present levels of face-to-face patient care from extended hours practices be maintained? If yes, can you explain why?

If it is not maintained, does DoHA expect this patient load to transfer to public hospital emergency departments? If not, why not?

If A & E attendances increase as a result of the Medicare Local reforms will MLs be held accountable? Why won't MLs simply blame inadequate funding from the Commonwealth Government for inadequate after hours services (as happened in the UK)?

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10 The present documentation from DoHA indicates that Medicare Local Directors are to be appointed under the Corporations Act.

So too, MLs are to take direct authority, responsibility and accountability for after hours care.

In-turn they may contract to 3rd party providers (presumably, Super Clinics, extended hours practices, co-located clinics, face-to-face home visiting MDS, GP after hours home visiting cooperatives etc).

Where patients are not able to secure adequate after hours care, are the ML Directors accountable for this lack of service provision?

Does this extend to accusations of Corporate Manslaughter where a patient has suffered a medico/legal event as a result of inadequate and/or inaccessible after hours care provided through a ML?

Is DoHA and the Government prepared to unconditionally indemnify Medicare Local Directors against these sorts of actions?

Does DoHA support ML Directors transferring medico/legal contingent liabilities to after hours service providers? How is it proposed that this be done? If this is to be done, will this be a mandatory condition applied to all Medicare Locals?

11 Will it be a mandatory requirement for all Australian MLs to ensure accessible and appropriate in-hour and after-hours consultations (including home visits where clinically warranted) on behalf of the patients Medicare locals/GP with high care needs (ACFs, frail aged and house-bound, palliative care and life extinct)?

Is DoHA aware that this cohort of highly vulnerable patients do not seem to have been provided for with timely and appropriate medical care in the current Medicare Local reforms?

12 Is it proposed that requests for medical care in aged care facilities, the frail aged and house-bound and life extinct requests be channelled through the National GP Triage service, or will these requests continue to be channelled through the GP/MDS relationship?

13 GPs presently use the GP/MDS relationship to cover “out of hours” components of the in hours period when their clinic or practice is closed. This provides patients access for patients to access urgent pathology and radiology results. Will the Nurse/GP triage service take responsibility for all out of hours urgent radiology and pathology results?

How will this be done for GP practices that opt out of connecting to the Triage service and don’t wish to be part of the Medicare Local 3rd party tenders for after hours services?

14 Is DoHA aware that a major conceptual failing occurred in the UK in the creation of Primary Care Trusts (PCTs) where the Trusts were established without guidelines nor standards about what was expected from their after hours patient services.

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The ML proposals closely duplicate the UK PCT model (including its well-documented and publicised failings and resultant patient deaths).

Does DoHA accept that guidelines and standards should be created prior to MLs establishment to ensure minimum acceptable service standards? If yes, who is to be tasked with this responsibility?

Will the Technical Working Group be able to examine, discuss and contribute to these ML guidelines and standards? If not, who is proposed to do this?

15 The soon to be established national GP Triage service is yet to acknowledge the GP as being pivotal in providing continuity of comprehensive care. NAMDS understands that the triage service will encourage GPs to switch their phone (especially in country areas) to the after hours triage service.

Is it intended that Medicare locals will also acknowledge the crucial 24/7 patient care role of the patients regular GP in providing continuity of care?

NAMDS notes that DoHA will require the successful GP Triage tenderers to send a clinical note of the AH consultation to the regular GP the following day. So far, there does not seem to be any funding for this universal GP care responsibility.

Will the ML or the Nurse/GP Triage service be responsible for funding the transferring and processing of patient notes by regular GPs for services carried out by 3rd party providers commercially remunerated by MLs?

Will this be a requirement of all preferred providers within an ML, including extended AH clinics and Super Clinics?

If so, how will it be funded and policed?

Who will be responsible for adverse medico/legal events and clinical follow-ups (the Triage Service, the ML or the patients regular GP) for patients seen by Medicare local 3rd party providers but whose follow-up care has been referred back to their day-time GP?

Who is going to be accountable for that patients care arising out of the after hours attendance or triage contact?

Are GPs entitled to opt out of receiving nurse and P triage notes and ML 3rd party provider reports? If they are, who will provide this continuity of care? If they are not, how is it proposed to force regular GPs to remain engaged 24/7 other than by a commercial means?

The TWG should note that approximately 25% of Australian GP practices have elected never to have (or have relinquished) accreditation. After abolishment of the after hours PIP in July 2013 it can be expected that fewer GP practices will choose to be accredited.

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Why should unaccredited practices accept 3rd party patient report referrals from the Nurse/GP Triage service or ML contracted 3rd party after hours providers when they are not remunerated for this potentially onerous responsibility?

How does DoHA plan to address this dilemma?

Summary

Getting after hours care in Australia right is a substantial challenge and a huge responsibility.

Presently, authority, accountability and responsibility for after hours is vested with 23,000 Australian General Practitioners.

Medicare Local reforms transfer significant parts of this authority, responsibility and accountability from Australian General Practitioners caring for patients in the community to local bureaucracies called Medicare Locals and 3rd party providers working in the sub-regional setting.

This is a momentous change in the Australian primary healthcare system that is being implemented at an unprecedented and courageous pace.

It is requested that written responses to these questions be provided to NAMDS and the TWG so that all parties can better understand the governments reform intentions.

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