National Association of Medical Deputising Services (Australia) NAMDS

The challenging new role for Medicare Local Directors and CEOs in facilitating and funding after-hours patient care in Australia.

NAMDS
National Association for Medical Deputising

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EXECUTIVE SUMMARY

The Commonwealth Government has announced that, from July 1, 2013, 62 Medicare Locals will, in addition to other roles, take over the authority, responsibility and accountability for the facilitation and funding of after-hours primary medical care services in Australia. Commonwealth Government funds will now be provided directly to Medicare Locals and not via general practitioners (GPs).

The government reforms also include the national expansion of a nurse triage telephone hotline, to include after-hours GP triage, on the 1st of July 2011.

The National Association of Medical Deputising (NAMDS) has expressed its concerns to the Government about the intended reforms, because they closely resemble the failed Primary Care Trust initiatives undertaken in the United Kingdom in 2004. These reforms caused the majority of UK doctors to abandon their responsibilities for after-hours patient care, a situation which remains unresolved in the UK some eight years later.

Apart from extended hours GP practices and emergency departments, MDS are by far the largest after-hours service providers in Australia, comprising nearly 100% of the home visiting capacity of the Australian metropolitan primary health care system. These services, which must operate during the whole of the defined after-hours period, are essential when caring for residents of aged care facilities, the frail, elderly and house-bound, palliative care patients, life extinct patients and the very young with anxious parents.

Importantly, under the current GP-led direct funding model, a patient attended after hours by a medical deputising general practitioner is returned, as soon as practicable, to the care of the patient's regular GP. This ensures comprehensive, ongoing and coordinated patient care in Australia 24/7. These are some of the major benefits of the current 24/7 primary healthcare system in Australian.

Under the existing Australian MDS model, as defined by various Commonwealth Government regulations, the MDS primary stakeholder is the general practitioner.

Under the proposed Medicare Local reforms, it now appears the MDS primary stakeholder will become the Medicare Local. The concept of the ML accepting the authority, accountability and responsibility for after-hours patient care is a substantial variation on the current Australian primary medical care system. The outcomes of this are difficult to predict.

As in the UK, NAMDS believes that once their after-hours payments are withdrawn, it is likely that most Australian GPs will transfer authority, accountability and responsibility for after-hours patient care to Medicare Locals. This will produce the highly undesirable outcome of fragmenting the 24/7 primary medical care services in Australia.

Medicare Local CEOs and directors need to be alert to these dangers, and be assured that the care systems proposed by their staff will not disenfranchise daytime Australian GP management of 24/7 patient care, fracture fragile existing after-hours services and not jeopardise patient access to genuine and essential home based after-hours primary medical care.

INTRODUCTION

The Commonwealth Government commenced substantial reforms of Australian 24/7 primary health care and after-hours patient care systems when it announced that:

- Divisions of General Practice (previously GP controlled organisations) would be replaced by Medicare Locals (MLs).

- Medicare Locals will be governed by a board of directors comprised of a broader range of health professionals and community representatives constituted under the Corporations Act.

- Medicare Locals will (in addition to other roles) take over authority, responsibility and accountability for the facilitation and funding of after-hours primary medical care services in Australia, from July 1, 2013.

Presently authority, accountability and responsibility for ensuring 24/7 patient care in Australia is assigned to **General Practitioners**.

The Government's announced Medicare Local reforms also included:

1. The national expansion of a nurse triage telephone hotline to include after-hours GP triage from the 1st of July 2011.

2. The termination from 1 July 2013 of the After Hours Practice Incentives Program (AH PIP). These PIP payments presently fund:

(i) The 24/7 patient care responsibilities of Australian GP practices, which includes after-hours care.

(ii) Via the GPs practice, the funding of Medical Deputising Services contracted directly to GP principals (with funds sourced from the AH PIP) These services provide after-hours coverage to 17,500,000 Australians.

3. From 2013, the tendering of after-hours care services, (such as Medical Deputising Services) by Medicare Locals with funds directly provided by the Commonwealth Government to Medicare Locals (not via GPs).

BACKGROUND

In 2010 the Federal Government announced its intentions to cancel PIP Tier 1 payments to all Australian GPs, starting on July 1, 2011. This was planned to occur prior to any Medicare Locals being formed and in advance of any new mechanism to care for Australian patients after-hours.

The government announced that the savings from the PIP Tier 1 incentive were to be allocated to fund the new $40 million per year after-hours GP triage service, an add-on planned to the national nurse call service.

NAMDS expressed its concerns about the intended reforms because they closely resembled similar initiatives imposed on the Primary Care Trusts of the UK in 2004. **These failed reforms saw 95% of UK doctors abandon their after-hours patient care responsibilities, a problem still unresolved.**

In its negotiations with the current government, NAMDS contended that there is nothing in the proposed Australian Medicare Local reforms that would avert the same patient abandonment outcomes inflicted on the UK primary medical care system.

The key issues of concern, expressed by NAMDS to the Prime Minister and Health Minister include:

- That general practitioners should remain responsible for 24/7 primary medical care in Australia and should continue to receive a subsidy for their important and in many cases, unavoidable after-hours patient care roles, even more so in regional, remote and rural Australia. How this can occur once the GPs after-hours PIP is removed is difficult to understand.

- Medical Deputising Services should remain service providers who are clinically responsible to daytime GPs. This would preserve the 24/7 continuity of care for patients in-hours and after-hours, facilitating the maintenance of Australia's high standards of integrated and coordinated patient care.

- NAMDS expects that Medicare Locals will strive to avoid unintentionally weakening well-functioning Australian after-hours patient care services. Central to this is the need to avoid triangulating the doctor-patient relationship, which happened in the UK.

- NAMDS contends that nurse and GP telephone triage services can never replace face-to-face after-hours patient care. Data from the NHCCN shows that around 20-25% of all calls received lead to a recommendation for face-to-face medical care within four hours. The planned changes (if executed with limited funding to GPs and MDS) will improve telephone access but simultaneously weaken face-to-face access through extended hours GP practices and MDS. This will leave patients with no choice but to attend the nearest emergency department or country hospital.

A failure therefore to match or integrate nurse and medical triage advice with face-to-face medical care, could perversely encourage patients to attend public hospital emergency departments.

The result could be a cost shift from Commonwealth-funded Medicare benefits payments for home visiting and extended hours GP practice, to State-funded public hospitals.

This contradicts the policy outcomes the Commonwealth government sought when it announced the Medicare Local after-hours reforms which were intended to reduce waiting times in emergency departments and improving access to after-hours services to all Australian patients.

MEDICAL DEPUTISING SERVICES (MDS) MODELS OF CARE

The Commonwealth-defined after-hours period equates to roughly 70% of the hours in any given week. The present role of accredited MDS' is to care for GP's patients during the defined after-hours period, then report back to the regular GP on any patient care delivered during the after-hours period.

To fulfil this role, Medical Deputising Services exist in all Australian capital cities, with around 650 deputising GPs working after-hours, caring for a national population of around 17,500,000 people. Australian MDS have a combined capital value in the vicinity of $125 million.

Additionally, MDS services are required to meet a Commonwealth regulated MDS definition and must be accredited to the RACGP standards. Some MDS are also quality assured to ISO 9001.

All Australian MDS's have well-established, complex and detailed software and hardware systems which link in-hours and after-hours patients and doctors.

Crucially, these MDS systems are presently integrated with more than 9,000 GP practices with many MDS services able to electronically transmit patient reports directly to GP practice software systems. This allows MDS's to visit approximately 600,000 people each year in their homes with a compound annual growth rate of 7.5% PA.

Other than extended-hours practices and EDs, NAMDS MDS's are the largest after-hours service providers in Australia, comprising close to 100% of the home visiting capacity of the Australian metropolitan primary health care system.

Importantly, a patient attended by a medical deputising general practitioner after-hours is returned to the regular GP's care. This ensures comprehensive, continuing, coordinated and cost-effective patient care around the clock. All of these are among the major positives of the Australian 24/7 primary healthcare system.

Two benefits emerge from the supporting role of an MDS to daytime General Practice principals:

- Patients receive 24/7 care, including home visits, where clinically warranted.
- GPs get valuable time off for CPD, recreation, rest and family during the Commonwealth defined after-hours period.

Under the Australian MDS model, which is defined in Commonwealth Government regulation (refer to the AMDSP guidelines under the Health Act) the MDS' client is the Principal General Practitioner.

Under the proposed Medicare Local reforms, it would appear that the role of MDS' client will shift from the general practitioner to the Medical Local. If ML's accept authority, accountability and responsibility for after-hours patient care, this looms as a momentous change to the Australian primary medical care system. It has very significant implications for 24/7 patient care, some of which are explained and discussed below.

IMPORTANT STATISTICS

BEACH data shows 7.05 million Australians are seen face-to-face by a doctor in the defined after-hours period each year.

- 5 million Australians are seen each year in extended hours GP practices. These patient contacts are presently funded by a combination of PIP Tier 1 and Tier 2 of the AH PIP + higher CMBS rebates and, depending on the geographic location of the clinic, bulk-billing incentives.

- 1.2 million people are category 4 and 5 patients attended in state-funded emergency departments yearly.

- 600,000 Australians are home visited by Medical Deputising Services.

- 250,000 patients are home visited by general practitioners. Often, these are home visits done by regional, remote or rural GPs who don't have access to contract Medical Deputising Service support.

Of the 850,000 Australians home visited each year by daytime GPs or their nominated MDS service:

- 35% are residents of aged care facilities, are frail, aged and house-bound.
- 10% are patients with multiple chronic illnesses.
- 25% of the home visits treat very young children, often with anxious parents.

FUNDING MODELS (EXISTING)

For a decade, Australian governments have paid general practitioners for their onerous 24/7 patient-care responsibilities via the Practice Incentive Program, for which there is an after-hours component.

- The highest after-hours PIP Payment is AH PIP Tier 3 of $6,000. This is paid to each full-time equivalent GP within a practice.

- The least remunerative is AH PIP Tier 1 which is $2,000 per full time equivalent GP within a practice.

A GP practice claiming PIP Tier 3 ($6,000) for each FTE GP receives 98 cents per hour for the GPs 24/7 patient care (and after-hours attendance) responsibilities. PIP Tier 1 pays GPs 33 cents per hour.

Interestingly, PIP payments, including the after-hours components, have never been CPI adjusted since their introduction over 10 years ago.

NAMDS contends that most Australians would be shocked at the paucity of these after-hours PIP payments to doctors. Our view is that it is highly unlikely that any other group of Australians would be prepared to accept onerous 24/7 patient care responsibility, given the inadequacy of PIP payment offered by successive Commonwealth Governments.

This chronic underfunding highlights the significant goodwill and responsibility that GPs exhibit in caring for their patients 24/7, as well as the fragility of the GP-managed patient care funding systems that , it is proposed, will be fully transferred by the government to Medicare Locals.

Sadly, there is a significant danger that by abolishing after-hours PIP payments and re-directing this funding to Medicare Locals, the government will unintentionally diminish the present services offered after–hours by GPs. This abandonment of patients certainly occurred in the UK and NAMDS believes this most undesirable outcome could be repeated here, unless the proposed new system is carefully administered by Medicare Locals.

Surprisingly, the Department of Health and Aging contends that Australian GPs will continue to remain responsible for 24/7 patient care in Australia without receiving the after-hours PIP. In late 2010 I was asked by a senior DoHA officer, “why should the government pay doctors for 24/7 patient care when they have to do this anyway, as mandated by the RACGP standards?”

Another issue, as yet unrecognised by the government or incoming Medicare Local directors, is what potential damage changes to the after-hours PIP payments to general practices will do to the broader financial drivers of general practice accreditation in Australia?

Many Medicare Local directors may be surprised to learn that general practices are not obligated to undertake accreditation in Australia. Instead, GP practices are financially incentivised to become accredited via the Practice Incentives Program (PIP).

The PIP Program includes a substantial after-hours component to encourage GPs to either provide after-hours care for patients directly, or to ensure continuity of care for patients via a contracted provider such as an MDS.

Presently, after-hours PIP payments to General Practices amount to $57 million per annum. These payments are financially significant for general practice. For example, for a 6 FTE doctor regional practice claiming Tier 3 of the PIP (and

presuming that all PIP payments are accessed), the following financial benefits are available:

	Total PIP payments	Total Tier 3 AH PIP	% PIP reduced
RRMA 1	$177,599.07	$29,818.32	20%
RRMA 2	$177,599.07	$29,818.32	20%
RRMA 3	$244,488.93	$29,818.32	15%
RRMA 4	$255,118.88	$29,818.32	14%
RRMA 5	$297,638.69	$29,818.32	12%
RRMA 6	$265,748.83	$29,818.32	14%
RRMA 7	$318,898.60*	$29,818.32	11%

* **Includes rural loading of $106,299.53**

NAMDS argues that removal of the after-hours PIP incentive will have an impact on the drivers of GP accreditation in Australia. This is already evident in the data showing a progressive reduction in both GP accreditation and AH PIP claims since 2008.

Medicare Local directors should note that unaccredited GP practices are not subject to the same controls that apply to accredited GP practices. In addition, it may also become more difficult to keep GPs from accredited practices engaged in 24/7 primary patient care if they relinquish accreditation.

MEDICARE LOCALS TO REPLACE DIVISIONS OF GENERAL PRACTICE

Announcing the new role for Medicare Locals, Health Minister Nicola Roxon wrote to NAMDS in July, 2010.

In the letter Minister Roxon stated, “Medicare Locals are to subsume the role of Divisions of General Practice, to become independent legal entities with strong links to local communities, health professionals and service providers”. This, she claimed “would enable Medicare Locals to respond more effectively to local needs through more coordinated care, **improved access to services** and via more ‘driven’ integration of services across primary health care, hospital and aged care services.”.

The Minister’s message is that the ML reforms are intended to encourage improved access to services for patients.

How possibly can Medicare Local directors improve universal after-hours access for their community? Presently, the ML model in Australia closely resembles the Primary Care Trusts (PCTs) model deployed in the United Kingdom, the very same PCTs the incoming government of Prime Minister Cameron intends to abolish and replace with GP-controlled 24/7 patient care - the existing Australian model!.

Medicare Locals are intended to be important and influential community health organisations because they are designed to have governance structures that facilitate fund-holding on behalf of both the Commonwealth and State governments. Thus, substantial funds are provided to Medicare Locals to ensure services exist and are universally accessible. Presumably, Medicare Local directors will be held

directly responsible for service provision and accessibility AND be politically accountable when the services fail or are unavailable.

Medicare Locals will, in future, be required to call for and fill tenders for third party service providers, for the provision of community healthcare services previously undertaken and/or managed by GPs, GP Practices or state and Commonwealth agencies.

Under the new Medicare Local model, GPs will no longer be the gate-keeper of after-hours patient care in Australia. This role will be shared between Medicare Locals, after-hours care contractors, including medical deputising services and the general practitioners who agree to participate in any new arrangements.

One of the first tasks given to Medicare Local directors is to appoint after-hours primary medical care service providers. The Medicare Local model adopted by the Government requires PIP funding allocated to GPs to be redirected to after-hours providers such as MDS via a tendering process. In return, Medicare Local directors are expected to secure universal access to after-hours care for all members of the community.

Historically, after-hours primary medical care services in Australia have been difficult services to establish and operate. They are extremely complex in nature and commercially fragile.

Fortunately, many parts of metropolitan Australia have excellent after-hours services in place which operate well. However, in some parts of Australia, MDS have failed to remain sustainable. This is especially so in rural, remote and regional Australia, where the onerous task of caring for patients 24/7 falls directly on daytime GPs working at night and on weekends.

For Medicare Local directors the key task will be to not destroy or damage existing services which function well.

A NEW MODEL FOR AFTER-HOURS CARE

It would appear that the future clients of medical deputising services may be Medicare Locals and not general practitioners.

In mid-2011, NAMDS pointed out to DoHA that this change will significantly impact on patient care in Australia. The problem is not the specifics of how Medicare Locals will address after-hours care, but in the service delivery model for after-hours care itself.

MDS' have over 650 after-hours doctors deputising on behalf of the patients of daytime general practitioners.

In this existing model, 650 after-hours doctors have access to the patient records of 9,000 day time GP practices. The daytime GP's patient records form part of MDS' patient record system. Information can and does flow freely, without any additional patient consent needed, because MDS doctors care for patients **within a practice**

that spans the in-hours and after-hours period. This explains why the after-hours doctors are called Medical Deputising General Practitioners.

When an after-hours doctor from a medical deputising service attends a patient from a subscribing practice, the after-hours doctor sees that patient with the consent of the daytime doctor, and is often armed with computerised clinical instructions about preferred care.

So too the principal GP has access to all the deputising doctor's patient reports. The system is rational, comprehensive, coordinated and continuous. The systems are also largely electronic, computerised and span whole cities. The capital costs invested in these metropolitan-wide medical deputising services in Australia is substantial and unique.

A comprehensive and coordinated after-hours primary medical care home visiting system is crucial for those who are aged, infirm and house-bound, aged care facility residents, patients with multiple chronic illnesses, drug seeking patients, patients with potentially dangerous psychological conditions and those families with a deceased person at home who require a life extinct certificate. No other service can replace the services provided by MDS', other than ambulance evacuation to emergency departments.

In summary Medical Deputising Services presently operate **within** the primary care system under the direction of general practitioner principals. MDS' presently work for GPs and the GPs are our clients. MDS' care for GP's patients, on their behalf.

This will change when Medical Deputising Services are contracted to Medicare Locals. In this new paradigm, there is no guarantee, nor any requirement, that GPs will coordinate the work of the after-hours provider who cares for their patients, when patient care is handed back to the GP when next their rooms re-open.

As in the UK, NAMDS believes it is possible that many (if not almost all) GPs will, at the first opportunity, transfer authority, accountability and responsibility for after-hours patient care to Medicare Locals. Such a consequence would severely fragment the 24/7 primary medical care services of Australia, and is highly undesirable.

Medicare Local directors need to be alert to these dangers and will need to be assured that the care systems proposed by their staff will not fracture fragile existing services, they'll be sustainable and will indeed improve patient access to care.

Another matter poorly understood by either the Government and DoHA is that AH PIP payments are **NOT** just to remunerate day-time general practitioners for their after-hours attendances, whether carried out themselves or by MDS contractors. They also pay GPs (and their practices) for the myriad follow-ups and referrals that flow from patients who are attended after-hours, which need to be resolved during day-time practice.

This complex, continuous and individualised exchange of patient data and information between daytime and after-hours practice is both time consuming and costly – and in future it seems, will not be subject to any recompense by the PIP.

Also, if GPs abandon or reduce their support for 24/7 care in Australia after July 1st 2013, the contingent liability of patient care may unintentionally transfer to Medicare Local directors, unless the contracted provider supplies an indemnity.

This has significant implications for ML directors. At the very least ML directors would be advised to:

1 Obtain ML-funded directors and officers insurance.
2 Acquire professional indemnity insurance to cover off ML director risk.
3 Demand that after-hours providers are accredited and prove an indemnity to ML directors before agreeing to tenders.

MEDICARE LOCAL DIRECTOR INDEMNITY, CONTINGENT LIABILITY AND INSURANCE RISKS

The medical risks and legal liability that will accompany Medicare Local directors are matters that have not been well explained in the Medicare local guidelines produced by DoHA.

What is known is that Medicare Locals will contract to after-hours providers for the provision of universal after-hours access, including home visits.

Presumably, Medicare Locals will require service providers to provide evidence of quality assurance, professional indemnity and a full indemnification of Medicare Local directors against action by patients attended by the after-hours provider, from making claims against service provider and/or the funder (Medicare Local).

Many MDS' already have indemnity cover in the order of $20,000,000.00 per annum. Quality assurance standards are measured against both the RACGP standards, ISO 9001 and against the Commonwealth definition of a medical deputising service. This, together with an unconditional indemnity, should provide medico/legal protection for ML directors

However, a significant additional problem exists for ML CEOs and directors.

It is well known that in many parts of Australia around 30% of patients do not have a regular GP.

MDS' can identify these patients and provide a starting point to write to these patients, encouraging them to create, build and maintain a relationship with a daytime GP.

In addition to these patients, there will be many daytime GPs who elect not to be involved in ML control of after-hours care, who will abandon their after-hours care responsibilities after July 1 2013, when they lose access to PIP payments. The medical profession is already surveying what level of abandonment can be expected after July 1 2013.

For those patients without a regular GP (or without an ML participating practice) who are attended after-hours but in need of significant additional follow-up primary

medical care in-hours, the means through which that care will be provided is difficult to ascertain. Who will do this for patients who don't have a regular GP or where their regular GP has elected not to participate in after-hours arrangements established by the new ML? Who will assume responsibility for this follow-up care? Will it be the MDS, or is it the ML?

The only option for the MDS (or other service providers) is the highly undesirable outcome of referring this cohort of patients to ED. How though, will the after-hours provider know if there's been adequate, or indeed any, clinical follow-up care undertaken? This is a very significant medical-legal issue because it leaves a potential litigation trap, which directly involves service providers. Arguably, it might also involve the ML Directors who have created the model through which the patient's continuity of care paradigm has been fractured and compromised.

THE NATIONAL EXPANSION OF NURSE AND GP TRIAGE SERVICES

Many states in Australia have established nurse call centres that operate 24/7. For example Queensland has had "13Health" operational since 2007. Other states have had their services up and running for similar periods.

Prior to 2006, the Howard Government increased funding to these services and since this time successive Commonwealth Governments have been trying to consolidate these services into a national service.

In 2010 Medibank Private purchased McKesson. Soon afterwards the Government announced the addition of an after-hours GP triage component to the nurse call service, and awarded the contract to Medibank Private. The new GP triage service commenced operation on July 1st 2011. Around this time COAG announced that all the state call centres would merge into a national service.

This consolidation is now complete. Promoted by both Coalition and Labor Governments, these reforms have been a long term key strategic goal of DoHA, whose objectives seem to be:

- That nurse and GP triage has the potential to reduce the need for face-to-face patient contacts which will lead to cost savings for the Commonwealth.

- That the overuse of emergency departments by category 4 and 5 patients can be resolved via nurse and GP telephone triage services reducing patient attendances at these facilities, via self-care and GP attendances.

- That call centres can improve patient access to the appropriate face-to-face care, when clinically warranted.

When NAMDS pointed out to DoHA that nurse triage in Queensland and Victoria has dramatically increased after-hours attendance rates at home they were initially dismissive.

The experience of NAMDS members is that while nurse and GP telephone triage services increase patient self-management in lieu of after-hours attendance at an

ED, it also potentially promotes the availability of MDS', extended hours general practice and other face-to-face medical services.

Therefore, while there's an increase in the percentage of people self-managing after telephone nurse or GP triage, this is insignificant compared to the number of people newly advised of the availability of non-ED after-hours services like MDS'.

These acknowledged facts from the last published National Health Call Centre Network report card confirm the experiences of NAMDS members:

1 The most common advice to the callers using the triage service in 2010 is "see a doctor within 4 hours" (21.39%). The second most common recommendation is to "see a doctor within 24 hours" (16.62%).

2 50.75% of patients aged over 15 years of age are either advised to call an ambulance (5.12%), attend an ED (11.82%), told to see a doctor immediately (12.42%), or see a doctor within 4 hours (21.39%).

3 If the advice to see a doctor "within 24 hours" during the weekend is added to the statistics, some 67.37% of patients are likely to be referred to face-to-face medical care by HealthDirect.

4 Looking at the data set over 2010, the number of patients referred to EDs appears to be steadily increasing, while the number of patients referred to their regular GP or extended hours GP practice appears to be steadily decreasing. This trend needs further examination to establish how it is occurring.

At first glance, it appears that the NHCCN is cost shifting patient demand from CMBS funded GPs and MDS to state-funded Emergency Departments. This cost shift is confirmed by the data provided from the NHCCN in 2011. If correct and replicated, this data will concern state Health Ministers as this is the opposite of the outcome expected.

For example, the early 2011 data provided by the National Health Call Centre Network (NHCCN), following the implementation of a $40 million after-hours GP triage service, shows the following:

A. Through inadequate systems to inform triage staff about face-to-face MDS service availability in the community, the NHCCN has unintentionally adopted a preference for referrals to EDs, in lieu of GP or after-hours GP attendance.

B. Anecdotal advice is that Nurse and GP's triage professionals routinely advise patients to attend EDs, irrespective of available alternative extended hours GP practices or medical deputising services.

ABOLISHMENT OF AFTER-HOURS PRACTICE AND INCENTIVE PAYMENTS TO GENERAL PRACTITIONERS

The current Government has announced that all after-hours PIP payments to GP practices will be abolished from the 1st of July 2013.

To implement the reform, several things will need to occur:

A The current Labor Government will need to remain in power beyond the hand-over date set for July 2013, because the Coalition, if elected, has given the commitment it will reinstate the after-hours PIP payments to GPs.

B Medicare Local fundholding for GPs presumes that when GPs are finally denied remuneration for after-hours care, they will not abandon their responsibility for 24/7 patient care coordination. This view contradicts what happened in the UK, which in NAMDS' view, is what's likely to happen in Australia.

C Rural, remote and regional GPs are particularly disadvantaged by the removal of the after-hours PIP. Other than Medicare Locals handing GPs the after-hours PIP funding directly, it is hard to envisage how the ongoing process will work. Additionally, it will be a difficult task for the Medicare Local CEOs or directors to try and convince an already stressed and overworked rural or remote general practice workforce to accept 98 cents per hour for being on call 24/7.

D Unless Medicare Locals receive substantially increased after-hours funding, their capacity to fill after-hours contracts is in jeopardy. The danger is that this may leave the Medicare Local directors holding the political blame for the under-funding caused by the Commonwealth, resulting in withdrawal of essential 24/7 healthcare services.

An additional complication, so far not well understood, is the huge volume of metropolitan primary medical care that is presently funded and facilitated by combining PIP Tier 1 and Tier 2 of the AH PIP and used to subsidise "extended hours" GP practices.

Extended hours general practice is a fragile service offering because:

- The continuation of poor CMBS rebates does little to encourage Australian GPs to work clinic shifts late at night and long shifts on weekends.

- Increased after-hours and weekend penalty rates arising from staff moving from AWAs to new and higher awards, which include after-hours and weekend penalty rates under the Fair Work Act

- Soon-to-be abolished PIP payments

NAMDS members have already reported clear market evidence of extended hours practices reducing their hours of operation, or closing altogether. .

Medicare Local CEOs and directors, the government and DoHA, need to be alert to the danger that extended hours GP patients might lose existing levels of access to extended hours practice and shift to ED attendance (effecting an unintentional cost shift from the CMBS to state-funded EDs).

Considering the volume of attendances catered for by extended hours GP practices (5,000,000 patients attended per annum) it is doubtful whether state EDs (1,200,000 category 4 and 5 patents attended PA) would be able to cope with an increase of patients of this magnitude.

CONCLUSION

Medicare Locals are already established nationally. They include professional boards with directors appointed under the corporations act with significant five year budgets.

One of the first responsibilities for ML directors will be to approve tenders for after-hours providers in their local area. These tenders are required to include the provision of services for 3-5 years, and the national budget is in the order of half a billion dollars.

As at the 1/7/2013, GPs will have their after-hours PIP abolished, saving the Government $57 million per annum.

The extent to which GPs then abandon 24/7 patient care coordination, after the removal of the PIP, is difficult to estimate. The NAMDS' view holds that a significant percentage of GPs will be incensed by these changes, and will abandon responsibility for 24/7 patient care.

How patient care will be coordinated between day-time and after-hours care still remains to be resolved and is a very complex policy challenge.

At the very least ML CEOs and directors should seek further instructions from DoHA, which might guide directors in their deliberations.

ML directors and CEOs will need to ensure that they are adequately insured and indemnified against legal action arising from clinical and organisation contingent liabilities associated with contracted after-hours arrangements.

DoHA is presently drafting many of the rules that will govern the management of after-hours services by Medicare Locals. NAMDS hopes that this will include model contract guidelines and standards for the contracting of after-hours primary medical care providers in Australia, and the protection of ML directors.

The after-hours guidelines developed for MLs by DoHA have been approved by the Health Minister. What is now required are some overarching rules which can be implemented to guide Medicare Local directors in the tendering process. Key matters that need to be included are probity standards, tender periods, timelines and appeals, patient access criteria, GP engagement standards, patient reporting, confidentiality and consent, Informed financial consent, PCEHR compliance, doctor security, indemnity, quality assurance and accreditation.

Finally, MDS service models are potentially very fragile with most relying heavily upon a combination of Commonwealth Medical Benefits Schedule (CMBS) payments, workforce regulation to support medical recruitment and retention and day-time GP subscriptions to facilitate commercial sustainability.

In transitioning to Medicare Local funded models of after-hours care, ML directors will need to be very careful not to:

- Undermine the 24/7 nature of the Australian doctor-patient relationship.
- Disenfranchise regular GPs from 24/7 care coordination and support.
- Reduce extended hours GP practice in their community.
- Fragment patient care between in-hours and after-hours practitioners.
- Reduce patient after-hours medical care accessibility.
- Increase pressure on State funded emergency departments.
- Decrease after-hours doctor safety.
- Increase “silos” between care providers.
- Endanger the commercial sustainability of MDS in Australia.

Additional reading

See www.namds.com , go to the media tab and access the paper titled “Medicare Locals – questions from NAMDS”. This document was sent to the Prime Minister and Health Minister to try and better understand the government’s reform intentions. NAMDS continues to await answers to the issues raised.

See www.namds.com , go to the media tab and access the paper titled “Understanding after-hours medical care in Australia” – NAMDS paper presented to DoHA 2010 (Updated December 2011).