NAMDS National Association for Medical Deputising

Friday, 29 August 2014

After Hours Review
General Practice Support Section
Primary and Mental Health Care Division
Department of Health
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RE: Written Submission - After Hours Primary Health Care Review (After Hours Review)

The National Association for Medical Deputising (NAMDS) is the peak body representing after-hours medical deputising services (MDS) in Australia and seeks to facilitate and encourage high standards of after-hours primary medical care. Medical Deputising Services directly arrange for medical practitioners to provide after hours medical services to patients of Practice Principals during the absence of, and at the request of, the Practice Principals and utilise facilities and processes which ensure continuous access to care and continuity of patient care. NAMDS as an association of member services who provide after hours care to over 20,000,000 Australians, providing medical deputising to an estimated 9000 FTE GPs, is therefore well placed to provide pertinent information in regard to this review of After Hours Primary Health Care. NAMDS submission will respond in turn to the following sections referred to in the Departments invitation.

1. **The key principals for after hours primary health care services.**

- NAMDS contend that General Practitioners play an integral role in the coordination of patient care during the after hours period and have relied on the support and interrelationships in place with Medical Deputising Services.
- Patients cared for after-hours by MDS include the frail–aged and elderly, residents of aged care facilities, those with multiple chronic illnesses who are house-bound, families with young children and palliative care patients, as well as the general community. Medical Deputising Services work extremely well in metropolitan Australia and in many parts of regional Australia. Without such services, many of the patients MDS care for after hours would be forced to attend already over-crowded public hospital emergency departments
- MDS that provide coverage for the entire after hours period and in particular the unsociable hours period, as opposed to limited after hours service providers, rely on existing income streams to maintain viability. Evidence suggest that General Practitioners are working less hours and avoiding any after hours responsibility thereby placing additional pressure on after hours services. This is compounded by an ageing population and an increased difficulty in patients accessing daytime appointments when desired.

2. **The role of General Practitioners and general practice in delivering after hours services.**

- General Practitioners play an integral role in the continuity of patient care across the after hours period and in hours period post an after hours intervention. Prior to the removal of the after hours PIP, authority, accountability and responsibility for ensuring 24/7 patient care in Australia was assigned to General Practitioners.
- Under the RACGP Standards, accredited practices were obligated to provide or arrange 24/7 care accessibility to patients. In response to the removal of the PIP with funding then coordinated through Medicare Locals and in some instances a lack of funding support for GPs, interpretation changes were made by the RACGP to this after hour standard. Consequently NAMDS members have reported some day-time GP practices abandoning their after hours care responsibilities. If left unresolved, this will endanger Australia's

excellent systems for ensuring patients can access face-to-face after hours medical care, including doctors' home visits.

- NAMDS contends that General Practitioners should remain the controllers of 24/7 patient care systems in Australia and should continue to be paid for their important (and in many cases, unavoidable) after hours patient care roles (even more so in regional, remote and rural Australia). This may need to involve more effective government regulation of a general practice PIP equivalent style payment.
- When an after hours doctor from a medical deputising service attends a patient from a subscribing GP practice the after hours doctor sees that patient with the consent of the day-time doctor and often with computerised clinical instructions about preferred care. So too, the principal GP has access to all of the Medical Deputising service patient reports for their patients. The system is rational, comprehensive, coordinated and continuous. A comprehensive and coordinated after hours primary medical care home visiting system is crucial for those who are aged, infirm and house-bound, ACF residents, patients with multiple chronic illnesses, drug seeking patients, patients with potentially dangerous psychological conditions and those families with a deceased person at home that require a life extinct certificate.

3. Delivery challenges of after hours primary health care services in rural and remote regions.

- NAMDS contend that there is no alternative to GPs in rural areas providing face to face care for their patients after hours and that GPs must be supported in fulfilling this significant burden.
- The government should enhance its support of rural and remote doctors who are required to personally attend patients 24/7 by applying a rural loading to after hours Medicare rebates and reinstating an AH PIP equivalent.
- The elimination of inefficiencies associated with after hours funding through Medicare Locals and the cost associated with these bureaucracies would make it possible to better fund rural and remote after hours General Practice.

4. Experience/views on the Practice Incentive Program (PIP) after hours incentive.

- For over a decade, Australian governments paid General Practitioners for their onerous 24/7 patient care responsibilities via the Practice Incentive Program, for which there is an after hours component. Interestingly, no PIP payments (including the after hours component) have ever been CPI adjusted since their introduction. A GP practice claiming PIP Tier 3 ($6,000) for each FTE GP receives 98 cents per hour for the GPs 24/7 responsibilities. PIP Tier 1, pays GPs 33 cents per hour. NAMDS takes the view 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 24/7 patient care responsibility for the meagre PIP payment offered by successive Commonwealth Governments.
- It is important to note is that the previous AH PIP payments were not just to recompense day-time general practitioners for their after hours attendances (whether carried out themselves or by MDS contractors). It also paid GPs (and their practices) for the myriad follow-ups and referrals that flow from patients attended after hours, but needing to be resolved during day-time practice.
- NAMDS believe there are opportunities to reform the previous AH PIP model of funding to improve value and bolster patient access to genuine after-hours care.

5. Experience/views with Medicare Locals being responsible for funding and incentivising after hours primary health care services.

- The transfer of after-hours financing to Medicare Locals has triangulated and fractured the relationship between day time general practice and after hour's home visiting doctors.

- Medicare Locals have been an additional bureaucratic layer adding to cost of after-hours care provision. All after hour's services report large bureaucratic waste within Medicare Locals by officers who have neither patient care responsibilities nor any knowledge of the importance of face-to-face medical care.

- Some Medicare Locals directly contravened funding guidelines regarding the maintenance of existing well-functioning after-hours services, which in turn risks their financial viability and therefore may reduce access to accredited after-hours care that is currently available to members of their community.

- In transitioning to a Medicare Local funded model of after hours NAMDS contends that it has resulted in:

  - Undermining the 24/7 nature of the Australian doctor patient relationship
  - Disenfranchised regular GPs from 24/7 care coordination
  - Fragmented patient care between in-hours and after-hours practitioners
  - Increased "silos" between care providers
  - Diluted the interpretation of RACGP Standards related to providing access to after hours care
  - Endangered the commercial sustainability of MDS in Australia.

6. Potential future arrangements for funding and incentivising after hours primary health care services, including advantages and disadvantages of potential options and their relevance to rural and remote regions.

- The greatest threat to after hours care in Australia is GP abandonment of their 24/7 care responsibilities. Other than maintaining an after hours PIP equivalent it is difficult to see how this risk can be avoided. Any future arrangement should re-affirm the long-standing policies of having GPs as the core gatekeepers of the Australian healthcare system, including 24/7 patient care coordination responsibility.

- MDS/GP data sharing is an essential component of Australia's 24/7 Primary Health Care System. Key features include: attendance of Aged Care Facilities; special patient reports;drug seeking patients (and DGP security), in return day time GP security alerts from MDS;life extinct patient management services;in-home after hours frail elderly support services and palliative care. All these features are linked to provide a seamless and workable service in the defined after hours period. Without day-time GPs maintaining 24/7 care responsibility for patients, these systems would collapse or fragment into direct MDS to patient relationships. Any future model of after hours care needs to maintain the key features which sustain the MDS model so that aged care facilities, the frail aged and house bound patients can be home visited after hours. This essentially requires daytime GP engagement and some form of GP payment to fund these coordinated and costly support services to after hours MDS practice.

- Future funding arrangements should be DoH managed rather than PHN managed, purely because of the centralised cost benefits. Arrangements should provide cover to accredited and non-accredited practices to allow all Australians 24/7 coverage and involve a return to previous RACGP interpretation of standards related to after hours care provision. Further the NAMDS/AMDSP MDS definition needs to be appended to RACGP standards to ensure the bona fide provision of services to the community. Alternatively the AH PIP equivalent payment model criteria will need to be refined to achieve the same outcome.

- NAMDS has developed a refined funding model to achieve the following policy objectives: **1**. Return decision making and control of after-hours care to GPs to coordinate in the interests of their patients **2.** Maximise access to after-hours services on a nationally consistent basis **3**. Reward clinics who remain open for extended hours **4.** Reward GPs that serve their patients through their own home visits **5**. Ensure quality provision in the after-hours period **6.** Minimise opportunities for practices to claim benefits without actually providing after hours services **7.** Cost no more than the previous AH PIP scheme, returning savings to the Commonwealth budget.
- The NAMDS proposal provides three different funding elements to support three different approaches to providing after hours care and is detailed on the following pages.

PROPOSED FUNDING STREAMS

NAMDS proposes three levels of funding broadly equivalent to the previous AH PIP Tiers 1, 2 and 3, namely:

Stream 1: Supporting GPs and engaging accredited medical deputising services

- NAMDS proposes that both General Practice and MDS be supported through the first funding stream. This will be achieved by providing a payment of $400 per FTE GP per quarter paid 50 % to the GP Practice and 50% to the MDS contracted by the General Practice for the provision of domiciliary care and universal access to after-hours primary medical care (Note, this figure is less than the previous Tier 1 AHPIP payment – this permits the extension to non-accredited GP practices while maintaining existing cost levels. Where a GP Practice is unaccredited a payment of $200 per FTE would be made directly to the MDS only).
- NAMDS proposes that the relationship between the Practice and the Medical Deputising Service be specified in a uniform contract that forms the basis of MDS and GP Practice payment claims to Medicare Australia. The purpose of the Practice/MDS contract is to confirm the agreement between the parties that patients can genuinely access care 24/7, including during the unsociable hours, that each practice (and its contracted MDS) reports opening hours and after hours contact details to HealthDirect, such that patients can be hot transferred from HealthDirect to their regular GP (or contracted after hours provider) and that the MDS maintains accreditation to both the RACGP standards for general practice and service standards in accordance with the definition of an MDS as set out in section 3GA of the Health Insurance Act 1973.
- NAMDS believes this structure for Stream 1 funding provides several important benefits:

1. Includes all General Practices (not just accredited practices) ensuring widespread patient access to genuinely accessible after-hours care
2. Choice of MDS is returned to the GP – who is best placed to assess quality and service provision based on patient feedback, patient reports and related clinical quality issues.
3. GP Practice may nominate a new MDS at any time – maximising contestability based on the quality of MDS service
4. Maintains the principle that after-hours payments are directly available only to accredited services, by making payments only to the accredited MDS, for non-accredited General Practices while maintaining access for their patients .
5. Delivers high quality care through engagement between GP Practice and the chosen MDS on patient reports, patient special instructions and relevant clinical follow-up
6. Provides income to the actual service provider and deliverer of the patient care service
7. Notification of chosen service provider to HealthDirect (linked to the GP practice in the national directory) ensures that patients requiring after hours face to face consultation can be transferred direct to the selected MDS – providing significantly better patient access and the potential for auditing of compliance and value for money
8. Accredited GP Practices are financially supported and incentivised to support them with those continuity of care elements that occur in their daytime practice post an after hours intervention.

Stream 2 – Supporting extended operating hours in accredited GP Clinics

- NAMDS proposes that accredited General Practices be supported in the provision of extended clinic operating hours through the second funding stream. This stream would replace the AH PIP Tier 2 and would provide accredited general practices $500 per FTE GP per quarter for extended hours general practice where the clinic is opened 15 hours or more during the Commonwealth defined after-hours period.
- This funding stream is expressly designed to support extended clinic operating hours and to provide accessible, affordable care during part of the after-hours period. Unlike the former Tier 2 AH PIP, this payment does not support extended hours provision through availability for after-hours domiciliary visits. Instead, access to Stream 2 payments is contingent upon having a Steam 1 arrangement in place with an accredited MDS. Practices who wish to provide extended hours practice and provide 24/7 care for their patients can access Steam 3

- NAMDS proposes that when lodging claims for payments to Medicare Australia the practice will be required to confirm that it has notified HealthDirect of the practices' extended hours, the telephone contact details of the practice and the supporting after hours arrangement which ensures patients have 24/7 access to primary medical care, including to doctors' home visits where clinically warranted.
- NAMDS believes this structure for Tier 2 funding provides several important benefits:

1. By focusing support on extended clinic operating hours, community access to extended hours service is maximised, including for patients that do not have a regular GP relationship
2. Maintains the principle that PIP type payments are only available to accredited practices
3. By focusing on clinic operating hours, audit problems associated with other forms of extended hours of operation are minimised (noting that actual provision of after-hours services by GPs is addressed by the proposed third funding stream)
4. The requirement to advise Health Direct of operating hours will enable the Nurse Helpline to transfer callers to clinics during extended hours – if the clinic is closed the matter can be flagged for audit by Medicare Australia

<u>Stream 3: Supporting after-hours provision by GP practices that provide 24/7 cover to patients, including domiciliary home visits where clinically warranted</u>

- NAMDS proposes that this funding stream replaces the former AH PIP Tier 3. This proposed stream is structured as a service provision incentive payment similar to the GP Aged Care Access payment; that is, it will be structured to reward the actual GP who provides the service provision in the out of hours period and who supports genuine 24/7 service availability.
- It is also proposed that the payment level would vary between practices in RA Areas 1-3 and those in RA Areas 4-5, to reflect the significant differences in service provision options and models in those locations.
- This structure is specifically designed to address the concerns of the Commonwealth Auditor General concerning abuse of the Tier 3 AH PIP, while continuing to reward and support those doctors who choose to provide 24/7 service to their patients.
- To be eligible for the payment, the GP within the practice will have to show:

1. That the claimant GP has attended 52 out of clinic domiciliary after-hours attendances for the quarterly claiming period (Items 597 and 599)
2. Each claim must include at least 10% unsociable hours domiciliary claims (Item 599)
3. The practice is required to lodge with HealthDirect the 24/7 contact details for both the practice and the doctor on call to ensure genuine and continuous access to care during the whole of the Commonwealth defined after hours period

- Where the practice meets these requirements, a Stream 3 payment of $1,000 per claimant GP per quarter is available to accredited practices in RA 1-3 areas.
- A payment of $2,500 per claimant GP per quarter is available to accredited practices where the practice provides 24/7 access to primary medical care for their patients.
- NAMDS believes this proposed structure for Stream 3 provides several benefits:

1. It rewards practitioners who actually deliver services in the after-hours period at a level that demonstrates their ongoing commitment to after-hours service delivery
2. It responds to concerns that the old AH PIP Tier 3 payment was being accessed by claimants that did not actually provide genuine after-hours services to patients
3. This incentive payment is aligned with the existing aged care access incentive payment which has proven to be an effective model.
4. The payment level will be skewed towards practitioners in rural and remote areas to reflect the especially high demands on GPs in these areas
5. The availability of the GP on a 24/7 basis will be advised to Health Direct and contact details made clear: where a patient is transferred from HealthDirect and the service is not available this can be flagged for follow up by Medicare Australia
6. Note these funds are not available for consultations by doctors working in MDS or extended hours clinics

Conclusion

NAMDS believes this proposed structure for incentive payments for after-hours service provision will return primacy of responsibility for after-hours care to GPs and provide financial support for them in this crucial role, while continuing to support increased accessibility for all Australians to services in the after-hours period. The funding model is designed to reward genuine availability for service provision, with each stream designed to support a different mode of after-hours service provision – medical deputising, extended after-hours clinic and 24/7 service delivery.

The proposed structure continues to focus on accreditation as the basis for access to payments, but widens access to service by providing support for unaccredited GP practices to engage a deputising service. By reporting MDS arrangements, clinic hours and 24/7 availability to Health Direct, services to patients can be enhanced by allowing direct transfers of callers to relevant services enhancing continuity of primary medical care in Australia.

7. **Experience/views on after hours GP helpline.**

- That nurse and GP triage does not (nor will it ever) replace face-to-face after hours patient care. Indeed, 2011 data from the NHCCN shows that after nurse and/or GP triage 26.7% of all patient calls lead to a recommendation for face-to-face medical care within four hours. The experience of NAMDS members is that nurse and medical triage increases patient awareness of service availability and thus increases after hours demands.

- Failure to match nurse and medical triage advice with face-to-face and genuinely accessible medical care perversely encourages patients to attend public hospital emergency departments. The result is a cost shift from Commonwealth funded Medicare benefits payments to home visiting and extended hours doctors to state funded public hospitals. This is the opposite policy outcome sought by the government when announcing the Medicare Local after hours reforms.

- Substantial savings could be made through removing the GP hotline and maintaining the well-functioning Nurse hotline. Better outcomes for patients may be possible by improved linkages to face to face after hours care provision through services subscribed to by patients daytime GP to enhance continuity of care.