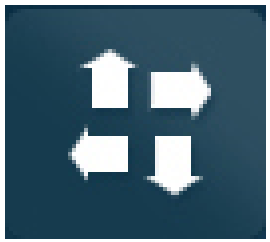
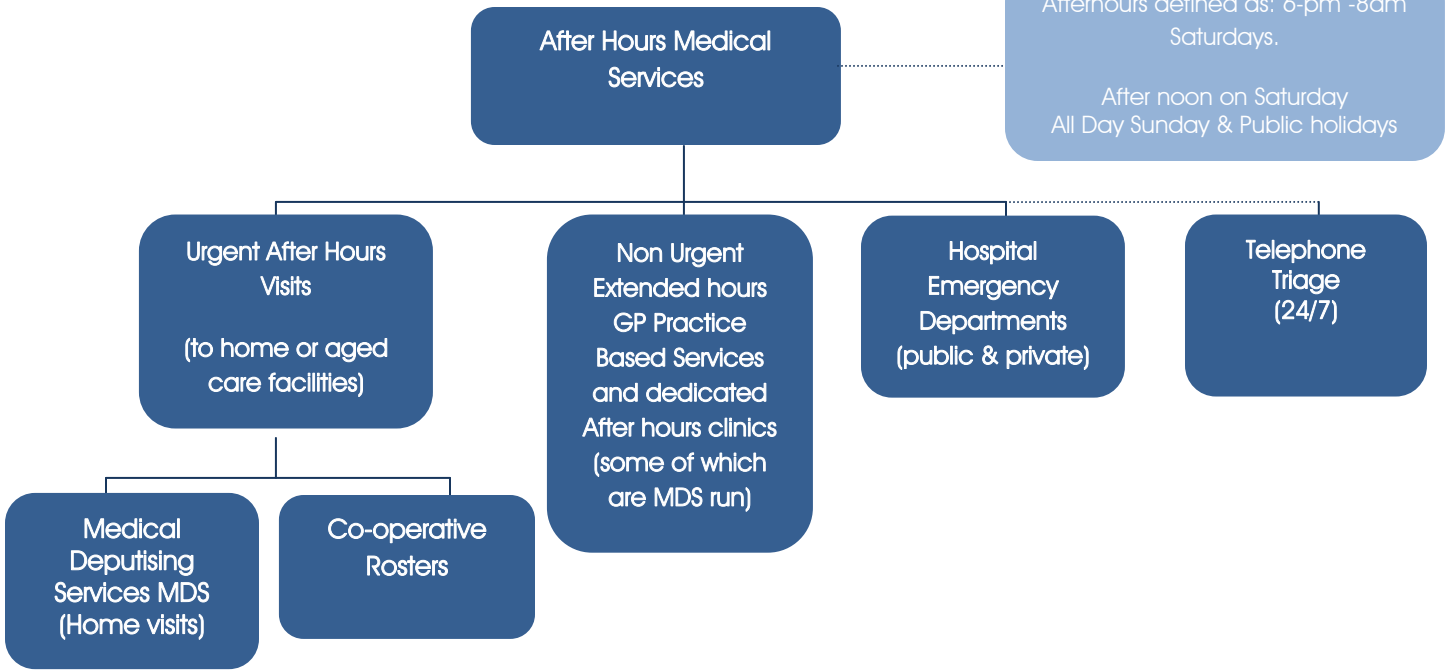


After Hours Medical Care Service in Australia

NAMDS AHPMC Summary Paper

After hours Medical Services Market Definition: Urgent & Non Urgent

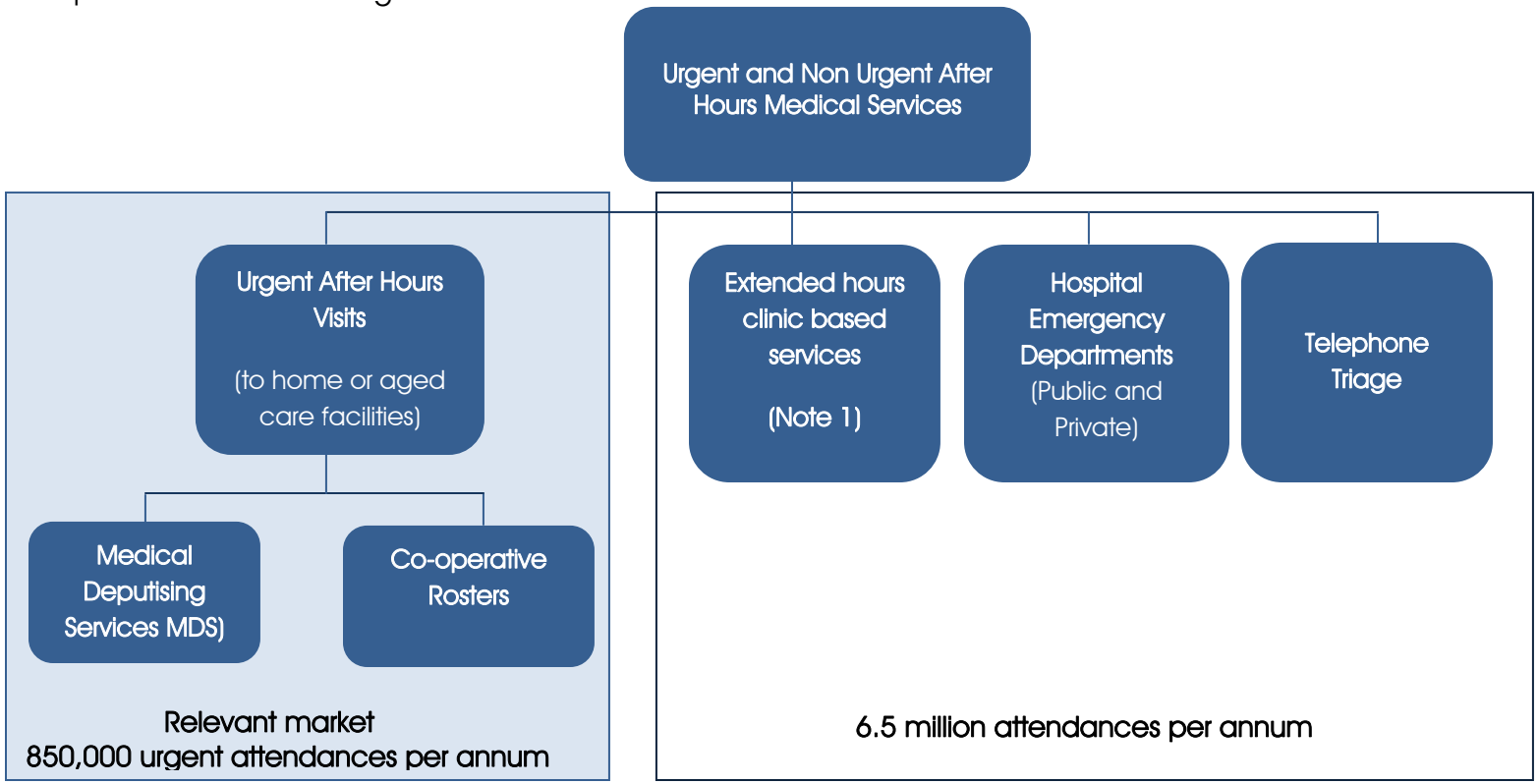
The After Hours Medical Services market comprises a number of different service delivery types:



Attendances per annum (2009)	0.6m	0.25m	5.0m	1.5m	Small
Share of After Hours Services	9%	4%	64%	23%	Small
Definition	• After hours MDS service subscribed to by GPs who prefer not to do after hours visits themselves • May take the legal form of a company or of a cooperative • MDS Role: Increasing • Cooperative role: decreasing	• After hours visits are carried out by a GP from within the practice on a roster basis • Multiple GP practices may cooperate to spread the load and reduce the number of on-call nights per GP • Role: Decreasing (rapidly decreasing or absent in metro Australia)	• Extended hours clinics / After hours clinics • Some 24 hour clinics exist, but majority close at around 9-11pm • Role: Increasing	• Number of after hours non-admitted emergency visits in "Non-urgent" and "Semi-Urgent" triage categories, presenting at public hospitals by state in fiscal year 2007-08 • Excludes private hospitals (~6% of total ED presentations) • Role: Public, increasing • Role: Private, static	• National/ State run nurse triage systems are currently in operation, now being subsumed into a national service ("Healthdirect") • Doctors advice to be added • Provide advice to patients and direct them to the most appropriate form of care • Role: increasing

RELEVANT MARKET DEFINITION – AFTER HOURS HOME VISITS

The relevant market for MDS is the "After hours home visits" market, which includes all GP visits during after hours periods to patient homes and aged care facilities.

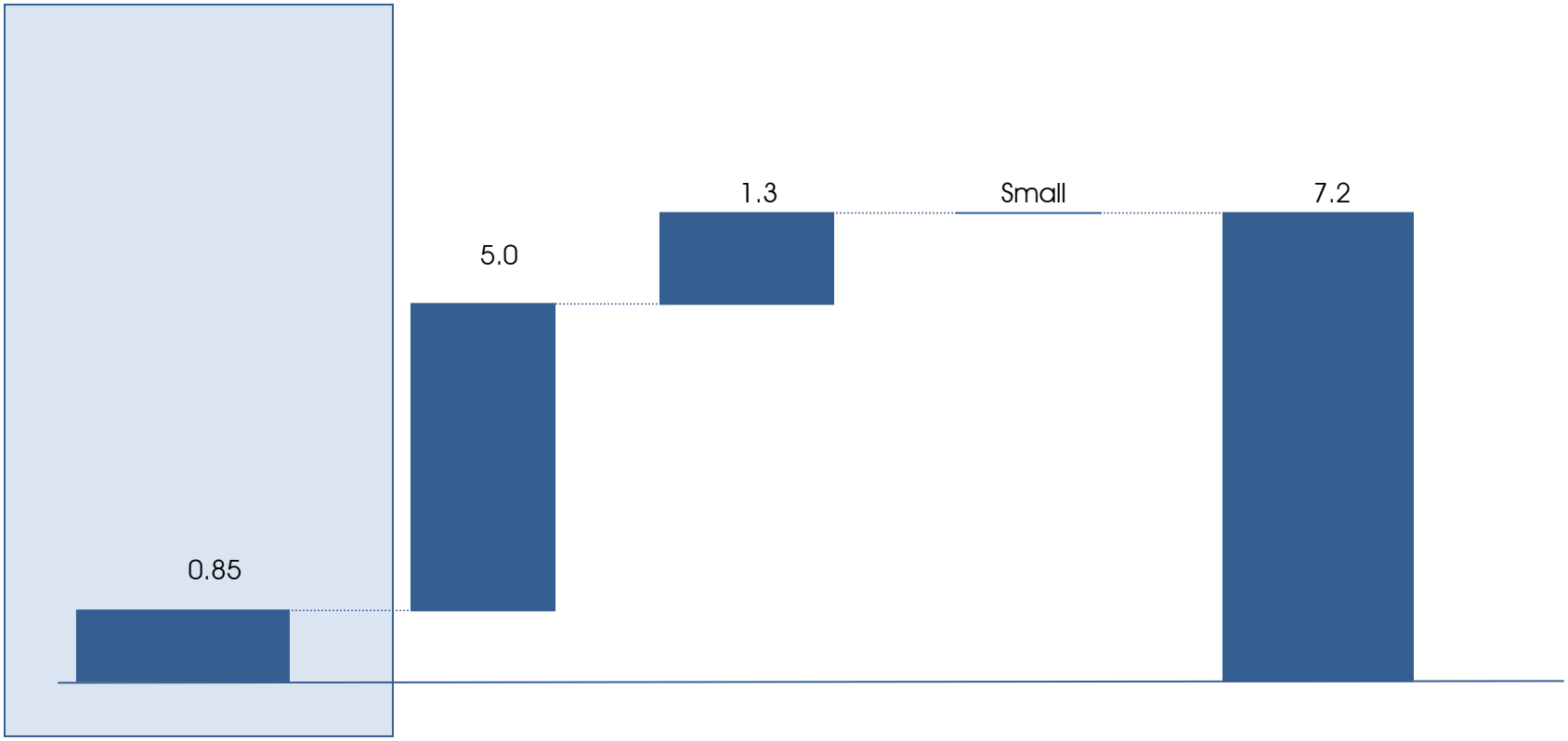


Source: Australian Institute of Health and Welfare, Medicare (MBS code data)

RELEVANT MARKET SIZE

The MDS Cohort represents 13% of the total urgent and non urgent After Hours Medical Services Market in 2009

Total After Hours Medical Services in Australia, M, 2009 (million patients P.A.)

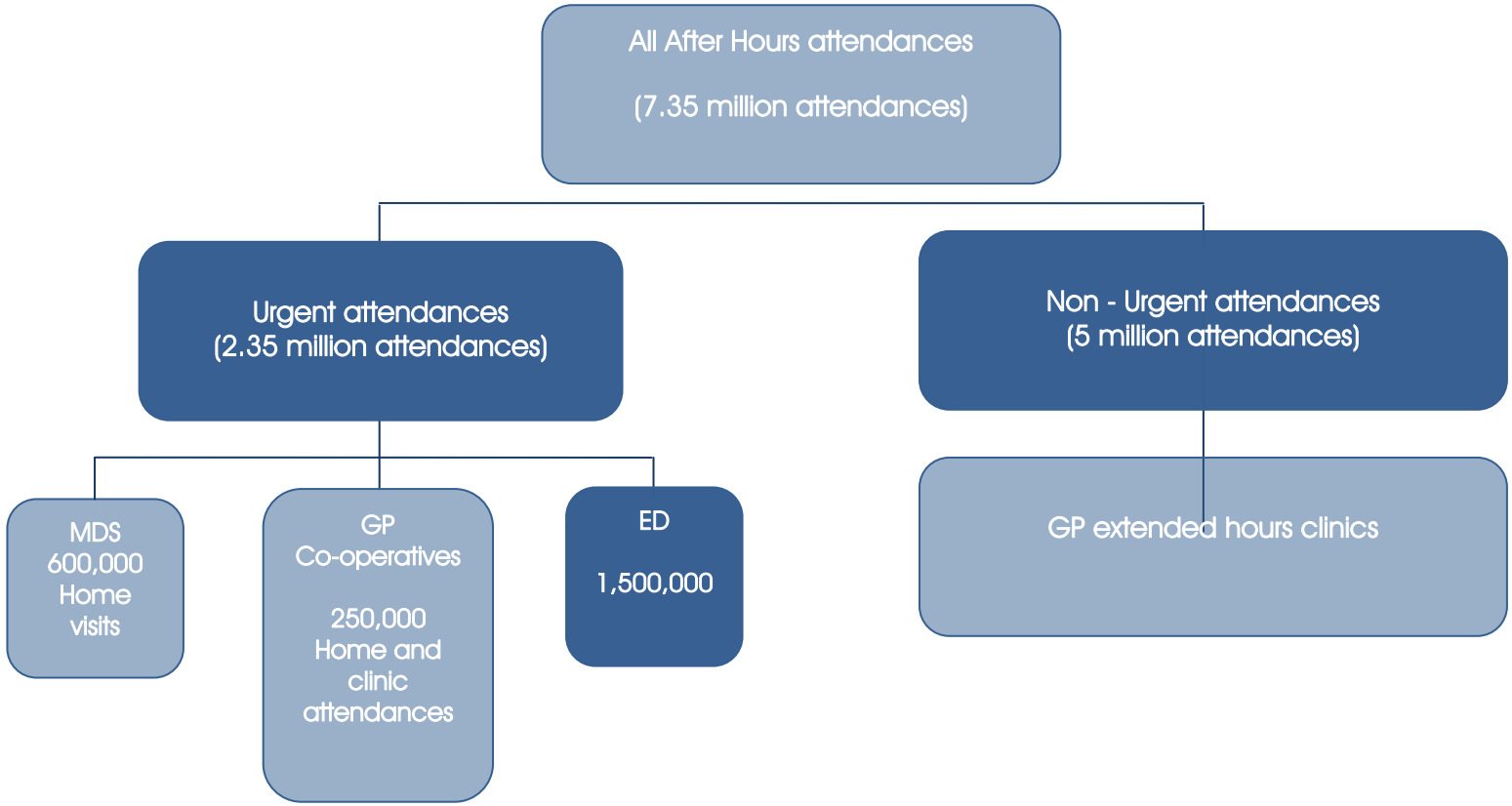


Relevant Market -13% of total

Source: Australian Institute of Health and Welfare, Medicare (MBS code data)

URGENT VS NON-URGENT PATIENT CARE IN AUSTRALIA

MDS represent 26% of all urgent AH attendances in Australia



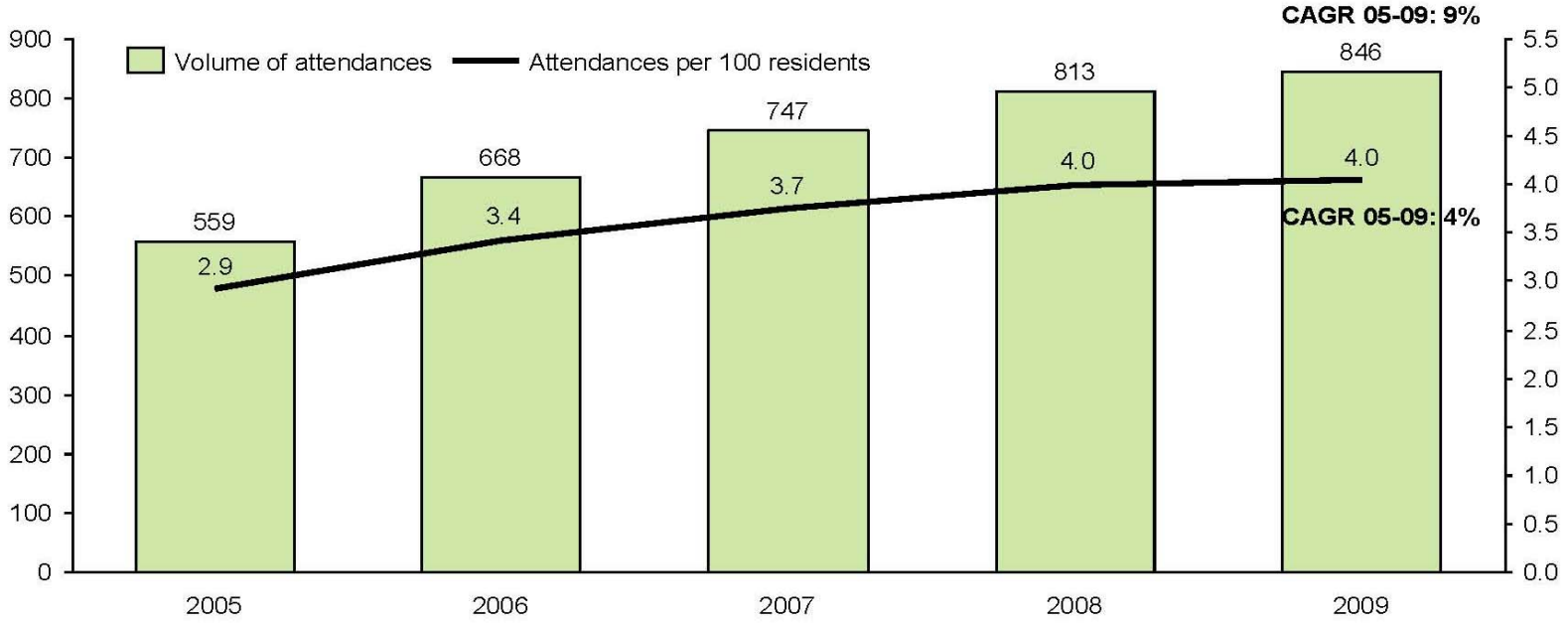
Share of after hours services	**26%**	**11%**	**63%**	
Definition	Essential for ACF frail aged house bound and very young patients.	Generally only present in regional and sub-regional Australia	Growing demand due to transfers from ACF and lack of alternative care symptoms	Generally, no home visiting component. No ACF attendances A.H.

HISTORICAL MARKET MOVEMENTS

The market for urgent and non-urgent AHPMC has shown strong volume growth over the past four years, growing in excess of 10% per annum.

Volume of Total After Hours attendances in Australia vs State, '000, 2005-2009

Total After Hours Visits



CAGR: Compound Annual Growth Rate
Note: Breakdown of MDS versus GP Co-Operative Roster not available over time
Source: Medicare

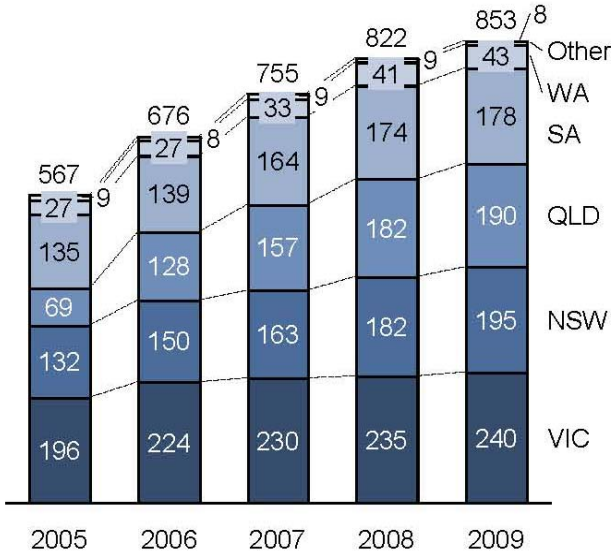
Excludes TAS. ACT. NT

HISTORICAL GROWTH OF AHMPC ATTENDANCES BY STATE

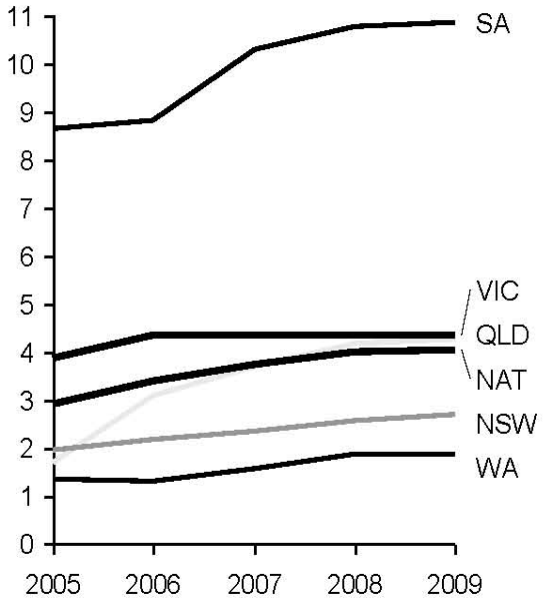
Growth rates have varied by state with Queensland in particular outperforming the rest of the market.

State trends in After Hours Visits

Volume of Visits



Volume per 100 residents



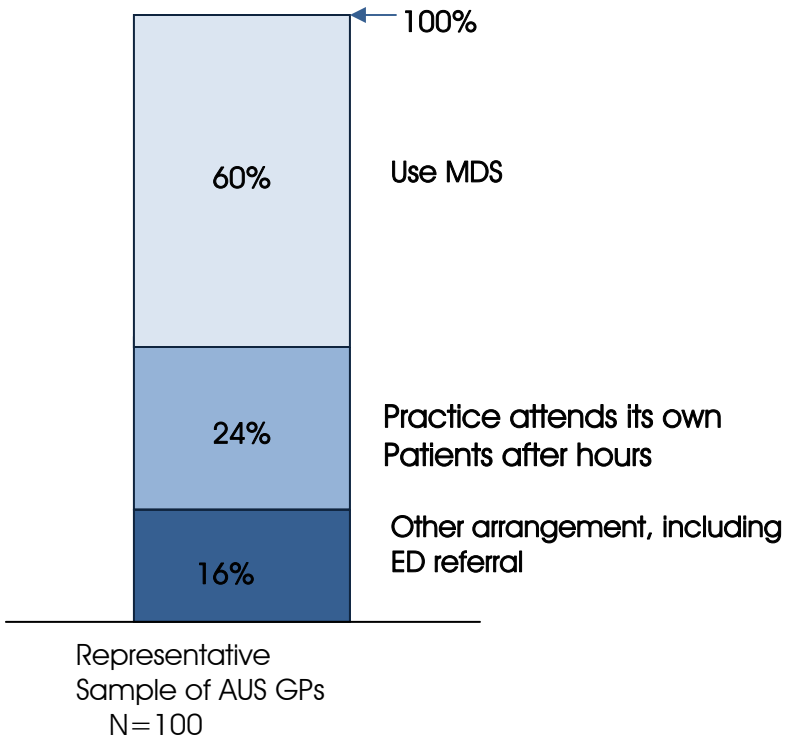
Growth in Queensland market reflects additional call volumes generated by the 13HEALTH triage service, population ageing (ACF) and strong population growth.

Source: Medicare

GP PROPENSITY TO SUBSCRIBE TO MDS

Around 60% of all Australian GPs subscribe to an MDS service. The propensity to subscribe appears to be driven by a number of factors.

Method of After Hours visit provision by Australian GPs, 2009



There are three key factors that appear to influence GP subscription to MDS services:

1a **Regulation** – to become accredited, practices must adhere to R RACGP standards. These standards require practices to provide access to after hours visits in return for a series of financial incentives (PIP) incentives. GPs can provide the service themselves or employ an MDS provider to do it for them. Only unaccredited practices are able to use "Other Arrangements" for after hours care (typically referring patients to a public hospital emergency department).

1b **GP Preferences towards working sociable hours –** Accredited GPs can choose to provide coverage themselves in return for higher PIP incentives, or opt to outsource to an MDS service for a lower set of incentives. NB unaccredited GPs may also subscribe to an MDS service, generally out of a sense of duty to their patients

1c **Availability of a local MDS provider** to meet GP requirements for after hours care – MDS providers do not provide full national coverage, so GPs in regional/rural/remote areas often have no choice but to provide the service themselves

Notes: This includes Co-operative GP groups who provide a deputising service
Source: BEACH (annual survey of 1000 individual GPs)

REGULATION – PRACTICE ACCREDITATION

Demand for MDS provision by GPS is driven by the voluntary practice accreditation process which requires them to ensure access to after hours visits.

General Practice Accreditation

- The means for **upholding general practice standards in Australia is via an accreditation** process, that ensures that best practice standards of care are in place 24/7
- Whilst **accreditation is volountary,** it **gives the practice access to a number of "Practice Incentive Payments"** - essentially a set of grants
- As a result, **68% of practices** in Australia are accredited
- One of the accreditation requirements is that Practices **provide access to after hours home Visits** to their patients
- If the **Practices choose not to provide after hours home visits themselves,** they are required to have a **formal agreement** in place with another organization that provides the access on their behalf – generally an **MDS organisation or co-operative (in regional Australia).**

Source: RACGP website

RACGP Standards for After Hours Visits

There are two accreditation agencies (AGPAL and GPA). In order to be accredited, General Practices must meet the standards developed by the Royal Australian College of General Practitioners (RACGP)

In the 4th edition of standards, the sections that influence provision of after hours visits state that:

- **CRITERION 1.1.3 Home and other visits**
  - Regular patients of our practice **are able to obtain visits** (where such visits are safe and reasonable) **in their home, residential aged care facility, residential care facility or hospital**, both within and **outside normal opening hours**
- **CRITERION 1.1.4 Care outside normal opening hours**
  - Our practice ensures safe and reasonable arrangements for medical care for patients outside our normal opening hours
  - Practices need a formal agreement with the alternate provider

REGULATION – PRACTICE ACCREDITATION INCENTIVES

Accreditation is incentivised by Government through a system of payments that encourage "quality care"; After Hours home visits are a crucial aspect of this (related incentives represent 19% of total incentives paid).

Quality stream	Quality prescribing
	Diabetes incentive
	Cervical screening incentive
	Asthma Incentive
	Indigenous Health Incentive
	eHealth incentive
Capacity stream	Practice nurse incentive
	After Hours incentive
	Teaching incentive
	Aged care process review
Rural support stream	Rural loading
	Procedural GPO payment
	Domestic violence incentive

Outline

- **Aim of PIP After Hours Incentive: encourage general practices to provide access to after hours visits, including home visits for the frail, elderly, ACF residents, the chronically ill and children**
- Payments intended to:
  - Help resource a quality after hours service
  - Compensate practices that make themselves available for longer hours
- After hours: Any time outside 6 pm-8.00am, weekdays, 12 noon Saturdays and all day Sundays and public holidays

Eligibility

- **To be eligible for the PIP After Hours Incentive, the practice must:**
  - Ensure practice patients have access to after hours care by a doctor, 24 hours a day, seven days per week. This is a core strength of the Australian primary care system which all Governments have protected and promoted
  - **Ensure practice patients have access to out of hours visits by a doctor**
  - Ensure formal arrangements are in place with any after hours care providers used

Total PIP incentives paid in 2008-2009 were $300m

After Hours PIP incentives were $58m (19% of total PIP incentives)

REGULATION – PRACTICE ACCREDITATION INCENTIVES

The after hours incentive is offered in three tiers depending on the level of coverage provided by the practice itself – with practices relying solely on MDS receiving the lowest tier of incentives.

After Hours PIP Incentive Payments – Basis of Calculations

- There are three levels (tiers) of after hours payments based on the level of after hours activity provided by the practice
- **Eligible practices are provided with an annual payment of $2 per Standardised Whole Patient Equivalent (SWPE) for each tier (tiers are cumulative)**

Level	Activity required for payment	Annual Payment per SWPE	Annual Award (Per FTE GP)*	Entity ensuring after hours coverage
Tier 1	• The practice must ensure **all practice patients have access to 24-hour care including access to out of hours visits at home, in a residential or aged care facility, and in hospital**, where necessary and appropriate • *Note:* **Where a deputising service is used** to meet this requirement, the deputising service must be **accredited against the relevant Royal Australian College of General Practitioners Standards for General Practices (RACGP), the practice must have a formal arrangement** with the deputising service and the MDS must meet with the NAMDS definition for workforce benefits.	$2.00	$2,000	Use MDS solely
Tier 2	• The practice must **meet the Tier 1 requirements and provide practice patients with after hours coverage themselves**. The number of hours to be provided per week is based on practice size (practices with up to ~two FTE GPs providing 10 hours per week, and larger practices providing 15+ hours) • Note: The participation in a roster system with other GPs can count towards the requirement of Tier 2 providing the practice's patients have access to the after-hours services. This includes the hours the GPs are available to provide after-hours cover as well as hours actually worked e.g. through cooperative arrangements.	+ $2.00	$4,000	Combination MDS plus practice / multi practice GP cooperative
Tier 3	• **The practice GPs provide after hours cover to practice patients 24 hours, seven days a week** • Note: For Tier 3 all after hours cover must be provided by practice GPs. The use of deputising services or any other cooperative arrangement utilising doctors not registered with the practice will not count towards this Tier.	+ $2.00	$6,000	Practice does its own (no MDS)

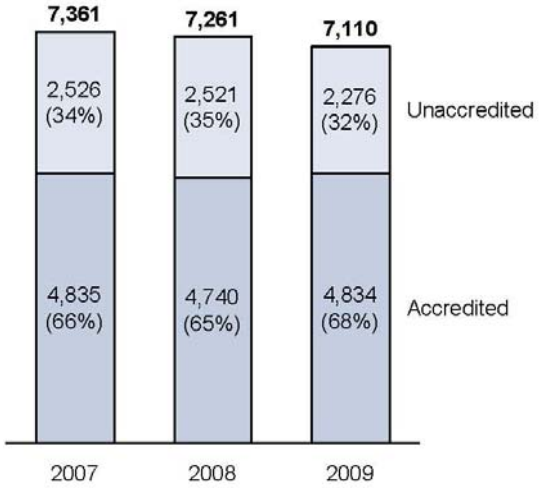
Note: *The average FTE GP sees 1,000 Standardised Whole Patient Equivalent (SWPE) annually

REGULATION – TRENDS IN PRACTICE ACCREDITATION

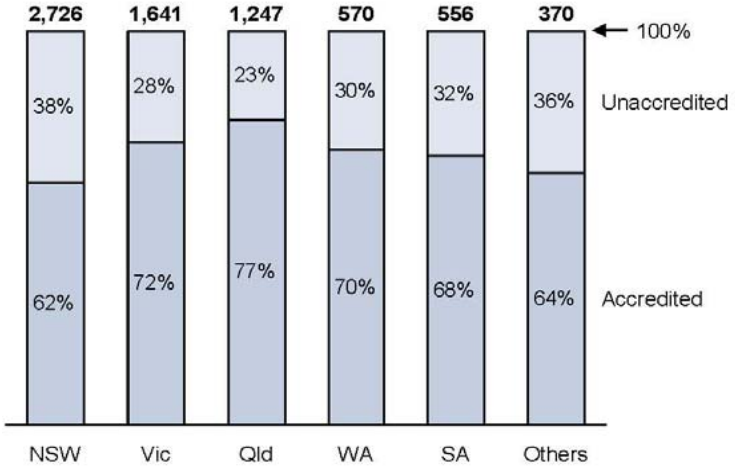
68% of General Practices were accredited by June 2009; the number of accredited practices has been flat over the past 3 years, whilst total accredited practices have declined[1]

GP Practices, Split Accredited versus unaccredited

National, 2009-2009 (fiscal years)



Breakdown by state, 2009 (fiscal year)

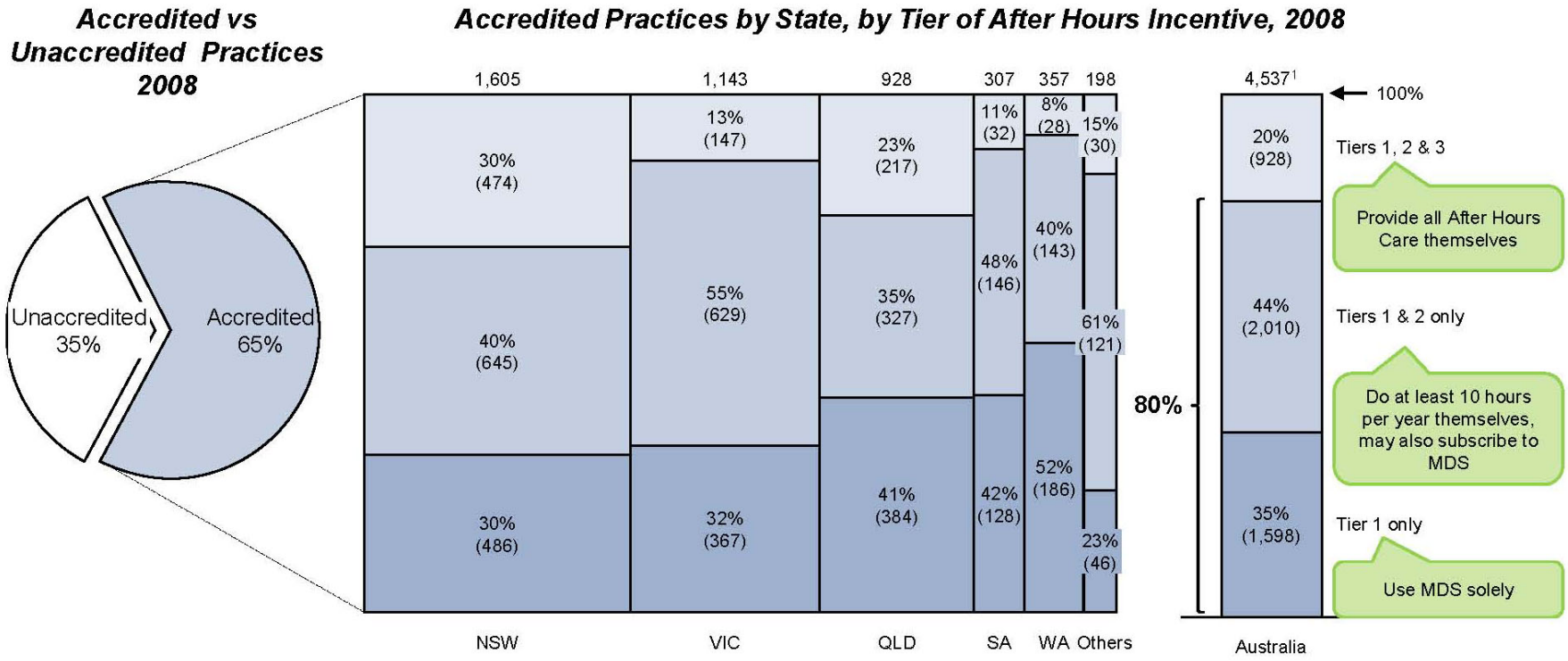


Note: 1) Practice numbers are not reflective of General Practitioners; The number of FTE GPs practising in Australia is increasing at about 2-3% per annum, implying that there is a trend towards larger practices with more GPs
Source: Productivity Commission

REGULATION – AFTER HOURS PIP INCENTIVES

In 2008 the majority (80%) of accredited practices fall into tiers 1 & 2 – these are the tiers that typically use MDS providers

Proportion of Practices by Tier of After Hours Incentive, Quarter to May 2008



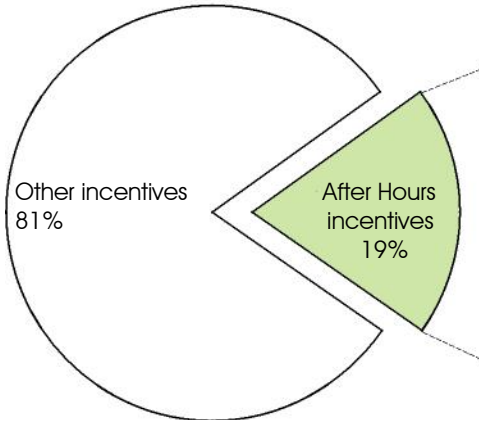
REGULATION – AFTER HOURS PIP INCENTIVES

PIP payments for After Hours incentives totaled $58m in 2009; around $9m related to practices participating solely in tier 1(i.e., using MDS only) or 0.38 cents per head of population

Annual After Horus Pip Incentive by Practice Tier

(figures annualized but based on quarter ending Nov 2009)

Total Annual PIP Payments



Breakdown of After Hours PIP Payments by Practice Tier

Total After Hours payments	Tiers 1,2 &3	Tiers 1 & 2	Tier 1
Total annual practice Incentives payments based on Nov 2009 quarter practice participation	*Practices participating in all three tiers – i.e., those providing 24 hours access themselves*	*Practices participating in tiers 1 & 2 providing at least 10 hours themselves; may also use MDS*	*Outsource 24 hour access to an MDS provider*

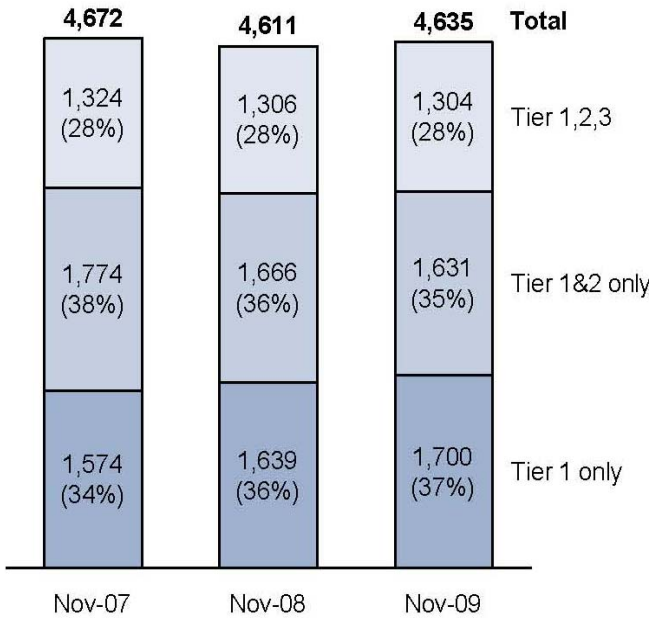
Source: Medicare, Australia

REGULATION – AFTER HOURS PIP INCENTIVES

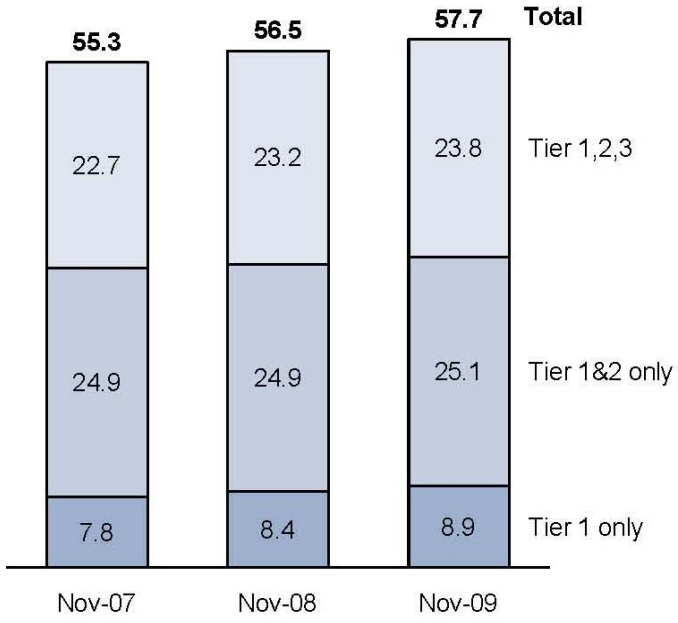
The Proportion of practices claiming Tier 1 only has been increasing over the past 3 years, at the expense of those claiming Tier 2; Tier 3 has remained flat. This reflects a growing reliance on MDS and falling interest by GPs in after hours care.

Proportion of Practices by Tier of After Hours Incentive. Q/E Nov-07 to Q/E Nov-09

Number of practices claiming After Hours incentive
By tier, Quarters ending Nov 2007-2008



Annualised After Hours PIP Incentive payments
Quarters ending Nov 2007-2009



Source: Medicare

GP PERSCPECTIVES ON AFTERHOURS VISITS (A.H. CLINICS AND HOME VISITS)

MDS services receive strong support from GPs as they significantly reduce their need to care for patients after hours.

Key messages

GPs often prefer not to do after hours visits as they are a burden

GPs do sufficiently well attending patients during the day, that they have no need to practice at night as well

Comments

- *"We use the MDS to relieve ourselves from having to do it. It is terrific for us as it really reduces our burden" (GP)*
- *"MDS providers are really useful to us, and the service we receive is of very high quality" (GP)*
- *"We signed up for an MDs provider years ago, long before accreditation enforced it. We just don't want to do the home and ACF visits ourselves" (GP)*
- *"I don't want to be called at all hours of the night. Its a lifestyle decision" (GP)*
- *"MDS services have helped us address burn out issues with GPs" (Govt. Official, DOHA)*

- *"I can make $300 per hour in my practice during the day, there is no point me doing the night shift for my practice patients when I have to field all the calls, and only do about 2 calls a night. If they are far apart this takes me a while, and will give me $160 per call" (GP)*
- *"We can't cope with the business as it is. It is a relief to use an MDS provider because it takes the pressure off us !" (GP)*
- *"We don't even interview prospective GPs when they apply for a position in our practice. We have so much work in the daytime alone that we virtually take them on without meeting them!" (GP)*
- *"I can't recruit GPs to my practice without an MDS. Doctors just aren't interested in AH care" (GP)*
- *"The female GPs ask what the AH arrangements are at the interview. Without and MDS we don't hear from them again" (GP)*

Source: GP Interviews

AVAILABILITY OF SUPPLY

MDS uptake is to a large extent also driven by supply; where a service is available there is generally strong uptake from local GPs

Key message	Comments
Where MDS providers are available and of higher quality, there is typically strong GP subscriber uptake and support	• *"Since the MDS became available virtually all of the local GPs have signed up. Prior to that we ran a co-operative amongst ourselves, it was a nightmare doing the roster. Everyone had an excuse why they couldn't work that night" (GP)* • *"In Australian cities the vast majority of GPs are subscribers to an MDS" (AMA)* • *"In metropolitan areas most GPs use MDS providers to service their after hours visits. The issue is in rural areas where MDS providers aren't available" (Govt. Official, DoHA)* • *It's the ACF patients and frail aged at home patients that are causing the problem, and its growing. MDS are now essential as this demand can't be triaged off or ignored" (GP)*

Source: GP Interviews

CONSUMER USAGE – DEMOGRAPHIC VARIATIONS

The demographic profile of At Home/Aged Care patients varies significantly by state. However, this the cohort of patients where demand is dramatically increasing and where substitution is impossible (other than ambulance evacuation to public EDs).

Total After Hours At Home/Aged Care attendances by Age Group, 2009

Key under-servicing pressures

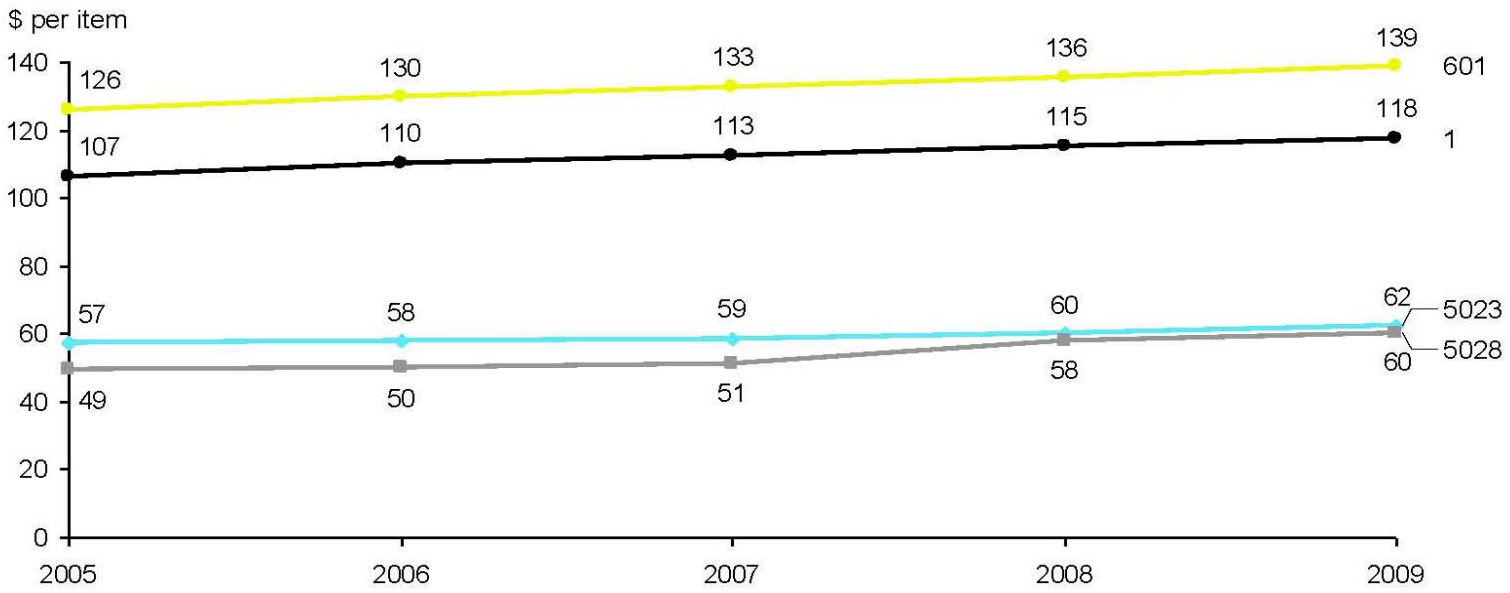
All NSW metro	0-14 demographic in Victoria	75+ demographic in Queensland	All WA	75+ demographic	Very young and very old

Source: Medicare (MBS Code data)

AVERAGE REBATES OVER TIME

The average rebate for after hours visits has increased broadly in line with inflation over the past few years.

MBS Average Claim for after hours at Home or Aged Care Facility visits, A$, 2005 to 2009



Source: Medicare

GPAH GRANTS

"GPAH" grants are available to MDS providers (although uptake has been low); each grant has a minimal value - $100,000 over two years

Outline

- A total of **$76.3 million in Commonwealth Government funding over the four years from 2008-09 until 2011-12** is available under the "General Practice After Hours" Program (GPAH)
- Aim is to support the viability of after hours GP services
- Programme runs for four years, due to end in 2011/12
- Replaces two previous four year grant programmes with similar parameters
- Up to 100 grants available each year of $100,000 each to assist after hours GP services with their operating costs

Selection Criteria

- Community need (35%)
- Access to a sufficient and appropriately-qualified GP workforce (35%)
- Service delivery model and quality of after hours GP service (15%)

- An appropriate and well-defined budget for the proposed service delivery model (15%)

Eligible Services Delivery Models

- Service delivery models utilising GP locums
- **Medical deputising services**
- Clinic-based GP services
- Home visit services, including visits to aged care facilities

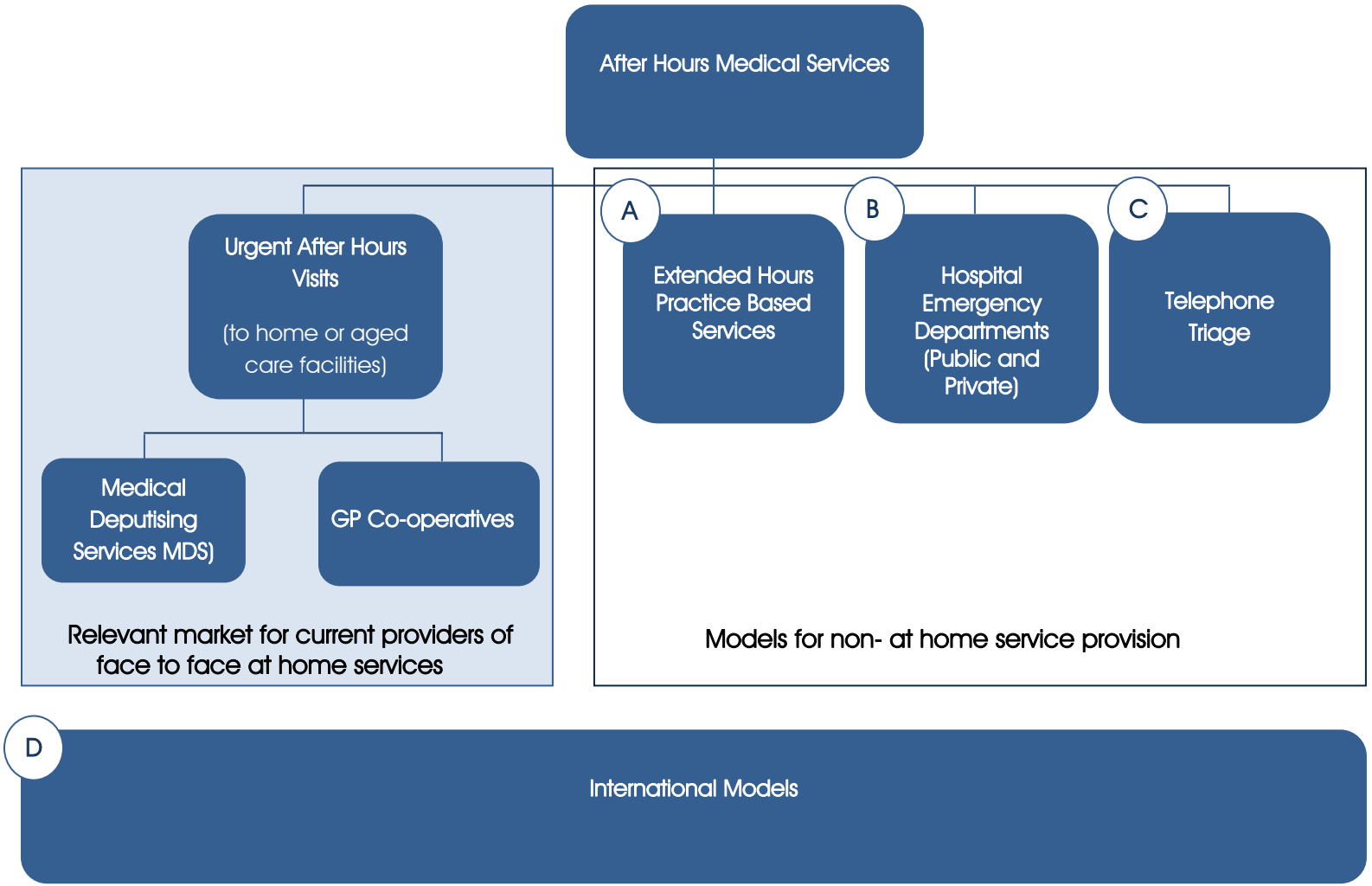
Eligible Expenditures

- GP on-call allowances
- **The cost of incentives for GPs to participate on after-hours rosters**
- Medical consumables
- Advertising costs
- **Costs of support staff specifically for the after hours service Recruitment costs**
- Training (must be after hours-related)

Source: Government Department of Health and Ageing

ALTERNATIVE AFTER HOURS MODELS - OVERVIEW

The clinic based After Hours Medical Services market comprises a number of different models that complete to some degree with urgent At Home / Aged Care attendances



EXECUTIVE SUMMARY – ALTERNATIVE AFTER HOURS MODELS

Alternative after hours models (such as nurse/doctor triage, extended hours clinics & GP super clinics) complement MDS services as opposed to detracting from them

An MDS style model is the most efficient way of servicing the GP after hours visits market, and for optimal efficiency this would be coupled with a GP telephone triage service.

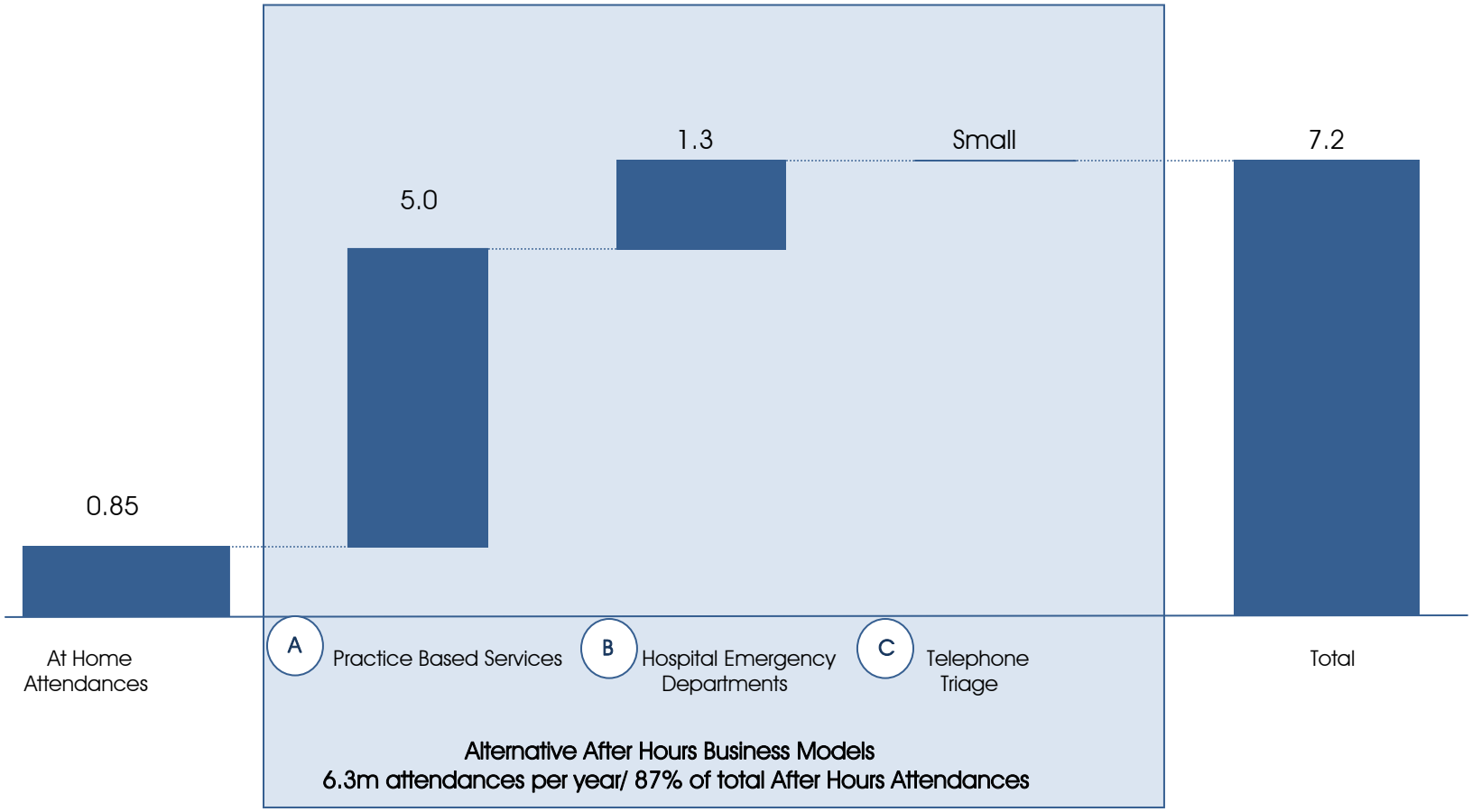
- The alternative after hours models represent a minimal threat to after hours visits. This is because MDS are dominant in the essential home visiting and urgent care of ACF, the house bound frail aged and the very young.
  - After hours clinics are (at face value) the cheapest method of treating after hours patients (based on comparison of rebates). However they generally require additional grants and funding to be sustainable. They also serve a different set of consumer needs and cannot replace after hours face-to-face home and ACF visits.
  - Super-Clinics are touted to provide access to after hours care, but the economics of provision will likely mirror extended after hours clinics and be unsustainable in the absence of government support. Super Clinics are intended to "fill gaps" in service requirements as opposed to replacing systems that are already functioning well – hence they will not supersede established MDS providers.
  - Hospitals are an expensive form of Primary Medical Care and government focus is on reducing the time spent treating such patients. Hospital treatment of ACF residents via ambulance is prohibitively expensive and unnecessarily stressful to the resident and family.
  - The net effect of telephone triage services tends to be a diversion away from EDs towards self-care of non urgent attendances, with a neutral effect on GP services. All MDS report that the national "Healthdirect" service has helped MDS grow by promoting increasing consumer awareness of the service and on referrals of urgent home visit patients. This is very evident Queensland after 4 years of 13HEALTH.

- A review of the International market provides some insights as to risks and opportunities for Australia
  - In most countries reviewed, a system for GP after hours home visits exist in some form driven by government regulation and funding. To all intents and purposes these models are similar to Australian MDS models.
  - To optimise efficiency, these services often operate in conjunction with GP/Nurse telephone triage systems.
  - Despite the presence of these functions, there is strong evidence that GP home visits per capita are very low in Australia. This reflects international patterns of home care illness management in lieu of Australia's very high rates of hospitalisation.
  - Data from France indicates that after hours visits are the cheapest form of after hours care available
  - The UK is the only market reviewed with a strong presence of MDS providers in the same forma as Australia. These have drastically reduced the pressure on UK GPs (supply of GPs and Locums in the UK is a real challenge)
  - In Canada, GP provision of After Hours services is not enshrined by regulation, and as a result, MDS style practices/GP co-operatives do not appear to have developed. Canada used public hospital EDs as the service provision for after hours.

ALTERNATIVE AFTER HOURS MODELS – MARKET SIZE

"Practice Based Services" - i.e., extended hours medical practices comprise the majority of alternative after hours encounters

Total After Hours Medical Service Encounters in Australia, M, 2009 (Millions)

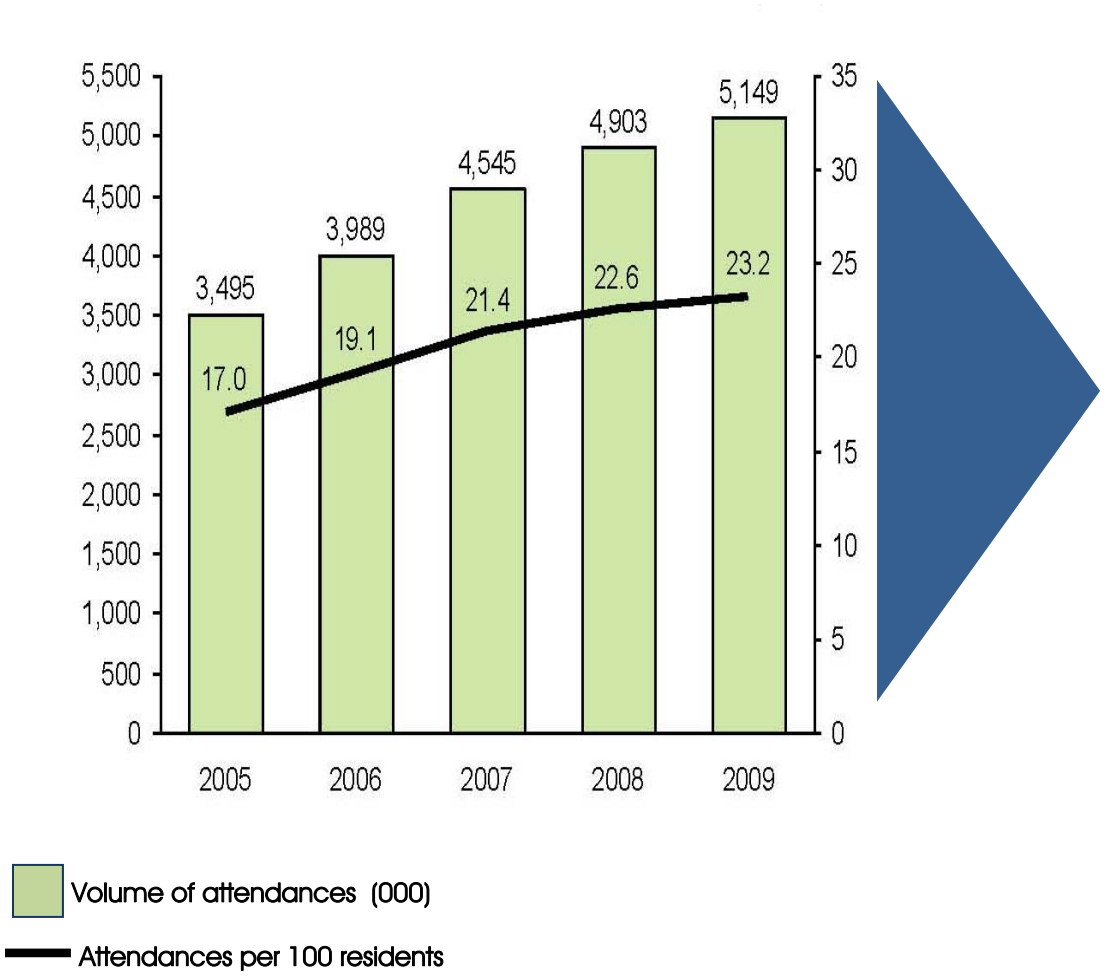


Notes: At home attendances includes Co-operative GP groups, MDS and GPs who attend patients after hours and who used the after hours items
Source: MBS, Australian Institute of Health and Welfare, AGPSCC BEACH Study

EXTENDED HOURS PRACTICE BASED SERVICES – MARKET SIZE AND GROWTH

GP extended hours after hours services have been growing strongly since 2005 (CAGR +9% P.A.)

Total After Hours Practice visits, 2005 -2009



Overview

After hours practice based services fall into two broad categories:

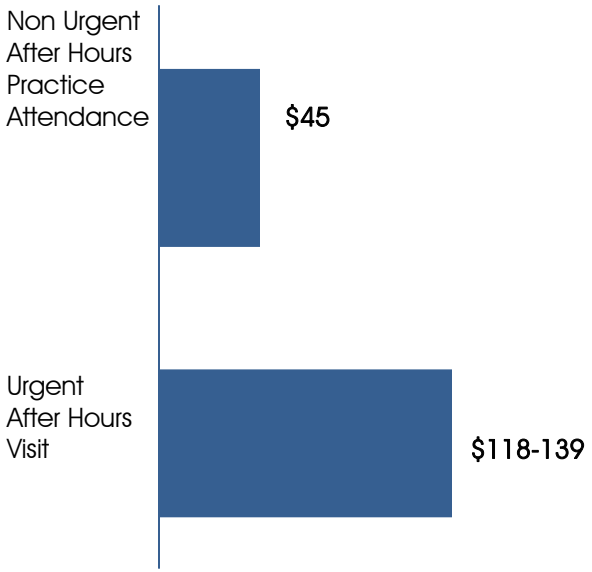
1. Normal GP surgeries with extended opening hours – (rarely 24 hours), but generally until around 10pm on a weekday, on a Saturday afternoon/Sunday.

2. Specific after hours clinics that only open during after hours periods; these are often "co-located" with an emergency department so that non-urgent ED patients can be diverted to the clinic to reduce hospital burdens. These clinics are generally funded via to GPAH and are normally uneconomic without external funding support.

PRACTICE BASED SERVICES – MEDICARE REBATES

Rebates for after hours clinic appointments are lower than for urgent after hours home visits.

Medicare Rebates, After Hours Practice Based versus After Hours Visits ($A)



Definition

Medicare rebate for item number 5020 (most frequently used item code for After Hours clinic attendances, representing 88% of AH clinic visits).

Medicare rebate for item number 1 (597) and 601 (599), [most frequently used item codes for after hours visits, representing 71% of visits]

Total Cost

5.1m patient visits in 2009 at a *Total cost of $241m (average $47 per visit)*

0.9m patient treated in 2009 *Total cost of $91m (average $106 per visit)*

Source: Productivity Commission (2007-08 National Hospital Cost Data Collection), Medicare

PRACTICE BASED SERVICES – ECONOMICS

Dedicated After hours clinics require a high level of support through grants and other funding, without which many would be unsustainable

Dedicated after hours clinics are universally grant funded

- The GPAH grants (refer to next section for detail) go almost exclusively to dedicated after hours clinics
- There are currently 300 GPAH grants in operation
- Grants are for $100,000 per annum – current cost is $15m per annum plus grant administration costs

Low patient volumes require GP wages to be subsidized to encourage workforce participation

- Patient volumes are extremely low, particularly during weekday evenings when they receive ~2 visits per hour to the clinics
- GP service fees equate to just $90 per hour (gross) in rebates, which is significantly less than the rebates earned during the daytime
- As such, GP salaries in dedicated AH clinics are typically subsidised to attract doctors

Heavier overhead structure than an after hours visit model

- After Hours clinics have a heavy (and ongoing) overhead structure given the volume low of patients they see, including:
  - Receptionist during opening hours working with penalty rates
  - "Operations Manager" – running day to day admin, rostering etc
  - General building maintenance costs
  - Complimentary Pharmacy and related equipment and supplies.

Anecdotal Advices

- *"GP co-located clinics are present in 6 hospitals in Victoria. They have been struggling to become financially viable, particularly out in the suburbs where it is difficult to recruit doctors" (GP)*
- *"Clinics were supposed to be self-funding after two years – but this hasn't worked. After a while they started to accept that it was sensible to close at 10pm (as the ED is less busy by this point anyway). The 24 hour concept definitely didn't work" (former advisor to the Commonwealth on After Hours care provision)*
- *"After hours clinics are [...] extremely costly to run as volumes are low [...] and they can't charge enough to cover costs (service fees relatively very low)*
  (MDS Industry participant)
- *"In France, AH clinics in rural areas have run into severe financial difficulties (due to the cost of construction, the maintenance, and the operations of the clinic). The threat of the funding coming to an end constantly remains" (French GP)*

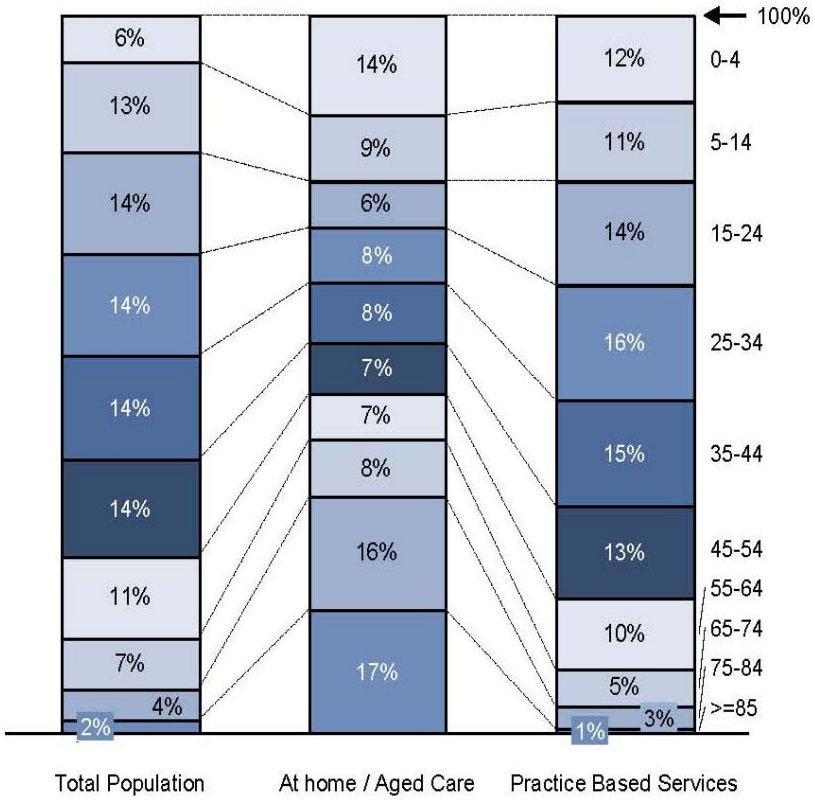
Source: "A Sustainable Model for GP After Hours Care " DOHA June 2006, Interviews

AFTER HOURS AND EXTENDED HOURS PRACTICE BASED SERVICES – PATIENT NEEDS

For the most part extended hours practices fulfill a different set of needs to after hours home visits

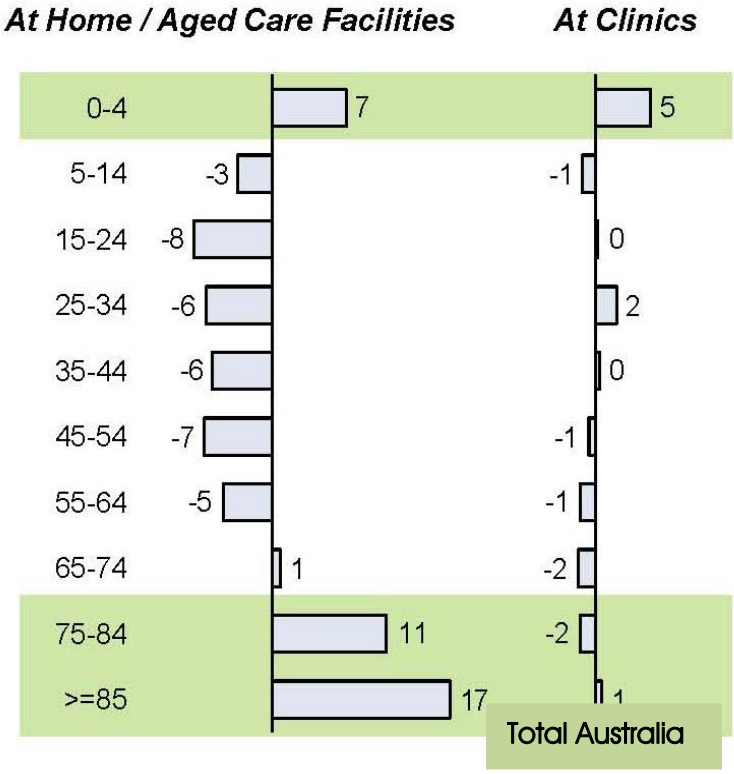
Variations in Demographic Profile

(Population vs After Hours Visit Patients vs After Hours Practice Based Service Patients)



Over/Under –indexing by Demographic

(Percentage point difference between population profile and patient care modality profile)



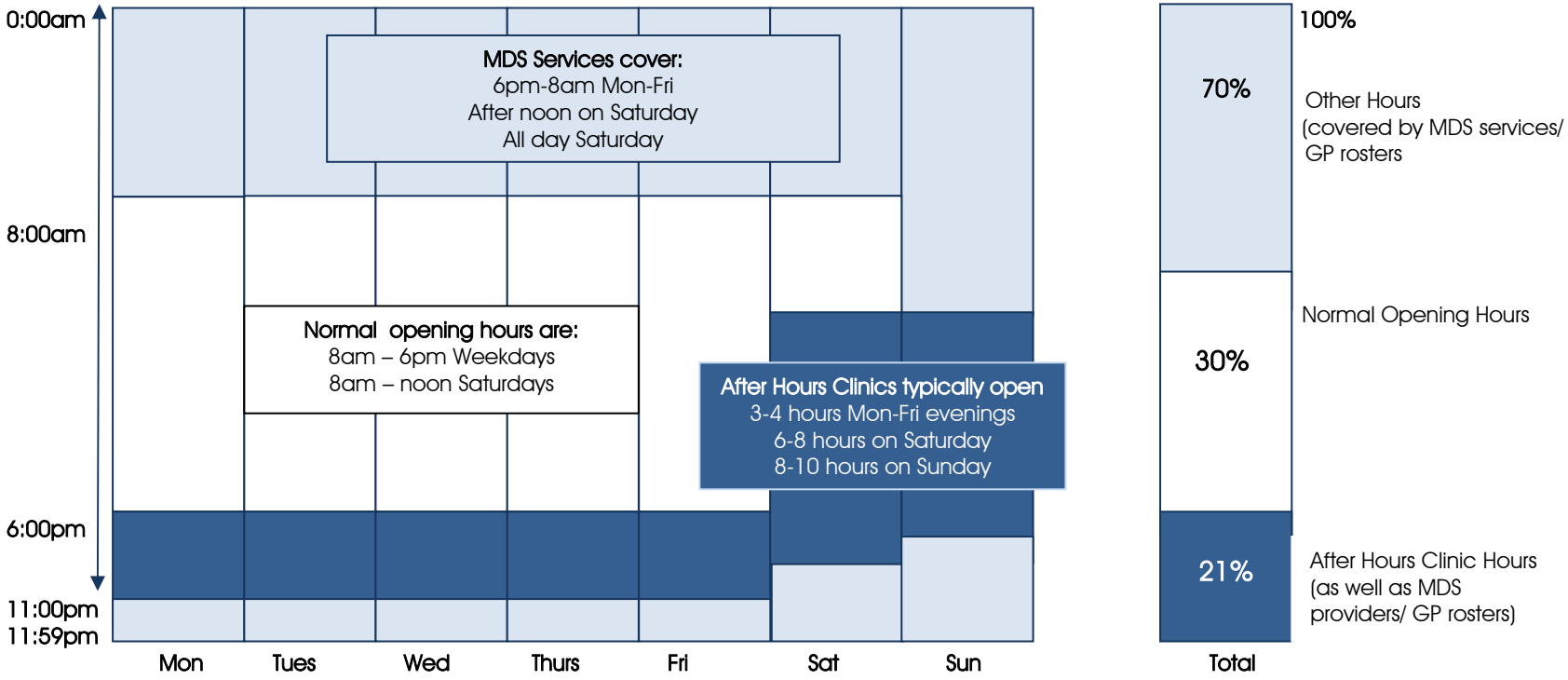
Note 1: MDS service the very young and very old who are house-bound. Extended hours clinics service patients some of whom would otherwise attend a day-time general practice

Note 2: Nurse/ Doctor triage are best suited to reduce AH clinic and selected ED attendances

ALL AFTER HOURS PROVIDERS SERVICES –HOURS OF ACCESSABILITY

Extended hours clinics do not open throughout the after hours period, focusing instead on the more "sociable and convenient" times. Only MDS and ED cover all hours.

Typical weekly coverage by type of service, by Day



PRACTICE BASED SERVICES – SUPER CLINICS

In their current form, super clinics reinforce the role of MDS.

Overview of objectives

- The Australian Government has now committed $275m over five years, to establish 36 "Super-Clinics" across Australia, intended to be operational by 2011. There are currently three clinics in operation
- No specific blueprint, but the objective is to provide a wide range of services from one base, that will fill gaps in service provision:
- — *"There is no hard and fast rules on what a superclinic may or may not provide. It really depends on local area requirements. The intention is to fill the gaps, not over-ride the current services in the area" (Govt. Official, DoHA)*

Provision of After Hours Care

- Provision of After Hours care is not stipulated in Super clinic contracts

— *"Part of the brief is to provide after hours care to areas where this service is lacking. If an MDS or GP Cooperative is already fulfilling this requirement, super clinics will not seek to over-ride them" (Govt. Official, DoHA)*

— *"The centres will offer after-hours access to general practitioners, specialists, mental health services, chronic disease management and allied health practitioners, and training for medical students and trainee specialists" (The Australian, February 2010)*

— *"Gladstone Hospital isn't coping because we're finding significant delays up there so one of the main purposes of the GP super clinic is to provide a full-time after-hours service" (The Observer, 25 January 2010)*

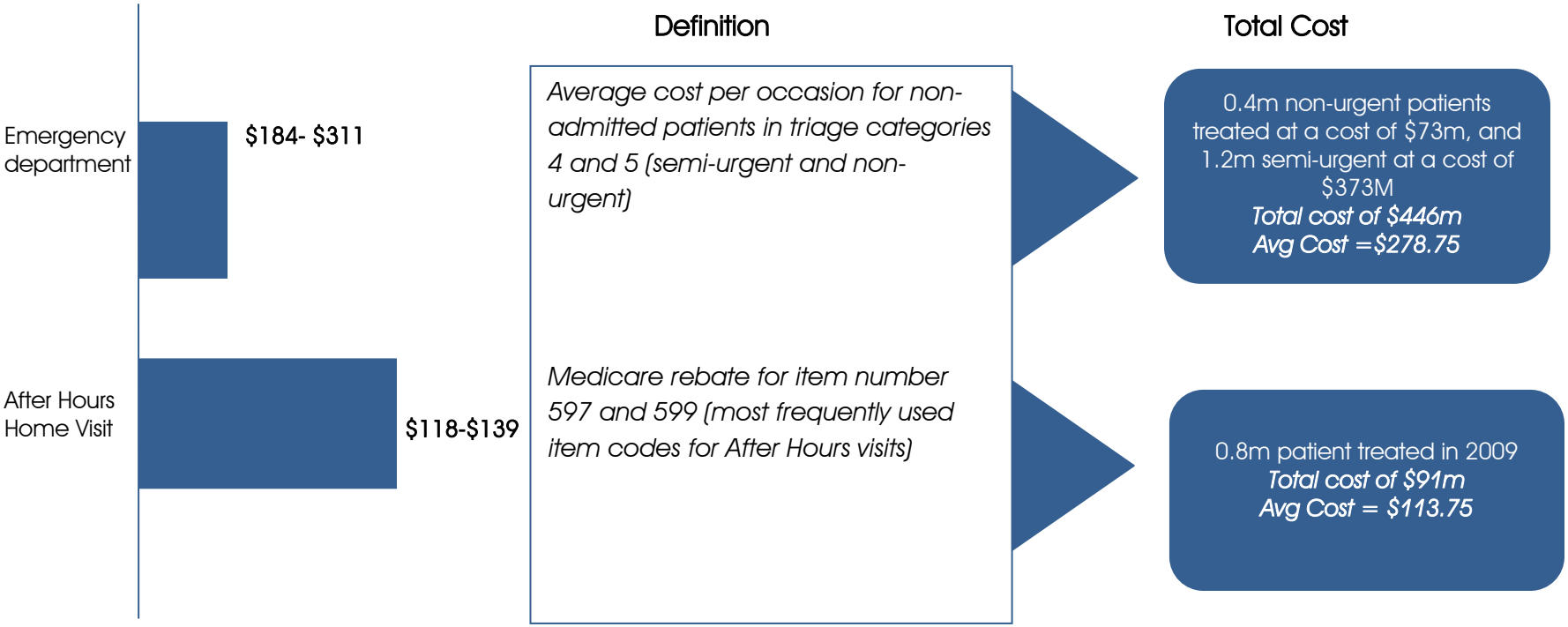
- After Hours home visits have not been mentioned as a feature, and are not on offer by the three Super-clinics currently in operation; one of the clinics (Strathpine) actually subscribes to an MDS service for all of its after hours visit requirements (Pers.Con.)

Extended hours are likely to be a key feature of the Super-clinics, however the experiences of normal After Hours clinics would imply that 24 hour coverage will be unsustainable. On call GPs for after hours house calls do not appear to be a feature of the offering at this stage. DoHA advises that they will not seek to override existing practices that are already functioning effectively.

HOSPITALS –ECONOMICS OF AH PRIMARY MEDICAL CARE PATIENTS

The cost to the governments is significantly higher when patients are treated in the ED versus via an after hours visit from a GP

Average cost per occasion of service



The average cost of treating a non-urgent case in an Emergency Department is higher than the cost of an after hours attendance (excluding any ambulance costs) – and contributes significantly to waiting list buildups; as such it doesnot represent a preferable alternative for Australia or other government(s)

INTERNATIONAL AFTER HOURS MODELS – KEY FINDINGS

A review of international after hours models provides support for the sustainability of MDS providers over the longer term

A centralised MDS style service appears to be the optimal way of servicing after hours visits (especially for the growing ACF market

- In all markets where after hours GP visits are a fundamental element to the Primary health care service portfolio, a centralised, MDS style service is the care model of choice

The model can be further optimised through the use of a complementary Nurse/GP triage system

- To optimise the efficiency of the model, GP triage systems are often used, with the main benefits being that:
  - More reliable diagnoses, resulting in a more efficient triage system

Evidence from France suggests that after hours visits are the most cost effective service delivery model for the after hours market

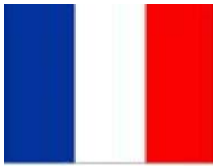
- Evidence from France where this model is in operation, suggests that the rate of After Hours visits is still higher than Australia and therefore Australia is still under-servicing the market by on–referrals to public hospital EDs.
- "SOS Medecin", the centralised model operating in metropolitan areas of France, publishes data that compares the costs of each type of After Hours intervention:
  - Home visits are the most cost effective way of treating patients after hours (€60), followed by after hours clinic (€71), hospital emergency departments (€104)

The UK is the only market with comparative Australian MDS style operations; there is a clear demand for the service, but quality issues have been encountered

- Until 2004, UK GPs were required to cover After Hours periods themselves; as of then they were given the opportunity to "opt" out and hand responsibility over to one of 150+ state run "Primary Care Trusts" to manage service provision. 90% of UK GPs chose to opt out causing widespread collapse of after hours service availability.
- This resulted in a surge of demand for MDS providers to fill the subsequent gap in service provision. A shortage of GPs in the UK led to MDS providers using overseas trained doctors that were not adequately trained, and a number of quality issues ensued (in a couple of instances, malpractice resulting in patient deaths) – as a result UK MDS provision has been tarnished. Doctor quality is not regarded as an issue in Australia due to DGP training programmes et al.

INTERNATIONAL AFTER HOURS MODELS

International models provide some insight into the potential evolution of the Australian Market (1 of 2)

Country	Summary After hours Models	Implication for Australia
FRANCE 	Afterhours model is in the process of changing. Practice based model is being phased out in favour of a nationally managed model structured in two parts – a ***Metropolitan and a Rural*** one with the same core integrated system with common features • The new model comprises a ***telephone based GP triage system*** that directs patients to the most appropriate form of care. • The system directs patient to either an after hours clinic if they have transport, a home visit if they are immobile or ACF patient, A&E or instructs them to wait until next morning. ***Of each of the options, a home visit is the cheapest*** • ***Per capita usage of the new model is thought to be around 0.03 for after hours visits*** (+0.02 per capita for Daytime home visits services); Total after hours visits in the market would be higher than this as the model is not yet fully operational and many after hours visits are still being performed by GPs	• ***Home visits are the most cost effective way of servicing the after hours period*** • From a National Healthcare System perspective there may be ***efficiency gains to be had through use of a GP triage service*** which can direct patients to the most efficient form of treatment • Despite the existence of this triage system, total per capita After Hour call-outs in France are still higher than in Australia, implying ***likely continued growth for the Australian MDS market***
NETHERLANDS 	Afterhours care is covered by compulsory universal health insurance Prior to 2000 , majority of after-hours care supplied by practice-based services, predominantly physicians collaborating over multiple practices • Practice based services have been phased out since 2003, with ***after-hours care now being provided by 120 MDS nationwide***	• In common with other countries, pressure on GPs to provide After Hours services became too much, and a national solution was sought • National solution relies on a universal ***MDS model***

INTERNATIONAL AFTER HOURS MODELS

International models provide some insight into the potential evolution of the Australian Market (2 of 2)

Country	Summary Afterhours Models	Implication for Australia
UK 	• Afterhours services primarily managed at a "Primary Care Trust" level (152 in the UK), with responsibility for a given geographical area • Each PCT chooses to organise the system differently, ***with the more "advanced" providing an integrated service*** (very similar to France but generally with a nurse operated triage system, with after hours clinics and home visits), and ***others operating like Australia with an MDS service put out to tender to private companies that can cover accessible services the the whole PCT***. NB those with an integrated system generally also employ an MDS service for the home visit element • There have been a couple of high profile cases of Doctor malpractice through MDS services and the practice is under review; Due to poor care quality the Government wants to hand responsibility back to GPs. Key election issue and likely outcome unclear at present • Per capita usage of home visits (including daytime), is much lower than in Australia (0.12 versus 0.19). However ED attendance is much higher than in Australia UK has a severe shortage of GPs which contributes to these low rates (~65 FTE 100,000 versus 88 FTE in Australia)	• ***Only other market with a strong <u>private</u> MDS provider presence*** • Highlights issue that ***maintaining Doctor standards is of paramount importance*** to prevent a backlash against the poor service quality from consumers and government Clear that ***from a GP perspective MDS services are a great proposition*** as, like in Australia, they allow them to opt out of night shifts unless they choose to reap the rewards of high salaries in return for anti-social hours.
CANADA 	• Universal healthcare system in operation in Canada, organised regionally (13 different regions) • There are no legal requirement for GPs to work after hours, although there is an incremental fee structure to incentivise them • After hours home visits are not a prevailing option, and patients are usually encouraged to go to late opening clinics, or the ER • Hospitals are over-run, with long wait times	Limited government intervention into provision of after hours care, despite the fact that this could alleviate issues with over-crowding in hospital emergency rooms and very poor management of house-bound ACF residents

SUMMARY OF LEADING OPINIONS (1 OF 3)

Government and Opposition feedback confirms that government support for After Hours GP care is likely to continue for the foreseeable future

Government and Opposition advice indicates that government support for at Home / Aged Care attendances (such as MDS providers) will continue, and most likely grow, as Australia ages.

- *"Visits to home and aged care facilities and clearly an important issue to address in order to provide access for patients that can't attend a clinic... We only expect demand for these types of services to increase not decrease as the population gets older. This area is under-serviced as it is, so government support in this area is only ever going to increase" (Pers. Con. Roxon 2009)*
- *"MDS services clearly provide a great level of support to GPs in metropolitan areas as the level of uptake is very high in these regions. They have been around for many years and provide a services that is widely used, that fills a gap in demand. Demand for services is even higher than supply" (Pers. Con. Abbott 2007)*

Industry leaders are equally expecting continued government support in this area

- *PIP incentives for After Hours has been in place for a while, and I would expect it to continue. It would be foolhardy of government to remove it as provision of after hours service as it is a real vote winner" (GP)*
- *"Governments unlikely to reduce support for After Hours care, if anything they will only increase it as it's such a tricky issue" (GP)*
- *On MDS provision: "Initially there was push back from government to provide incentives for a profit making company, but then it was argued that all GP practices pursue profits anyway!" (Medical Advisor to the Department of Health on rebate provision for After Hours services in late 1990s)*
- *"There will always be a place for MDS services, even when afterhours clinics work more effectively, as some patients (e.g. the aged) will require home visits" (GP Representative, AMA)*
- *On his view on MDS: "Government is focused on improving efficiency and waiting times in emergency departments. Government is likely to continue to support services that provide an alternative for patients, what other solutions exist other than face-to-face after hours care in the home by an MDS?" (GP)*

SUMMARY OF LEADING OPINIONS (2 OF 3)

After Hours GP care and MDS services align well with government policy objectives, and costs are a small portion of total spend on GP services

Alternative models of after hours care are complimentary, as opposed to substitutes, for MDS Services

- Extended hours clinics meet a different consumer need to after hours visits
- GP super clinic initiative aims to fill gaps in requirements as opposed to replacing models that are in place and working well, so these will not supersede MDS services in established areas
- Nurse telephone triage is a reality. MDS report a net positive impact on after hours face-to-face demand, especially if the triage service is encouraged to avoid an expensive ED referral
- 0nly MDS models integrated with a Nurse triage appear to offer a more efficient way of dealing with the After Hours attendance market. The impact would not necessarily be major, as in countries where it is in operation there is strong evidence to suggest that Home/Aged Care visits per capita are significantly higher than in Australia

No major quality issues with Australian MDS providers have emerged

- *MDS Medical Directors report that "There have not been any major doctor quality issues with MDS providers. Isolated cases have been raised, but nothing alarming. It is a given that locum medical practitioners are unlikely to be as experienced as GPs within a practice, but the nature of the role does not require as high a level of expertise anyway" MDS Medical Director*
- No Australian MDS has reported to have experienced any major quality issues according to NAMDS
- Interviews with GP subscribers have not raised any quality issues -although some are dissatisfied with patient waiting times

SUMMARY OF LEADING OPINIONS (3 OF 3)

After Hours GP care and MDS services align well with government policy objectives, and costs are a small portion of total spend on GP services

Any change in regulation that reduced reliance on MDS services would divert patients back to hospital ED which would cost government more and increase waiting lists

MDS provision of after hours care contributes to government's portfolio outcomes

Costs associated with administering after hours visits via MDS are low in the broader GP cost context

- *Federal and State governments are actively focusing on reducing the number of non-urgent emergency department attendances. A recent briefing document to the NSW Cabinet revealed that 40% of Emergency Department visits in NSW last year were of a non-urgent nature that could have been treated by a GP. NSW has the lowest usage of AHPMC items in Australia. The document called for reforms to primary healthcare payments that would encourage people to visit after hours doctors rather than casualty*
- *Prime Minister Rudd is actively trying to reduce ED waiting lists, for example pledging $500m earlier this month to EDs to encourage them to treat/refer/admit within 4 hours; After Hours GP services play well to this objective*
- *Outcome 4 Aged Care "Access to quality and affordable aged care and carer support services for older people"*
- *Outcome 5 Primary Care "Australians have access to high quality, well-integrated and cost effective primary care*
- *Of the $6 billion spent on GP services in 2008/9 (including PIP, DVA, GPI and Medicare) only around $140 million (2%) related to After Hours At Home/Aged Care attendances. This represents a total cost per head of population of $6.36, compared to a total cost per head of population for all primary care of $272.73.*

Other important matters

1. The fundamental basis on which patients in metropolitan Australia are cared for 24/7 is the RACGP standards for General Practice loosely supported by "regulatory and financial encouragement" via the AH PIP

2. MDS have avoided issues of quality that have plagued the UK by, close co-operation with the RACGP, state medical boards, in-house doctor training allied with workforce access programs such as the 10 year moratorium and AMDSP. 40% of all MDs Doctors are now female . This is due to the success of MDS security programs (Chaperones duress alarms, special patient files, drug seeking patient avoidance policies, NTBS patient/address data bases etc)

   Without these programs MDS would not be able to recruit an after hours workforce.

3. MDS/GP data sharing is an essential component of Australia's 24/7 Primary Health Care System.
   Key features include:
   - Attendance of ACF
   - Special patient reports
   - Drug seeking patients (and DGP security)
   - Life extinct patient management services
   - In-home after hours frail elderly support services
   - Palliative care

All these features are linked to provide a seamless and workable service in the defined after hours period. Without GPs day-time GPs maintaining 24/7 care responsiblity for patients, these systems would collapse.

A future model of after hours care needs to maintain the key features which sustain the MDS model so that ACF, the frail aged and house bound patients can be home visited AH.