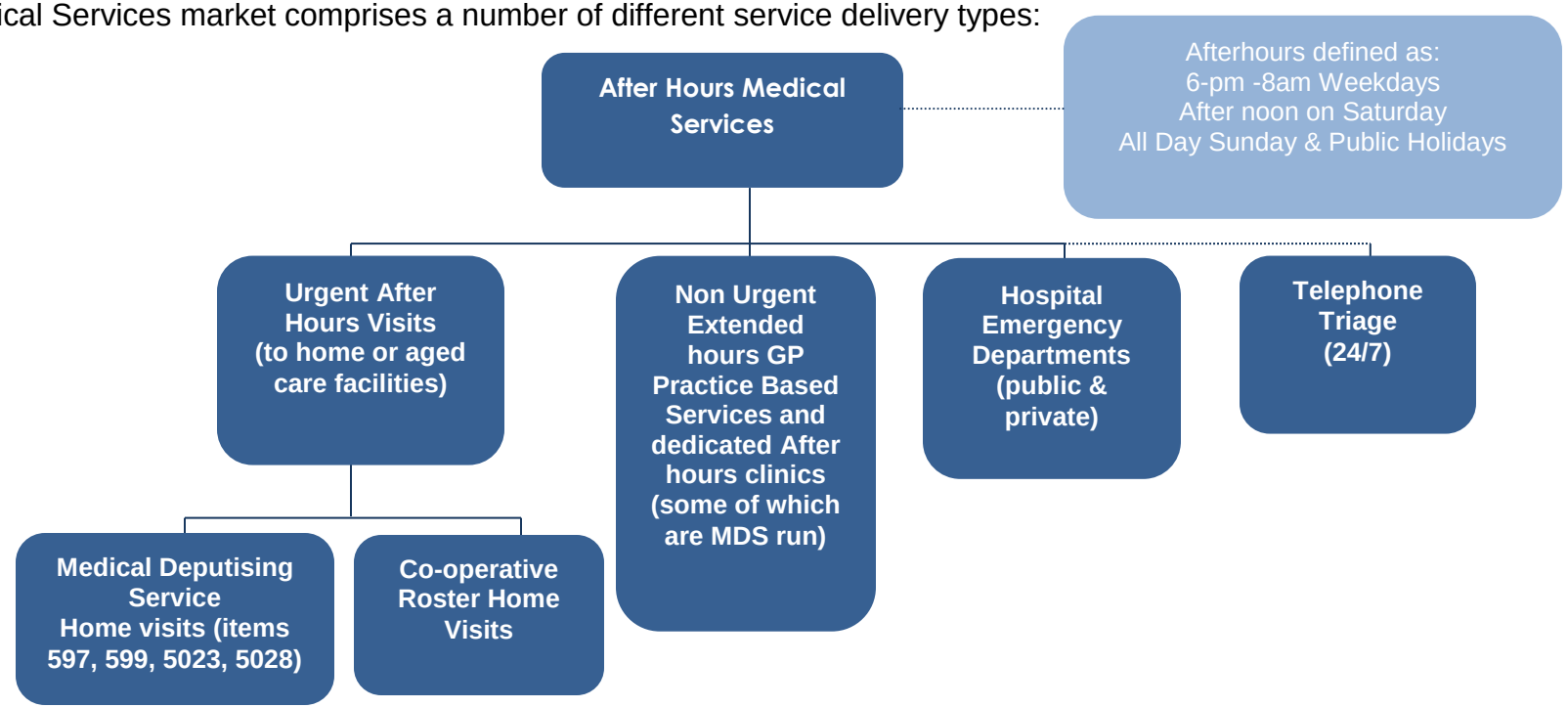
After Hours Medical Care Services in Australia

NAMDS After Hours Primary Medical Care Summary Paper

2014

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 (2013)	**1.51m**	**0.21m**	**7.23m**	**2.46m**	**Small**
Share of After Hours Services	**13.23%**	**1.84%**	**63.36%**	**21.56%**	**Small**

Definition

- After hours Medical Deputising Service subscribed to by Medicare Locals and/or individual GP Practices
- May take the legal form of a company or a not-for-profit enterprise
- MDS Role: Increasing

- 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, except in rural and sub-regional areas

- Extended hours clinics and/or specialist after hours clinics
- After hours clinics generally close before 11pm weeknights and 8pm on weekends
- Role: Increasing in metropolitan Australia

- 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 2012-13 (assumes that 70% of presentations were in the afte hours period, including weekends) [1]
- Data excludes private hospita ED attendances
- Role: Public, increasing
- Role: Private, static

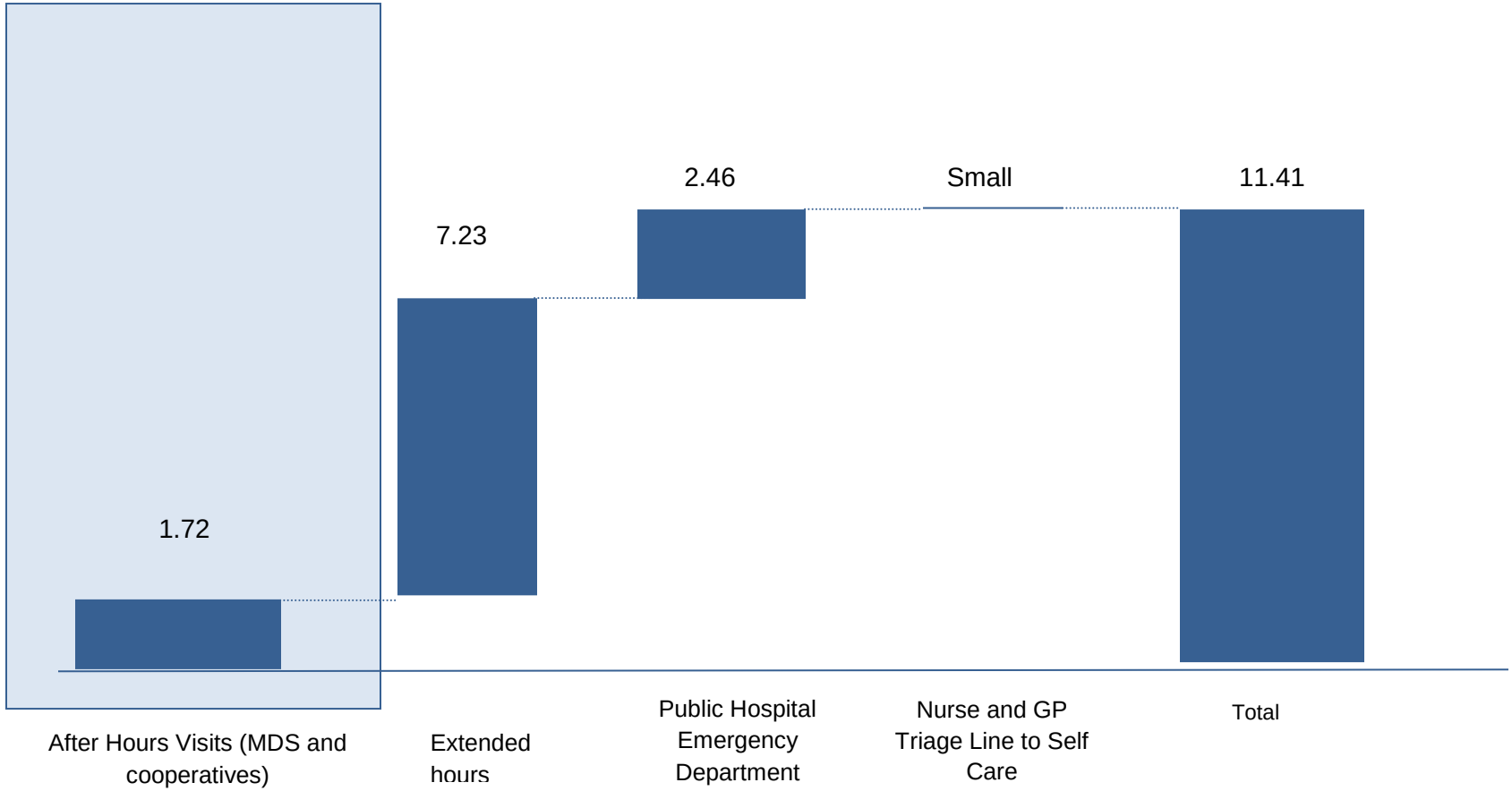
- National/ State run GP and nurse triage systems are in operation.
- Provides advice to patients and directs them to the most appropriate form of care.
- Majority of advice continues to be a face to face doctor attendance, largely at public hospitals, GP clinics, extended after hours clinics or MDS.
- Role: GP advice now capped at 220,000 calls p.a.

[1] Source: Australian Institute of Health and Welfare – Hospital Statistics 2013

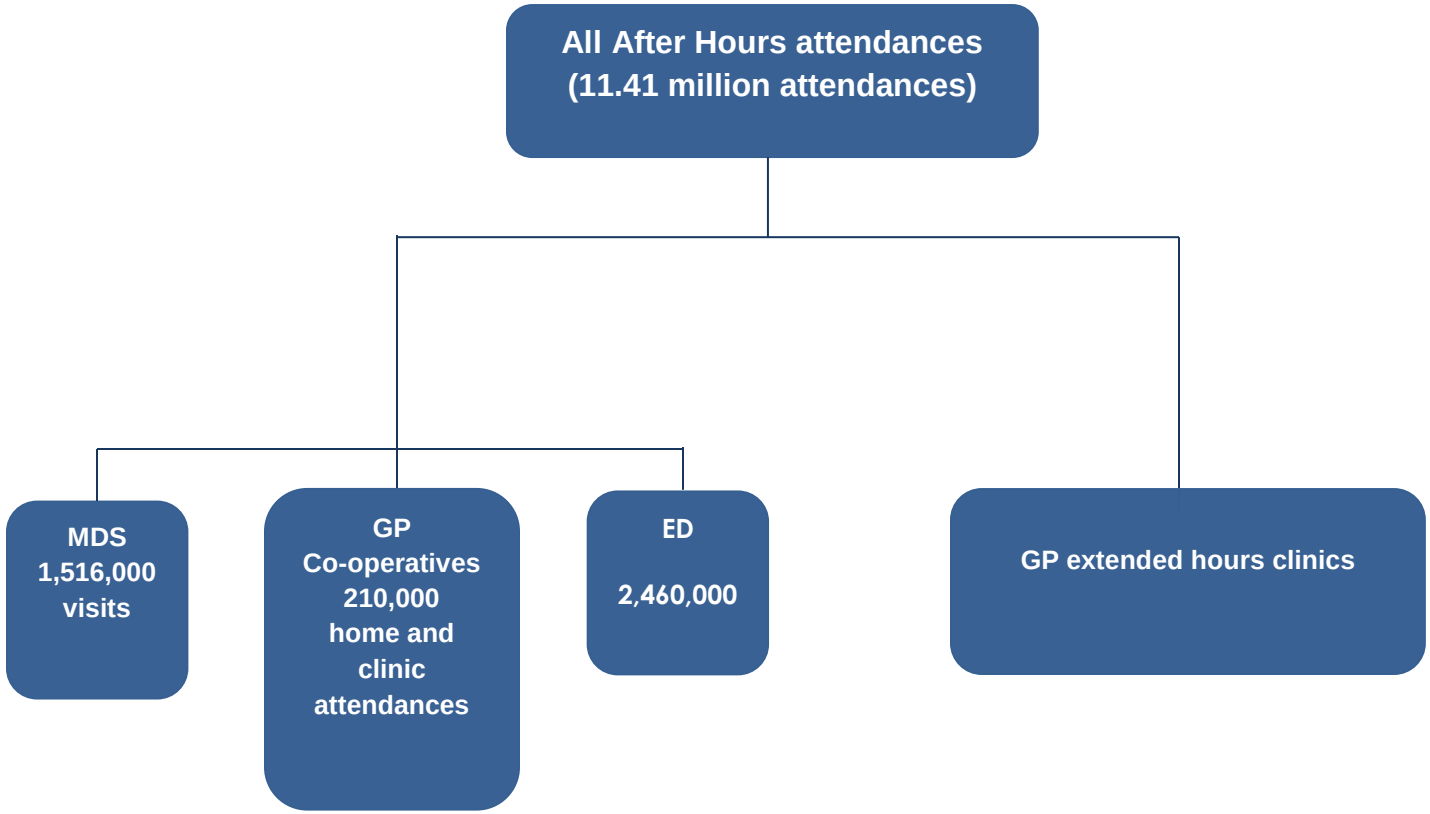
RELEVANT MARKET SIZE

The Medical Deputising Service patient cohort represents 15.07% of the total After Hours Medical Services Market in 2013.

Total After Hours Medical Services in Australia, M, 2013 (million patients p.a.)



AFTER HOURS PATIENT CARE IN AUSTRALIA



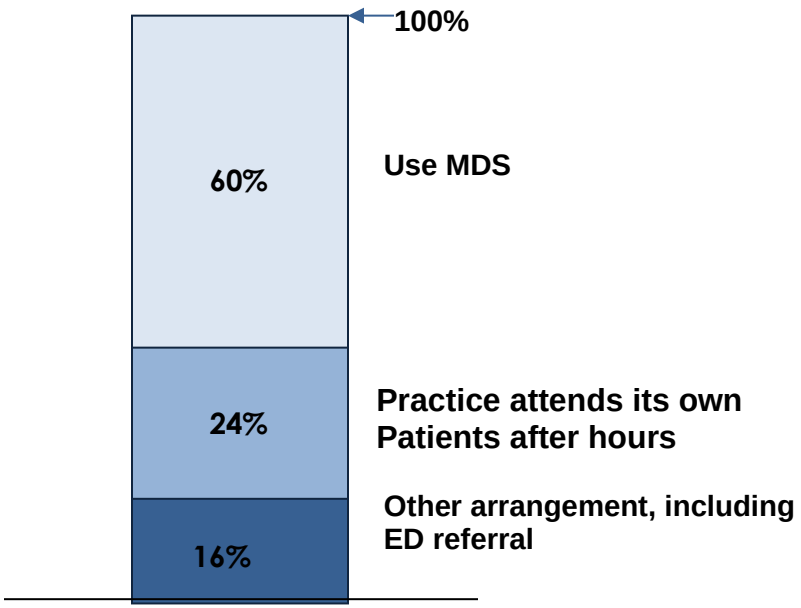
Share of after hours services	**37.92%** [1]	**5.25%**	**61.54%**	
Definition	Essential for ACF frail aged house bound and very young patients.	Generally only present in regional and sub-regional Australia	Growing demand due to transfers from ACF and lack of alternative care systems	Very limited home visiting component.

Source: Australian Institute of Health and Welfare – Hospital Statistics 13

GP PROPENSITY TO SUBSCRIBE TO MDS

In 2009, around 60% of all Australian GPs subscribed to an MDS service. The propensity to subscribe at that time was driven by a number of factors. This changed with the advent of Medicare Locals taking control of after hours in 2012 and subsequent changes to the RACGP standards allowing GPs to opt out of providing and/or organising 24/7 patient care.

Method of After Hours visit provision by Australian GPs, 2009



Representative
Sample of Australian GPs
N=100

Notes: This includes Co-operative GP groups
Source: BEACH (annual survey of 1000 individual GPs)

There are a number of key factors that influenced pre 2012 GP subscriptions to MDS services ie prior to the advent of Medicare Locals:

Regulation – to become accredited, practices needed to adhere to RACGP standards. These standards required practices to provide access to after hours visits. In return, the Government provided a series of financial incentives called PIP incentives.

GP Preferences towards working sociable hours – pre 2012, Accredited GP Practices could choose to provide after hours coverage themselves in return for higher PIP incentives, or opt to outsource to an MDS service for a lower set of incentives. Note, unaccredited GPs may also subscribe to an MDS service, generally out of a sense of duty to their patients.

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 had no choice but to provide after hours services themselves to meet the RACGP standards.

Medicare Locals assumed responsibility for after hours in July 2012 which led to a number of outcomes;

The **Doctor/patient relationship** was triangulated with the imposition of a new bureaucratic fund holder and service contract provider.

This increased **GP Practice costs** and confused the after hours doctor/patient relationship.

The interpretation of the **RACGP standards** were further diluted eliminating the necessity of GP Practices to provide 24/7 patient care as this responsibility now fell to Medicare Locals.

REGULATION – PRACTICE ACCREDITATION

Demand for MDS provision by GPs has in the past been driven by the voluntary practice accreditation process which requires GPs to ensure access to after hours visits (and 24/7 patient care coordination).

General Practice Accreditation (RACGP)

- Prior to 2012, the means for **upholding general practice standards in Australia was via an RACGP accreditation** process, that ensured that best practice standards of care are in place 24/7.
- Whilst **accreditation was voluntary,** it **gave the practice access to a number of "Practice Incentive Payments"** - essentially a set of grants from the Commonwealth Government.
- Prior to 2012, one of the accreditation requirements was that Practices **provide access to after hours home visits** to their patients.
- If the **Practices chose not to provide after hours home visits themselves,** they were 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).**
- However in July 2013, the RACGP amended its after hours standard in relation to Criterion 1.1.4 where it now states that;
  "Practices are required to demonstrate that they are aware of arrangements In place for their patients to access after-hours care, and Practices are required to have processes in place to alert patients to these arrangements".
- This new RACGP interpretation allows GP Practices Australia wide to refer patients to ED, Health Direct or next day care rather than provide and/or organise the provision of face-to-face 24/7 care from within their Practice. In the view of NAMDS, this is a substantial adverse change to the Australian primary medical care system and one not intended by Government.

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

Source: RACGP website

REGULATION – PRACTICE ACCREDITATION INCENTIVES (prior to 2012)

The after hours incentive were 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 prior to 2012

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

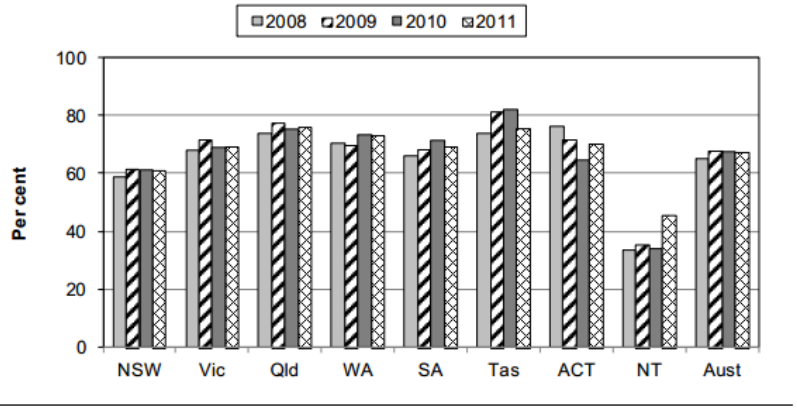
Level	Activity required for payment	Annual Payment per SWPE	Annual Award (Per FTE GP)*	Entity ensuring after hours coverage
Tier 1	• The practice must ensure **all practice patients have access to 24-hour care including access to out of hours visits at home, in a residential or aged care facility, and 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 - extended hours roster
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 face-to-face care 24/7 (no MDS)

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

REGULATION – TRENDS IN PRACTICE ACCREDITATION

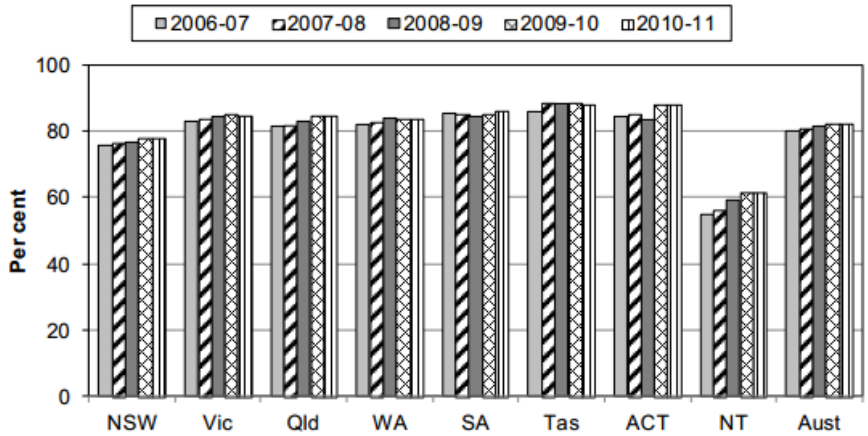
68% of General Practices were accredited by June 2011; the number of accredited practices has been flat over the past 4 years.

General Practices with Accreditation as of June 2011



Source: AGPAL (unpublished); Quality Practice Accreditation Pty Ltd (unpublished); Primary Health Care Research and Information Service and DoHA (unpublished) *Annual Survey of Divisions of General Practice 2010-11*; table 11A.39.

Proportion of General Practice patient care provided by PIP Practices

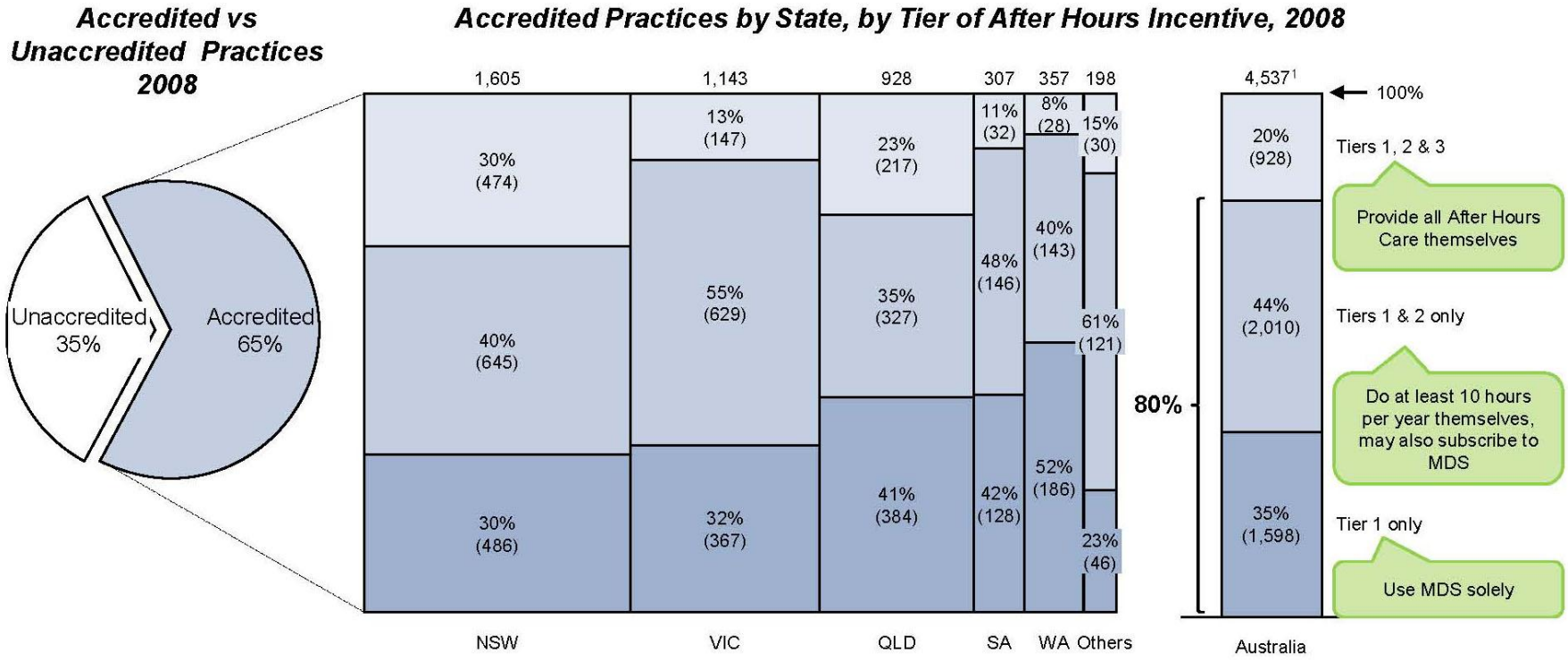


Source: Productivity Report on Government Sources (2013)
Note: Practice numbers are not reflective of General Practitioners; the number of FTE GPs practising in Australia is increasing at about 2-3% per annum, implying that there is a trend towards larger practices with more GPs

REGULATION – AFTER HOURS PIP INCENTIVES

Prior to 2012, 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

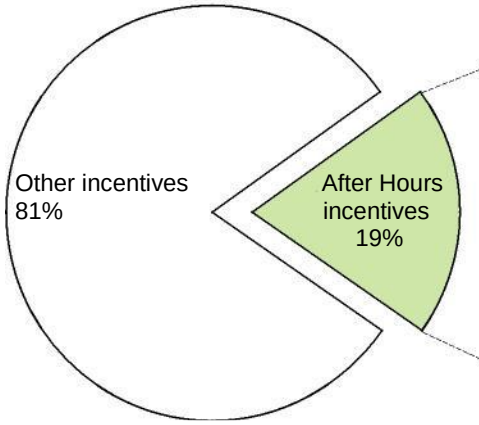


REGULATION – AFTER HOURS PIP INCENTIVES

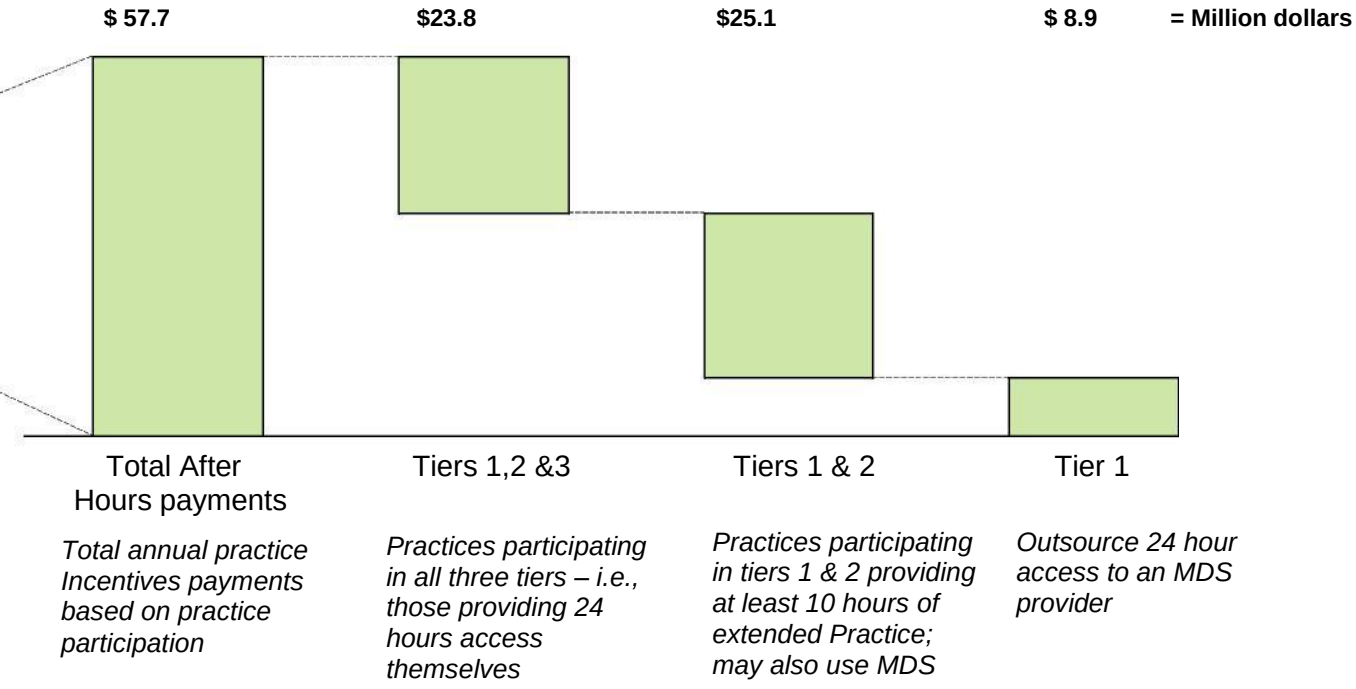
PIP payments for After Hours incentives totalled $58m in 2009; around $9m related to practices participating solely in tier 1(i.e., using MDS only) or 0.38 cents per head of population

Annual After Hours 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



Source: Medicare, Australia

REGULATION – AFTER HOURS PIP INCENTIVES

The Proportion of practices claiming Tier 1 was increasing prior to 2012 at the expense of those claiming Tier 2. Tier 3 has remained flat from 2008 - 2012. This reflected a growing reliance on MDS and falling interest by GPs in after hours care.

GP PERSPECTIVES ON AFTERHOURS VISITS (AH CLINICS AND HOME VISITS)

Historically, 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. It's 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 $130 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 an 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 service availability; for example, where a service is available there is generally strong uptake from local GPs.

Key message

Where MDS providers are available and of higher quality, there is typically strong GP subscriber uptake and support

Comments

- "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 is 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

Key under-servicing pressures

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

Source: Government Department of Health and Ageing

AVERAGE REBATES OVER TIME

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

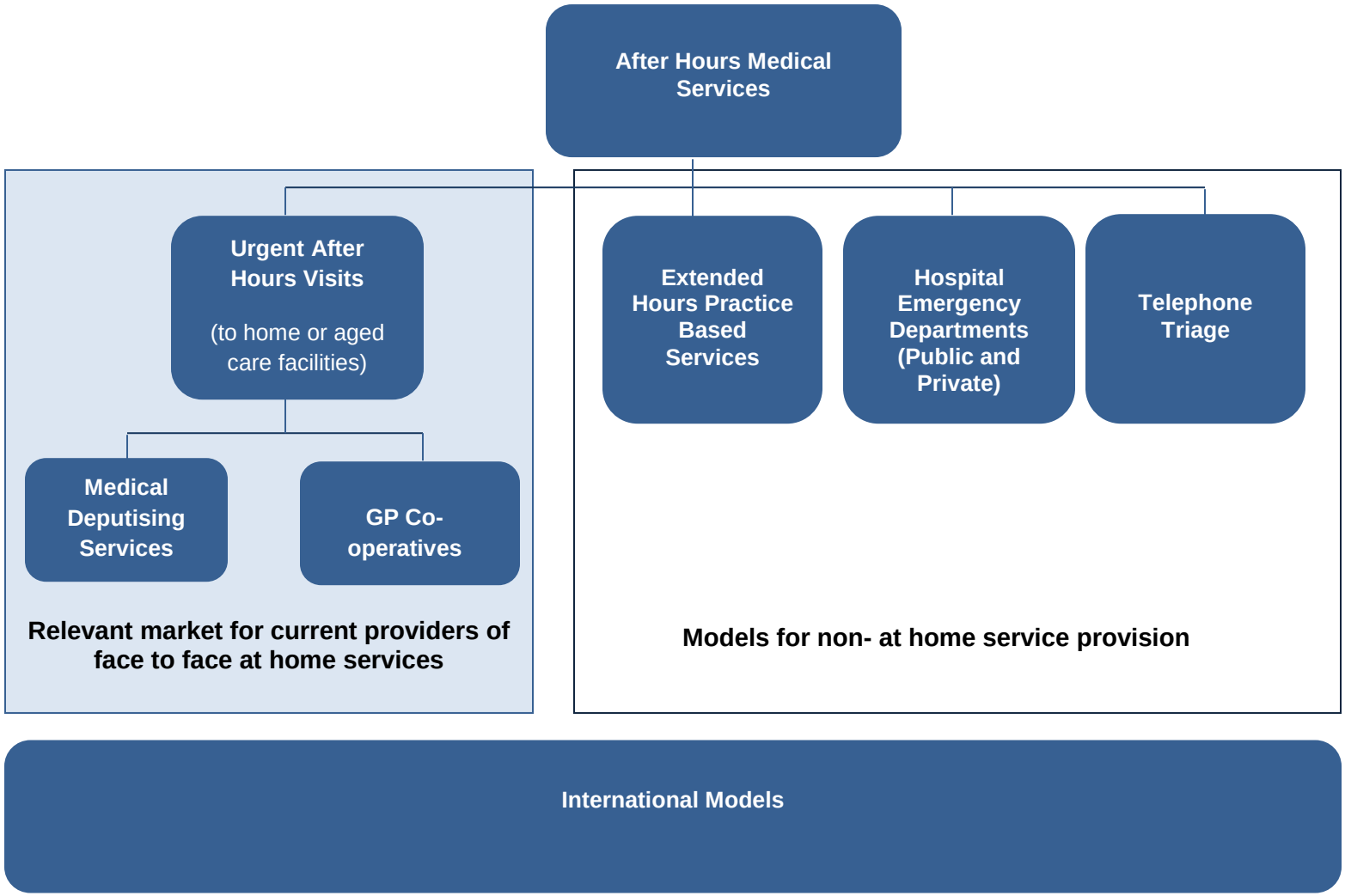
MBS Average Claim for after hours at Home or Aged Care Facility visits, $AUD, 2005 to 2014

Note: Item 597 was previously Item 1 and Item 599 was previously 601 before May 2010.

Source: Department of Health Services - Medicare Statistics- Item Reports 2014

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

- The alternative after hours models represent minimal competition 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.
- 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.
- Telephone triage services aim to divert patients away from EDs towards self-care. All MDS report that the national "Healthdirect" service has caused MDS growth by promoting increasing consumer awareness of the service and on-referrals of urgent home visit patients.

A review of the International market provides some insights as to costs and opportunities for Australia:

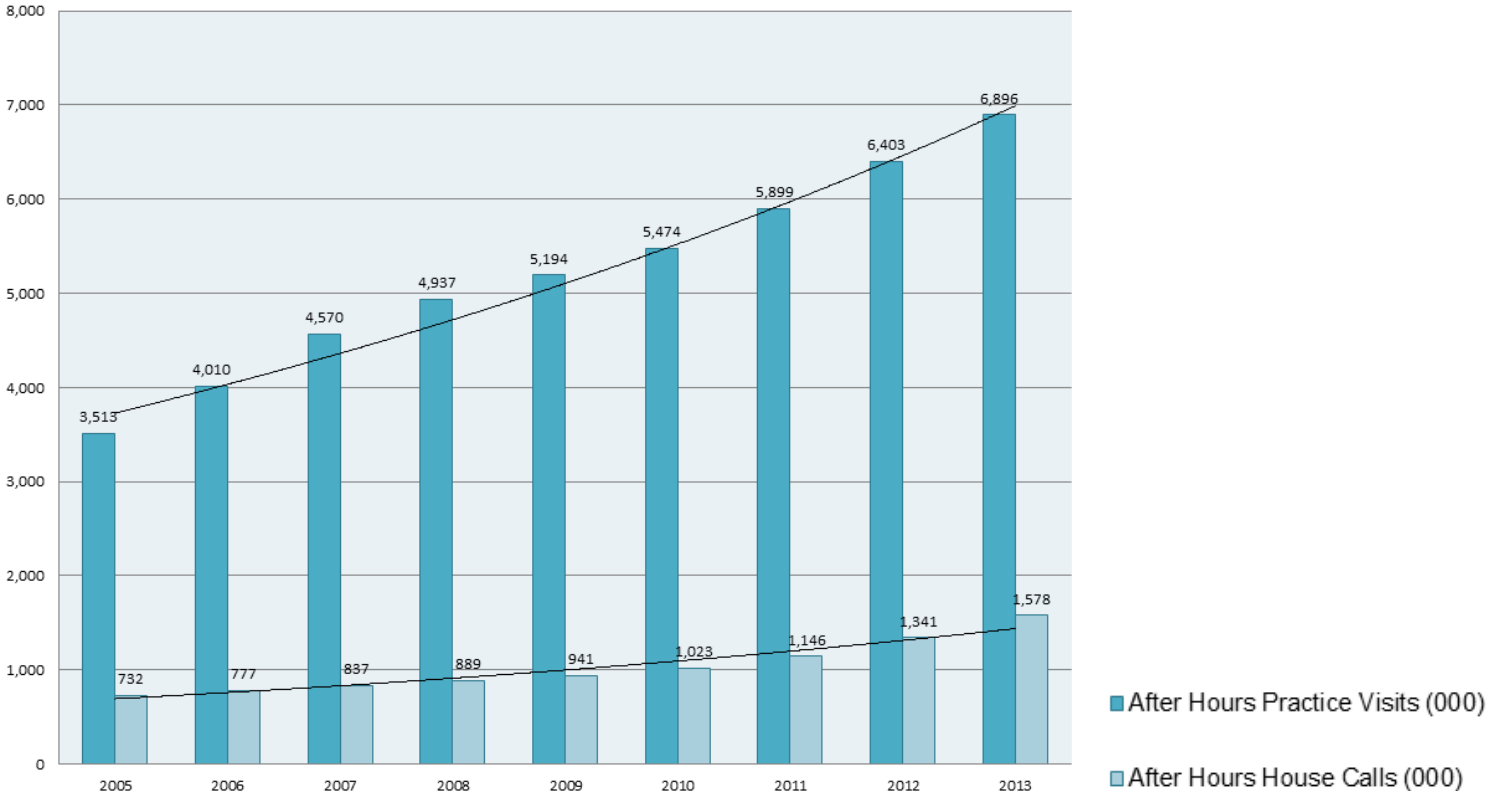
An MDS style model is the most efficient way of servicing the GP after hours visits market, and for optimal efficiency this would be coupled with a GP telephone triage service.

- In most countries reviewed by NAMDS, 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 alongside with GP/Nurse telephone triage systems.
- Despite the presence of these functions, there is strong evidence that GP home visits per capita remain 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.

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 AH Home Calls compared to AH Practice Visits, 2005 -2013



Note: After Hours House Call data shown above includes all item numbers including; 597, 598, 599, 600, 5023, 5028. Despite using all the urgent and non-urgent home visiting item numbers, the growth in the number of house calls continues to be less than the growth of after hours clinic consultations.

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.

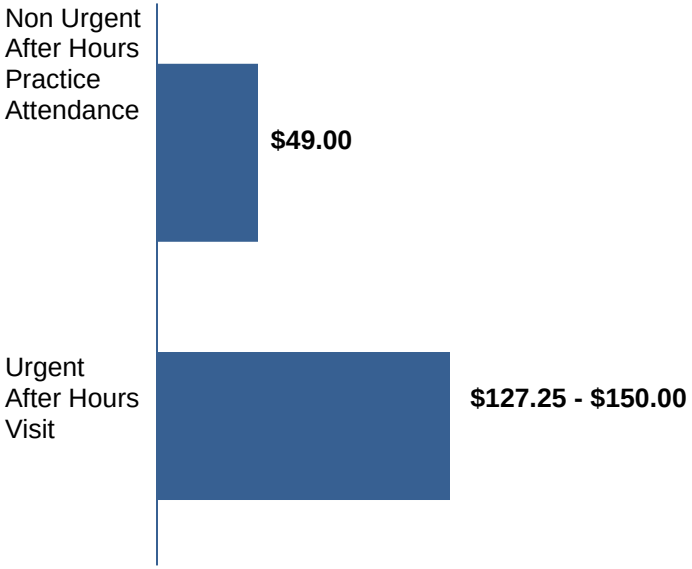
2. Specific after hours clinics that only open during after hours periods; these are often “co-located” with an emergency department so that non-urgent ED patients can be diverted to the clinic to reduce hospital burdens. These clinics are generally funded via a GPAH grant and are normally uneconomic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

Source: Department of Health Services - Medicare Statistics- Item Reports

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 ($AUD)



Definition

Medicare rebate for item number 5020 (most frequently used item number for After Hours clinic attendances)

Medicare rebate for item number 597 and 599 (most frequently used item numbers for after hours visits)

Total Cost

6.2m patient visits during FY 2013/14 at a ***Total cost of $306m (average $49.00 per visit)***

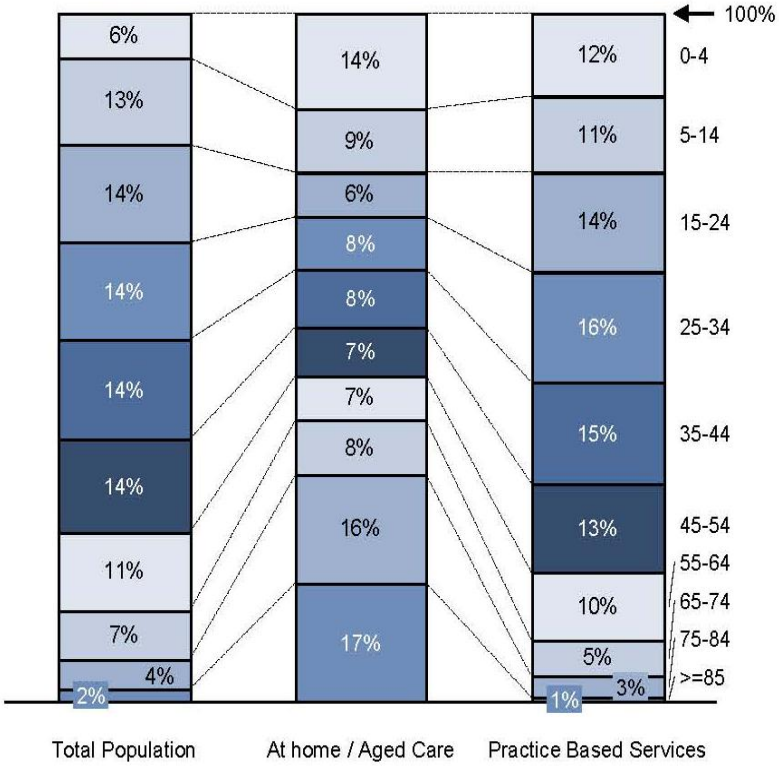
1.17m patients treated urgently at home during FY 2013/14 ***Total cost of $146m (average $131.43 per visit)***

Source: Department of Health Services - Medicare Statistics- Item Reports 2013 & 2014

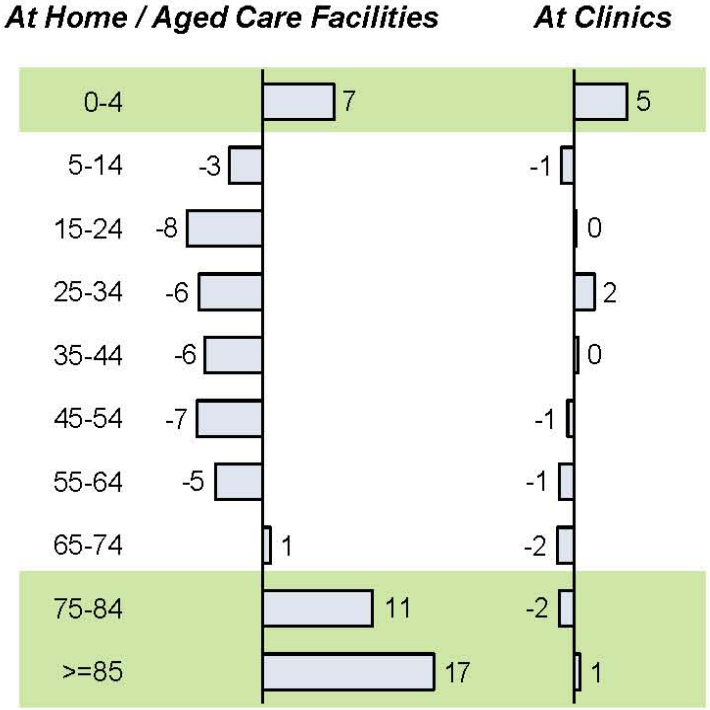
AFTER HOURS AND EXTENDED HOURS PRACTICE BASED SERVICES – PATIENT NEEDS

For the most part extended hours practices fulfil 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 population profile and patient care modality)



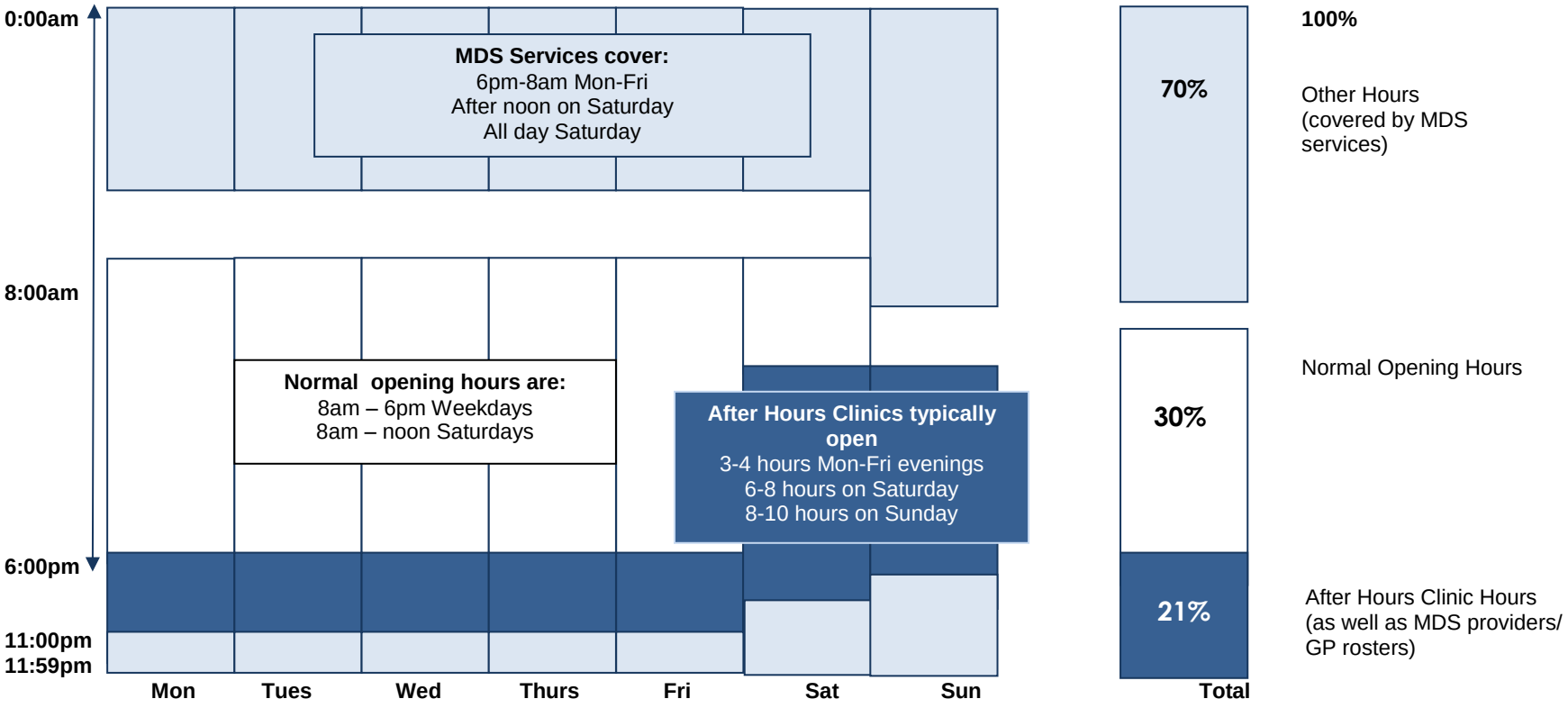
Note 1: MDS primarily service the very young and very old who are house-bound. Extended hours clinics service patients some of whom would otherwise attend a day-time general practice.

Note 2: Nurse/ Doctor triage are best suited to reduce 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” times. Only Medical Deputising Services and ED cover all hours.

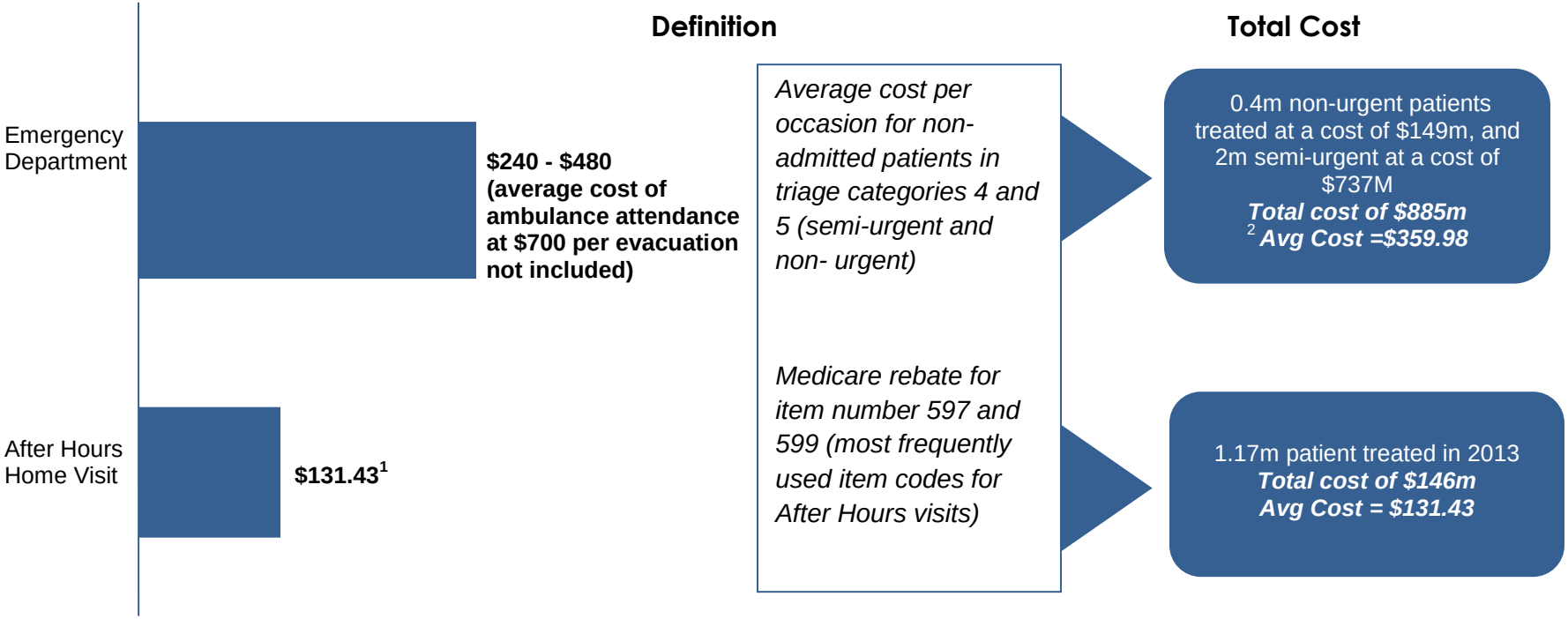
Typical weekly coverage by type of service, by Day



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 build-ups; as such it does not represent a preferable alternative for Australia

[1] Based on the average urgent after hours attendance cost from the Medicare Benefits Schedule 2014
[2] Calculation based on number of after hours, non-admitted emergency department attendances by the average cost of an emergency department visit ($360)

INTERNATIONAL AFTER HOURS MODELS – KEY FINDINGS

A review of international after hours models provides support for Australian MDS providers.

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

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

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

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

- 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
- To optimise the efficiency of the model, GP triage systems are often used, with the main benefits being that there is more reliable diagnoses, resulting in more efficient triage systems.
- 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)

- 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.
- In the UK, 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.
- The clinical standards of doctors working in accredited Medical Deputising Services that meet the NAMDS definition is not regarded as an issue in Australia. This is due to high quality training and induction programmes and the propensity to study for their RACGP Fellowship as part of their AMDSP professional development requirements.

INTERNATIONAL AFTER HOURS MODELS (cont.)

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. • Despite the existence of this triage system, total per capita After Hour call-outs in France are still higher than in Australia, implying 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 (cont.)

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 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. • Per capita usage of home visits (including daytime), is much lower than in Australia (0.12 versus 0.19). However ED attendance is dramatically 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 private MDS provider presence. • Highlights issue that maintaining Doctor clinical 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 viable 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 public healthcare system in operation in Canada, organised regionally (13 different regions). • There are no legal requirements 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 have to go to late opening clinics, or the ED. • Public 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 2)

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 are 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 service that is widely used, that fills a gap in demand. Demand for services is even higher than supply" (Peter Dutton, 2011)

Industry leaders are equally expecting continued government support in this area

- "Governments unlikely to reduce support for After Hours care, if anything they will only increase it as it's such a tricky issue" (General Practitioner).

- 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? (General Practitioner)

SUMMARY OF LEADING OPINIONS (2 OF 2)

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
- Nurse and after hours GP telephone triage is a reality. MDS report a net increase after hours face-to-face demand as a consequence.
- Only 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/ACF 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

Other important matters

1. The fundamental basis on which patients in metropolitan Australia are cared for 24/7 was the RACGP standards for General Practice, loosely supported by “regulatory and financial encouragement” via the After Hours PIP. This changed in 2012 with Medicare Locals taking over responsibility and concurrent reductions in RACGP regulatory oversight and regulation.

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. These costs have historically been paid by GP Practice subscriptions via the After Hours PIP.

3. 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
   - 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.