

AFTER HOURS PRIMARY CARE AND MEDICAL DEPUTISING SERVICES A MEDICARE SUCCESS STORY



National Association for Medical Deputising Services
Submission to the Medicare Benefits Schedule Review

Reference: After Hours 'Urgent' Item Review

December 2016

It is too bad that what everyone acknowledges as a valued part of the best medical care has become so rare ... if house calls are to survive, the medical profession must support the allocation of the resources needed to sustain them, within both the fee-for-service system and the managed-care world. It is unrealistic to expect that the dying and disenfranchised patients who most need house calls can be their own advocates.

Physicians should see this as an opportunity to revive a valued and effective part of medical care that patients need and families appreciate. We need more demonstration programs of home care that includes physicians. Every medical school and training program should require some experience in home care, which merits at least the minimal standard of “see one, do one, teach one.” House calls are highly valued by the neediest and frailest of patients. We should find a way to preserve and protect that simple kindness.

Article in New England Journal of Medicine, 1997, lamenting the demise of the house call in the US.

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1.0 Executive Summary

AFTER HOURS PRIMARY CARE AND MEDICAL DEPUTISING SERVICES A MEDICARE SUCCESS STORY

After hours medical deputising is high quality, high value for the patient, high value for the health system, beneficial for GPs and has grown in line with clear policy objectives. It is a Medicare success story.

Rather than changing the existing Medicare Benefits Schedule (MBS) structure and or item values related to after hours, which will have an immediate detrimental effect on the community, doctors and the health system, measures should be adopted to strengthen the success of previous government policies and the positive outcomes those policies are delivering to Australians nationwide.

The evidence is compelling that medical deputising is delivering the stated goals of the MBS Review:

- Affordable and universal access.
- Best practice health services.
- Value for the individual patient.
- Value for the health system.

Affordable and universal access – Medical deputising services (MDSs) are bulk billed and have grown over the past three years from a point where only 11.6 million Australians had access to this vital service in 2012, to today where that number now reaches 19.8 million.

This expansion of access means MDSs are now available in over 30 regional towns. MDSs are often the *only* after hours face-to-face primary care service, other than the high cost alternatives of emergency and ambulance, and the only service (other than emergency departments) available in the unsociable hours (i.e. between 11:00pm and 7:00am).

MDSs are provided in an environment where traditional after hours house calls by Australian GPs have collapsed – over 80% of Australian GPs do no home and aged care facility (ACF) visits. After hours is an area where there is a scarcity of workforce supply. Funding the expansion of medical deputising services to more regional and rural areas will improve patient access, and supplement the income of regional and rural doctors, helping to retain their knowledge and skills for the benefit of those areas, as MDSs do now in the regional towns in which they operate.

Best practice health services – Australian after hours home and ACF visit services can be confidently benchmarked against global best practice on all dimensions, including quality of care, quality of the doctors and continuity of care, with 'next day' patient reports provided to the regular GP. As such, MDSs underpin future health care delivery options such as the Medical Home, palliative care in the home, aged care in the home and other community based health initiatives. After hours home and ACF care is a service that health care system policy makers and Australians can be justifiably proud of.

High value care for the individual patient – MDSs support high value delivery of services that are appropriate to patients' needs, provide real clinical value and do not expose patients to unnecessary risk or expense. Patients are triaged to ensure unnecessary hospital visits are avoided. There are no out-of-pocket costs to deter access and patient feedback is deeply appreciative.

High value for the health system – MDSs clearly provide a more efficient alternative to emergency departments (EDs) for low acuity presentations with significant cost savings as a result. The cost per service of \$128 is materially lower than treatment in an ED (\$368) and significantly lower than the cost of an ambulance carry and ED treatment for an ACF resident (\$1,351). It also eliminates the high stress (and associated health complications) of ambulance carries for those residents.¹

The MDS sector:

- Provides a large proportion of the highly needed after hours primary care to vulnerable patients at home and in aged care facilities, including young children, the elderly, disabled Australians, Indigenous population and Veterans.
- Demonstrates high value to the health system by spending dollars as 'close to the patient as possible', a goal expressed by the Hon. Sussan Ley MP, Minister for Health and Aged Care.
- Demonstrates further value by contributing to the significant curtailment in low acuity ED presentation growth across Australia over the past five years. Low acuity presentations in the after hours period have *contracted by 0.7%* compared to overall growth in all ED presentations of 10%.
- Supports over 4000 general practices with processes, systems and commitment to securing and enhancing continuity of care with the patient's regular GP.
- Has invested in increasing the professionalism, clinical governance, information technology systems, training and clinical support for its doctors.
- Has invested in expanding access to these critical after hours visits outside of major metropolitan areas to a population base that now covers 19.8 million Australians, up from 11.9 million in 2012.
- Has invested along with Medical Locals and Primary Health Networks (PHNs) in building awareness among Australians about how to use the service appropriately and how to avoid unnecessary low acuity ED presentations.
- Has developed strict triage protocols and safeguards to ensure the service is used appropriately and does not displace matters that should be dealt with by the patient's regular GP.
- Can now provide the mobile, medical workforce required to support future health care initiatives such as palliative care in the home, the Medical Home concept, aged care in the home and other community based programs.

Our submission supports the maintenance of the existing MBS structure and items related to urgent and non-urgent domiciliary care and makes recommendations for improving the existing system to ensure continuity of care with general practice and the quality of care is further strengthened.

“Since Medical Deputising Services 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. Everyone had an excuse why they couldn't work that night.” GP, Brisbane, 2012

“Thank God you were available. My only other option was to load two sick kids in the car in the middle of the night and head to North Shore Emergency.” Mother, Sydney, 2016

“I heard about this service from a friend of mine in Brisbane. I am so thankful it's now available in my area too.” Mother, Townsville, 2016

¹ November 2016, *Deloitte Access Economics: Analysis Of After Hours Primary Care Pathways*.

NAMDS' RECOMMENDATIONS

NAMDS is the peak body representing after hours medical deputising services in Australia and seeks to facilitate and encourage high standards of after hours primary medical care.

Growth and sophistication of after hours home and ACF visits is very much a Medicare success story. To further strengthen the sector and ensure it continues to deliver high quality care cost effectively, NAMDS recommends the following:

1. NAMDS, the Commonwealth Department of Health and other key stakeholders collaborate to create an *industry wide* **Code of Conduct** with guidelines for:
 - A standard triage profile for emergency conditions that will be directed to the emergency department (and not warrant a home or ACF visit).
 - A standard triage profile for regular health care needs that will be referred to the patient's regular GP (and not warrant a home or ACF visit).
 - Standard protocols for addressing 'frequent user' requests and other complex patients: this would include adopting a standard protocol for monthly monitoring of frequent users/complex patients to determine if such patient behaviour is appropriate; any decisions about supporting such patients would be made in conjunction with the patient's regular GP.
 - Standard protocols for an MDS to receive special patient instructions from the GP with respect to any specific patient.
 - Standard protocols for accommodating medical practice instructions (e.g. practices that may be open evenings or Saturdays) and rules for informing a patient of their regular practice's opening hours when those practices are open in the otherwise defined after hours period.
 - Standard protocols for encouraging patients without a regular GP to form a clinical relationship with a GP.
 - Standard protocols to address attempted use of the service by individuals with a substance or drug dependency and other dangerous circumstances to ensure safety of all MDS doctors.
 - Agreed language to use in all awareness campaigns to ensure services are used appropriately.
2. **After Hours Taskforce:** The Deloitte Access Economics report is the first serious economic analysis of the best pathways for after hours for the health system.² It is an opportunity to work together to develop the optimal model of care. We suggest a Taskforce be formed with the Commonwealth Department of Health, NAMDS, peak patient groups, PHNs and other stakeholders with a remit to identify broader solutions for after hours care across the health system.
3. **Standard protocols to improve clinical handover and continuity of care:** NAMDS to work with the Royal Australian College of General Practitioners (RACGP) to identify ways to increase the breadth of clinical handover to aid MDSs in conducting home and ACF visits and to identify further ways to ensure continuity of care between an MDS and the regular GP.
4. **Adopt digital health records:** NAMDS to engage with the Commonwealth Department of Health and the Australian Digital Health Agency to:
 - Enhance the transfer of secure clinical communications between deputising services to subscriber general practices and to the My Health Record.
 - Develop improved methods of access to the My Health Record for out of hours deputising GPs.
5. **Define 'urgency':** NAMDS recommends the MBS Review Taskforce maintains the existing MBS item values and adopts the attached guideline for the definition of urgency. NAMDS has sought to clarify the meaning of urgency. Following consultation, advice has been drafted and approved by a conference of NAMDS members (see Appendix A).

² Ibid.

6. **Medicare training for doctors:** NAMDS to engage with the Commonwealth Departments of Health and Human Services to:
 - Develop improved guidelines and case examples regarding the appropriate use of relevant item numbers used by deputising doctors.
 - Support the role of deputising doctors in prescribing, including use of the PBS and the Prescription Shopping Programme.
 - Support the usage of Medicare online platforms such as HPOS.
7. **Peer group benchmarks:** NAMDS to collaborate with the Commonwealth Departments of Health and Human Services to set robust benchmarks for appropriate Medicare peer groups for after hours doctors. It has become apparent that Medicare “understands some providers have specialised roles in the community and that means they may be claiming a large number of urgent after hours items”.³ It is of high concern, however, that the peer group for after hours being used for comparison is not the providers with specialised roles (i.e. medical deputising services) but those 20% of regular GPs who may do one or two home and ACF visits a week. We recommend a like-for-like peer group be established for appropriate benchmarking.
8. **Awareness campaign regarding options in an emergency:** growing community awareness of after hours services will improve access and reduce low acuity emergency department presentations. As awareness remains sub-optimal, there is significant scope for further cost savings. We recommend a national awareness campaign be launched in collaboration with state and territory governments.
9. **Council of Health Ministers (COHM) study into opportunities for better ambulance triage:** better triage of low acuity ambulance callers is possible. NAMDS is currently working with Victorian and NSW ambulance services to develop processes for referring more low acuity callers to more appropriate services. We recommend the benefits of the program be explored by COHM.
10. **Commonwealth Department of Aged Care Working Party:** NAMDS recommends that such a party be established with the Commonwealth Department of Health, NAMDS and other key stakeholders including state and territory governments to identify better ways to ensure residents of ACFs have an after hours plan in place. Many residents enter a facility with a regular GP but do not have after hours plans established with their GP; patient expectation is that their GP is accessible, but often this is not the case. The current impact on ambulance and emergency department services is significant and extremely costly to the health system and clinically detrimental to the patient experience.
11. **MDSs should be allowed in-hours access to ACF patients** to treat urgent episodic illness at the specific request of the regular GP. Currently some GPs schedule regular visits but many will not attend an ACF for just one patient. With ambulance carries and treatment costs in the vicinity of \$1351 per patient, this is a significant and often unnecessary impost on the cost of our health system and a stressful experience for elderly patients (see Appendix B).
12. **Palliative Care in the Home Working Party:** a working party should be established with the Commonwealth Department of Health, RACGP, Palliative Care Australia, NAMDS and other key stakeholders including state and territory governments to identify ways to increase access to palliative care in the home. According to Palliative Care Australia, 70% of Australians say they wish to die at home, but only 14% do so. We recommend a working party be established to develop a position paper to address current shortcomings. We note this is one of the areas identified for reform by the Productivity Commission in its latest inquiry regarding human services.

³ April-August 2016, *Medicare Letter To Practitioners*.

13. **After hours introduction to a GP:** many (and a growing number of) after hours patients no longer have a regular GP. We recommend NAMDS develops a system in conjunction with the RACGP and Australian Medical Association (AMA) for the active introduction of after hours patients to GP clinics looking to expand their patient base.
14. **Accreditation standards and guidelines of the Approved Medical Deputising Service (AMDS) Program should be transparent and subject to collaboration and agreement from all relevant parties including NAMDS.**
15. **After hours support for rural and regional Australia:** under the current Medicare after hours items, medical deputising is not sustainable for smaller population centres. Funding is sought for a pilot program in regional Australia to support alternative models of after hours doctor services where the current Medicare items for after hours are too low to be sustainable.
16. **Alignment on continuity of care and other standards:** after hours providers who are not approved MDSs draw on the relevant MBS after hours item numbers but are not obligated to meet the conditions of, for example, continuity of care with the regular GP. We recommend the Commonwealth Department of Health be charged with formulating a means to ensure doctors engaged in after hours care (regardless of whether they are working within the auspices of an MDS or not) meet these standards.

KEY OBSERVATIONS

The Most Cost Effective Models for After Hours Low Acuity Care are Extended Hours Clinics and Home and Aged Care Facility Visits

- For the after hours treatment of low acuity illness (also generally referred to as GP-type presentations), after hours primary care options of extended hours clinics (\$93) and home doctor visits (\$128) are the most cost effective options.
- The cost of presenting to emergency is \$368 per patient if self-referred and \$1351 via ambulance. Other services have been costed as: Health Direct \$256; Hunter GP Access \$169.

Round the Clock Medicare Policy is Helping to Reduce Low Acuity Presentations to Emergency

- The government has had a policy objective to improve access to primary care through the Round the Clock Medicare initiative (increasing the rebate for after hours primary care services in 2005 and 2007), and this has helped. Low acuity presentations have declined from 54% in 2005-06 to 47% of presentations in 2014-15.⁴
- Since 2011-12 more severe presentations to ED (Categories 1-3) have grown at a higher rate (18.5%) than lower acuity (Categories 4-5) at 3.4%. Low acuity presentations in the after hours period have actually *contracted* by 0.7%.

A Large Number of Emergency Department Presentations and Ambulance Carries are Avoidable

- Large numbers of presentations to emergency departments are avoidable. In 2012-13, the Australian Institute of Health and Welfare (AIHW) estimated that 2.2 million presentations from a total of approximately 8 million (after hours and in-hours) to EDs were avoidable, GP-type presentations which cost the health system a total of \$809 million to treat.
- 1.4 million of these GP-type presentations are in the after hours period.
- Elderly patients living in an ACF are often transported to hospital via ambulance when they cannot access the services of a doctor during daytime weekday hours, when medical deputising is prohibited from operating.

There are Significant Ongoing Benefits to the Health System

- If a quarter of AIHW's estimated number of GP-type presentations to emergency were avoided by improving access to after hours clinics or medical deputising, the benefit to the health system would be \$81.8 million to \$93.5 million nationally each year.

“It was a lifesaver for me as my husband has cancer and is very weak. After his latest treatment he had a fall and hurt his back. I couldn’t get him down the stairs so it would have meant an ambulance when in fact all he needed was pain killers.” *Wife, Sydney, NSW*

“Can I just say I just had the most lovely doctor visit me. I have a high fever and gastro and he was so kind to me and came up with an excellent care plan for me. I am a nurse and honestly in my 8 years of nursing have never seen a doctor with such great bedside manner. His name was Andrew and he visited me tonight in Malvern East. So happy with your service I will be sure to spread the word! Much better than a long emergency trip thanks so much!” *Billie, Melbourne, Victoria*

⁴ Deloitte Access Economics, op. cit.

2.0 Overview of the MDS Sector and Recent History

2.1 The Role of Medical Deputising Services

- 2.1.1 The after hours home and aged care facility (ACF) visit Medicare items underpin a highly effective evolving system of medical deputising services (MDSs) in Australia. The system allows GPs to escape the burden of personally providing direct 24/7 care while ensuring patients have good access to urgent and episodic care, especially vulnerable groups.
- 2.1.2 Significantly, MDSs reinforce continuity of care with the regular GP, through the ability of MDSs (utilising information technology systems) to capture specific patient instructions from GPs (clinical handover) and to provide GPs with next day secure reports on home and ACF patient visits. Despite the lack of adoption of national consumer records, MDSs already have established methods of transferring data between their subscribing GP practices and doctors on the road.

Chart 1: Overview – medical deputising services

WHAT DO WE DO?	HOW DOES IT WORK?
<ul style="list-style-type: none"> • Our 11 members are medical deputising services (MDSs); we deliver circa 65% of all after hours home and aged care facility (ACF) visits • We provide doctor home visits for 'Urgent and Episodic' matters to patients at home and ACF residents – an essential service • We support over 10,000 GPs who subscribe to our MDSs to provide comprehensive and coordinated 24/7 care to their patients on their behalf • Not for routine/regular care • Primary patients: <ul style="list-style-type: none"> – Young children – Elderly in aged care facilities – Elderly in community • Patient report sent overnight to regular GP to ensure continuity of care 	<ul style="list-style-type: none"> • GPs engage MDSs through contractual arrangements to support them and their patients • Home and ACF visits funded through Medicare • Specific item numbers (mainly 597, 599) • Very few regular GPs do home visits anymore; we see their patients on their behalf • Hours: <ul style="list-style-type: none"> – 6:00pm through the night to 8:00am the following morning, Monday to Friday – Noon Saturday – Monday 8:00am – Public Holidays • Total cost of the program = \$230 million out of \$2.1 billion spent on after hours primary care

OBJECTIVE: Support 24/7 primary care and wherever possible, avoid unnecessary low acuity presentations to emergency departments

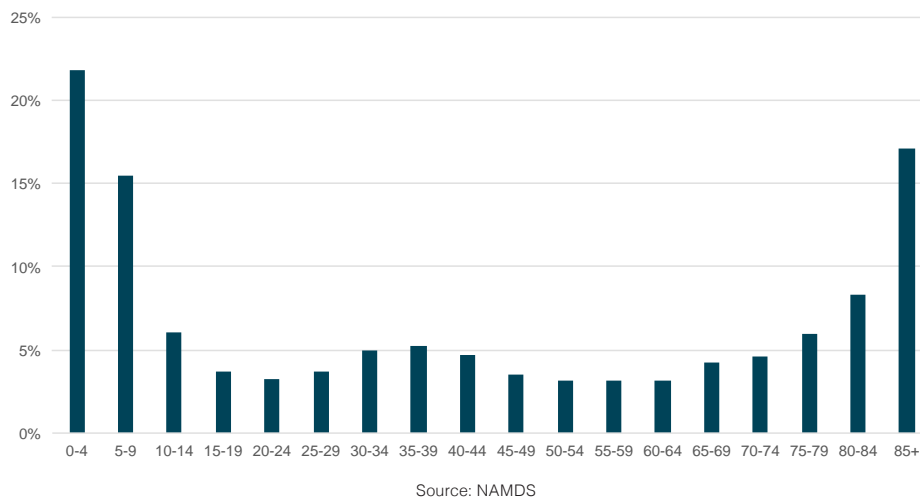
2.0 Overview of the MDS Sector and Recent History

2.1.3 MDSs provide after hours care to patients across a wide array of ages and needs. The mix of patients skew heavily towards several user groups:

- Children under four.
- Adults over the age of 75.
- Residents of aged care facilities.
- 60% of callers are carers (not patients).
- A high proportion of patients have mobility issues and other disabilities.

A breakdown of patients by age showing the typical skew to the young and the elderly is seen below:

Chart 2: Age penetration – sample (patients seen in past 3 years)



To get a sense of a 'night in the life' of an after hours doctor see Appendix C.

Patient needs within these groups do not change, even if availability of after hours home and ACF visits does.

“The patient is disabled and would have difficulty in accessing outside medical assistance after weekday hours and on a weekend or PH – uses a wheelchair. She required treatment on a Saturday afternoon of a long weekend. The doctor was able to diagnose her condition and start antibiotic treatment immediately. Delayed treatment in her case could have been quite dangerous in relation to infection in her leg prosthesis – to access hospital emergency care via ambulance would not feel to have been appropriate, however. Waiting times at ED in public hospitals is very difficult for this patient. The experience with the call centre was excellent and the waiting period was reasonable.” Kim, Mooroolbark, Victoria – Email Feedback

2.2 Lack of Access To After Hours Primary Care Emerged Between 1998 and 2008

- 2.2.1 The lack of access to after hours primary care services from 1998 to 2008 was a serious issue. Dr C Joyce writing in *Australian Family Physician* in December 2008 commented:

Declines in home visits by GPs have been reported in many European countries and concerns have recently been expressed about similar decreases in Australia. Data from the 2006-2007 Bettering the Evaluation and Care of Health (BEACH) study indicates that home visits represented less than 1% of Medicare claimable encounters (0.9%) in 2006-2007. This has decreased significantly since 1998-1999 when home visits were 1.9% of encounters. *Approximately three-quarters of GPs participating in BEACH in 2006-2007 reported providing no home visits.*

The time consuming nature of home visits, the relatively poor remuneration associated with them, large part time workforce, and concerns about personal safety may all contribute to increasing reluctance among GPs to undertake this type of consultation.

Any decrease in home visiting rates by GPs may impact on the health of the elderly, in particular the frail elderly. The majority of older Australians aged 65 years and over live in private homes (93.8%), with almost one-third in lone person households.⁵ (Emphasis added.)

- 2.2.2 In a more recent study on home and ACF visits funded by the Commonwealth Department of Health and published in *Family Practice*, September 2016, similar findings were noted:

Declines in the rate of GP home visits over recent years and decades have been noted consistently across developed countries despite increases in the elderly proportion of the population and in rates of home visit-associated conditions such as dementia. The causes of the decline are complex, but barriers to provision of home visits have been found to include time constraints, inadequate remuneration, lack of equipment and concerns about safety and perceptions of risk of violence. Patients, however, especially older patients, see home visits as being essential to their well-being and to the GP-patient relationship.⁶

2.3 Emergency Departments Became the Default Option for Australians

- 2.3.1 The use of EDs for low acuity requirements in the after hours period has become the default option for most Australians.⁷

Professor Claire Jackson in her 31 October 2014 Report to the Minister for Health and Minister for Sport, *Review of After Hours Primary Health Care* (Jackson Review) noted the following:

Consumers generally were seen to have limited awareness of the services available to them in the after hours period or how to access the most appropriate care. In part this is associated with a 'needs to know' basis of after hours services. *The default option for consumers is often to go to the hospital or call an Ambulance.* One consumer indicated that her first point of call in the after hours was ambulance, she didn't necessarily want to call them as she knew it wasn't always appropriate, but she didn't know what other options she had (she had called the ambulance 11 times in the last year).⁸ (Emphasis added.)

5 Joyce, C. & Piterman AM, L., 2008, *Trends In GP Home Visits*, Australian Family Physician, vol. 37, no. 12.

6 Magin, P., Catzikiris, N., Tapley, A., Morgan, S., Holliday, E.G., Ball, J., Henderson, K., Elliott, T., Regan, C. & Spike, N., 2016, *Home Visits And Nursing Home Visits By Early-Career GPs: A Cross-Sectional Study*, Family Practice, 1-6, <<fampra.oxfordjournals.org/content/early/2016/09/14/fampra.cmw099.abstract>>

7 Patients who attend emergency departments are triaged into one of five categories based on how urgently they require care:

- ATS category 1 – Resuscitation: Immediate care is required.
- ATS category 2 – Emergency: Care is required within 10 minutes.
- ATS category 3 – Urgent: Care is required within 30 minutes.
- ATS category 4 – Semi-urgent: Care is required within 60 minutes.
- ATS category 5 – Non-urgent: Care is required within 120 minutes.

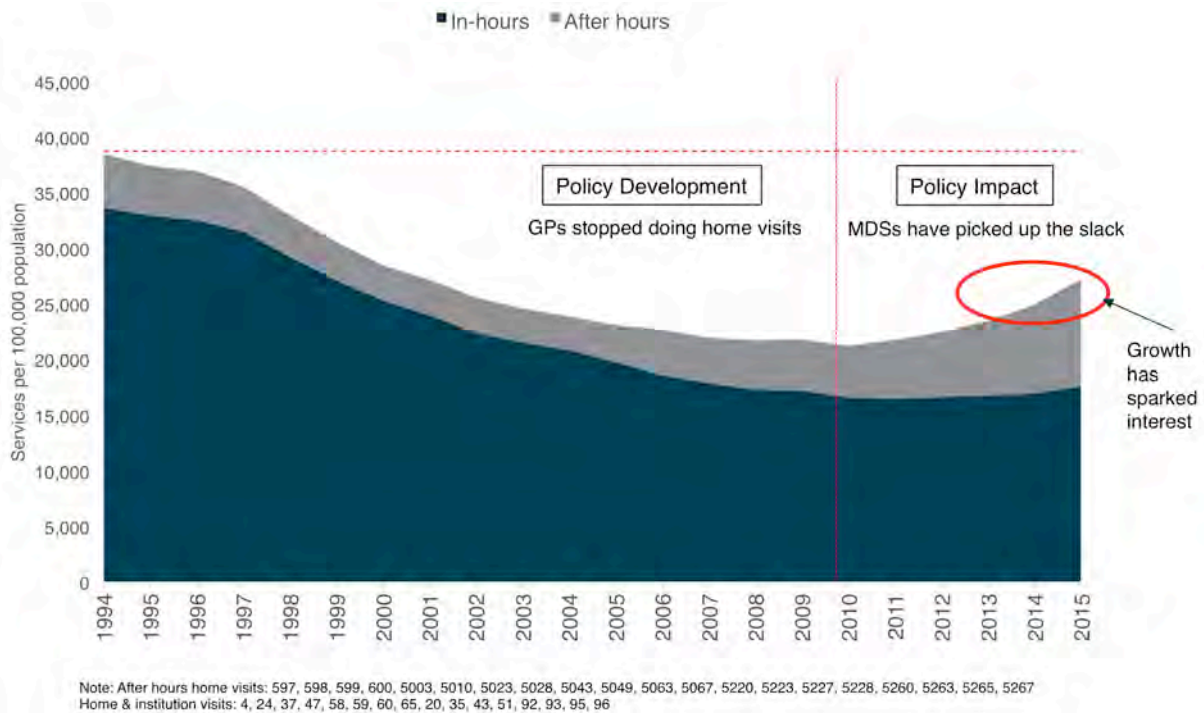
On average, 75% of patients are seen within the timeframes mandated by the triage categories. Patients are typically either treated and not admitted, treated and admitted to hospital, or transferred to another facility. Some patients will leave before receiving treatment. For the purpose of this report, we refer to the lower urgency categories 4 and 5 as low acuity presentations.

8 Jackson MBBS MD MPH CertHEcon GradCert Management FRACGP FAICD, C., 31 October 2014, *Review of After Hours Primary Health Care*, The Royal Australian College of General Practitioners.

2.4 Response from the MDS Sector

2.4.1 The trend observed in these studies has now started to reverse and access to home and ACF visits has increased, although rates of visits are not yet at the rate at which home and ACF visits were historically provided.

Chart 3: Home and institution visits by GPs (Medicare services per capita)



Source: Medicare

After hours home and ACF visits have grown in availability since 2012 when only 11.6 million Australians (52% of the population, mainly in metropolitan areas) had access to an after hours home or ACF service. That figure now rests at 19.8 million Australians (82% of the population, including regional communities across Australia), as services have expanded to regional centres. Of note, this care is generally *not* being provided by the regular GP but by doctors operating within MDSs. As Joyce noted in her 2008 paper:

Medicare statistics for the Practice Incentives Programme (PIP) indicate that only 27% of PIP registered practices (in 2007) provide all after hours care for practice patients, *with the remaining three-quarters outsourcing*. The number of after hours deputising services has grown rapidly in recent years, supported by new government initiatives. The provision of after hours care by deputising services rather than a patient's usual GP highlights the necessity of good communication and integration between different providers to ensure continuity of care.⁹ (Emphasis added.)

2.4.2 The role of the regular GP in providing after hours primary care to his/her patient base has deteriorated even further since the Joyce study. Since 2008, there has been a further pull back from these services and the vast majority of after hours services are now conducted by after hours providers (primarily MDSs) on behalf of general practice. Today, approximately 65% of after hours home and ACF visits are conducted by MDSs who are members of NAMDS.¹⁰

⁹ Joyce, op. cit.

¹⁰ Deloitte Access Economics, op. cit.

2.4.3 The role of MDSs was cited by the Jackson Review:

Medical Deputising Services (MDSs) play a critical role in accessible, quality after hours primary care, particularly in urban settings. The sector has seen much recent change, *with many locations across the country experiencing an increase in numbers of, and competition between, MDSs*. This parallels an increase in MBS after hours utilisation, particularly for residential aged care facilities (RACFs). Within this context, informants raised issues relating to medical support for RACFs (both in and after hours), optimal use of after hours care provided by MDSs and the financial drivers for most appropriate use.¹¹ (Emphasis added.)

2.5 Context for this Submission

2.5.1 While the Jackson Review did not examine the use of the after hours item numbers, it did recommend that:

The Commonwealth works with key stakeholders to urgently examine the rapid escalation in utilisation of after hours MBS items. The Department of Health should identify the relevant drivers responsible and work with PHNs and local stakeholders to develop optimal utilisation of this resource.

This is a fair suggestion and it is incumbent on all participants in the health care industry to look hard for efficiencies and optimal use of scarce health care dollars.

2.5.2 Growth in after hours care lies in three overlapping elements:

- Unmet needs, particularly of vulnerable patient groups.
- Increase in access to this service to areas of Australia that prior to 2012 did not have MDSs as an option.
- Increase in awareness regarding the options for consideration when primary care is required in the after hours period.

Specific policy initiatives were developed to address the lack of access to primary health care in the after hours period. By definition, if the policies are well constructed, Australians will opt for them when appropriate. As a result, they avoid using other more expensive forms of after hours health care.

2.5.3 Expansion of access into new locations between 2012 and 2016 is a direct result of two specific health care policies (amongst a variety of policy efforts) designed to strengthen the provision of after hours home and ACF visits:

- The AMDS Program: Many of the doctors engaged in home and ACF visits by MDSs operate under the 1999 Commonwealth Department of Health Australian Medical Deputising Service Program (AMDSP). As outlined in the Jackson Review:

The purpose of the AMDSP, which was established in 1999, is to expand the pool of available medical practitioners who may work for MDSs. Under the AMDSP otherwise ineligible medical practitioners can provide a range of restricted professional services, for which Medicare benefits will be payable, where the medical practitioner works for an approved MDS.

- Round the Clock Medicare and follow up initiatives of 2005 and 2007 to increase the value of the after hours Medicare items *in order to enhance access to the service*.

2.5.4 The AMDS Program remains important today. While new medical graduates may be influencing supply for daytime GP practices, this is not the case with the home and ACF visit sector.

11 Jackson, op. cit.

Q&A: Why are younger GPs doing no home visits? *Australian Doctor* (September 2016)

Dr Willett: “You learn a lot about the patient by going to their home. It’s a financial disaster but medically very useful.”

AD: “So remuneration is a factor in the low rate of home visit and ACF visits?”

Dr Willett: “Remuneration is a huge issue for all GPs.”

2.5.5 The supply of doctors to MDSs is becoming increasingly tenuous. Even with the AMDS Program, supply of after hours doctors remains a major challenge, and has been made more difficult with changes instituted by RACGP in January 2016. Notwithstanding that the community now depends on non-Vocationally Registered (non-VR) GPs to provide one in two home and aged care visits, such doctors receive little formal recognition for this experience. Until recently, non-VR GPs working as home and ACF visiting doctors under the AMDS Program could have a pathway to fellowship with RACGP (the Experience or Practice Eligible Pathway).

However, following the changes by RACGP earlier this year, this pathway has been dismantled and replaced with another training pathway capped at 50 non-VR doctors per annum.¹² One of the consequences of this change is that it is now even less attractive for young doctors to work as a home and ACF visiting doctor, with no opportunity to specialise in home and ACF visits and have a pathway to fellowship. The full implications and how this new pathway is working are still being assessed. A number of recommendations are made in this submission to address workforce supply.

2.6 The Importance of a Strong MDS Sector for the Future

2.6.1 The purpose of the Medicare items is even more relevant today. Consumers are increasingly seeking round the clock health care. The growth in female workforce participation (i.e. those that carry the primary role of managing family health matters, be it for children, elderly parents/in-laws, husbands and themselves), the 24-hour economy, and the greater awareness of risks from delayed treatment (e.g. Meningococcal disease), are contributing to this trend.

2.6.2 According to Palliative Care Australia, 70% of Australians say they wish to die in their own home, but only 14% do so. MDSs can and do offer palliative care after hours in close consultation with the regular GP. This is another example of the complementary and contemporary nature of the model, deserving of more consideration and review.

2.6.3 An evidence based approach shows a robust medical deputising model is the most cost effective response to addressing access, timeliness and increasing concerns about fragmentation of care.

“MDS providers are really useful to us, and the service we receive is of very high quality.”

GP, Melbourne

¹² RACGP website <<www.racgp.org.au/becomingagpp/imgaus/pep/>>

- 2.6.4 Medical deputising is evolving as a model with substantial potential to support significant cost savings for the taxpayer. Importantly, these cost savings do not entail any compromise in care, e.g. through a reduction in availability of care. By ensuring the right care is delivered in the right place at the right time, clinical efficacy and use of scarce health care expenditure is optimised.
- 2.6.5 Every health system faces a challenge to ensure access to after hours primary care without overburdening GPs and without directing patients to hospital as the default (and most expensive) provider.

The use of after hours doctors is a progressive and sustainable initiative. Primary care in the after hours, when used appropriately, represents a cost saving to the health care system over the default option.

Properly delivered, MDSs' delivery of primary care in the after hours reduces the strain on the hospital system while enhancing continuity of care with the regular GP. MDSs also provide a pathway to direct those patients without a regular GP towards having such a GP.

“I hurt my back severely at work and required major surgery. The home doctor service helped me greatly when my GP wasn't working and saved me from having to go to the hospital...I have recommended this service to all my friends, it's a great service and even though my case is not life threatening, to me this service saves me from going to hospital and takes some load off the hospital emergency department.”

Cassandra, West Lakes, South Australia

“As a person with disabilities, I find it an ordeal to go to a doctor after hours. As I need to order a wheelchair taxi, make sure that the clinic I am going to is wheelchair accessible. But with MDS I don't have any of that trouble. The doctors are caring and professional. And I am not wasting time and resources from the emergency departments.”

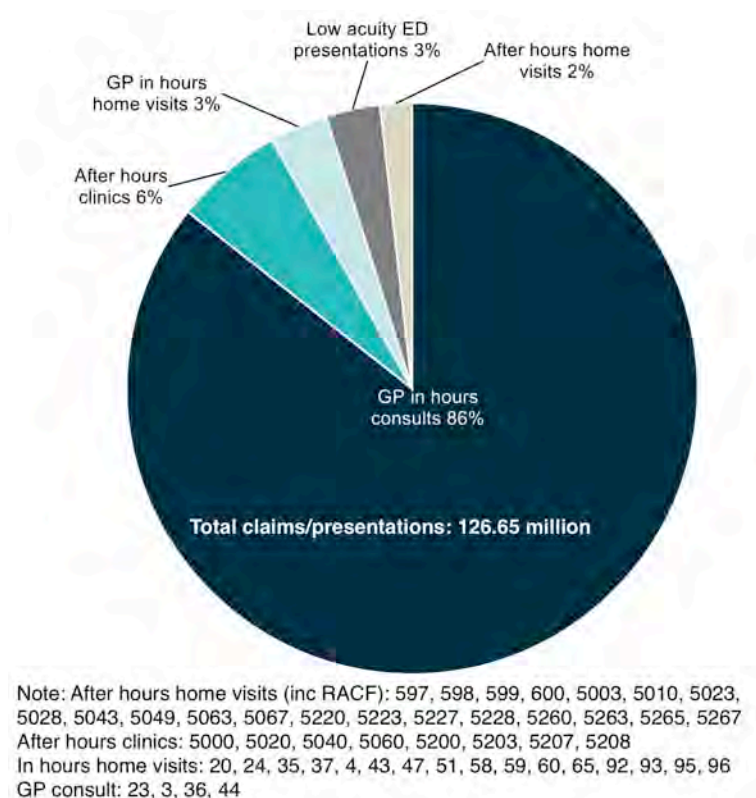
Sue, Brisbane, Queensland

3.0 The Options for Provision of After Hours Primary Care

3.1 After Hours Service Models

3.1.1 After hours primary care is comprised of several different service models. In total, after hours services (including low acuity ED presentations) represent 11% of total primary care services. After hours home and ACF visits represents circa 2.0% of this total.

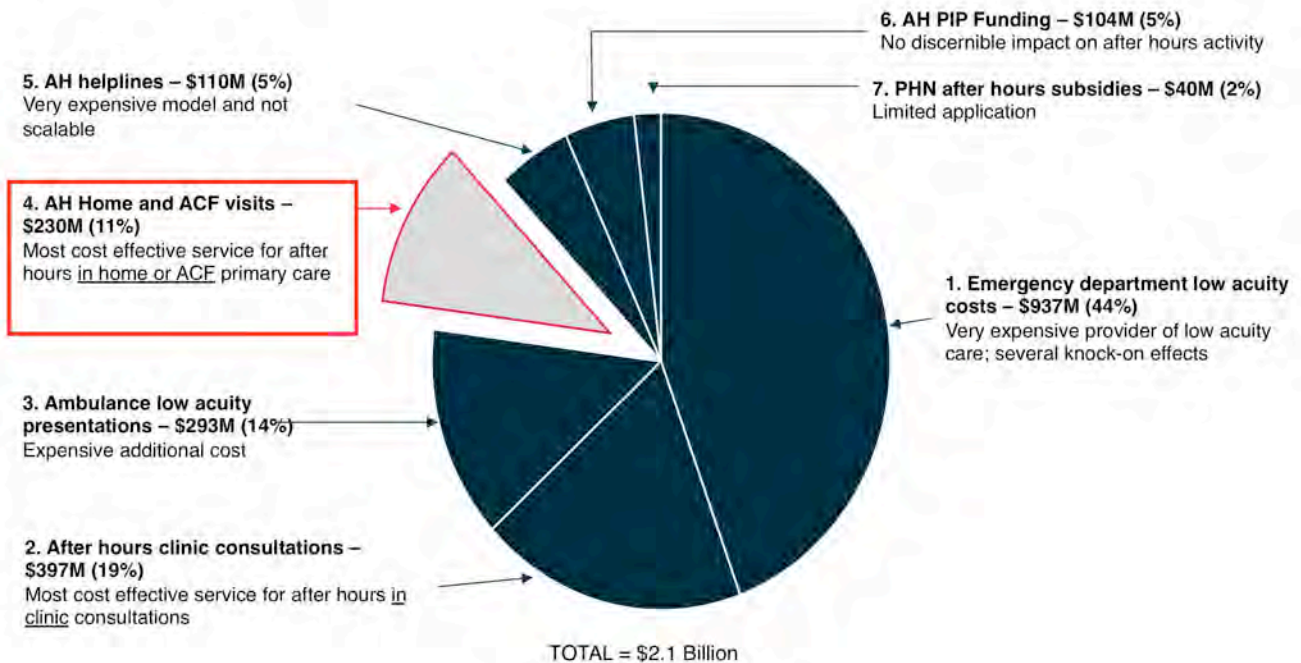
Chart 4: Total claims/presentations 2014-15



Source: Medicare Statistics, AIHW

Approximately \$2.1 billion is spent providing after hours primary care in Australia each year. This includes the cost of low acuity ED presentations, after hours clinics, ambulance carries (relating only to low acuity cases), after hours home and ACF visits, after hours primary care, after hours helplines, Practice Incentive Payment Funding and PHN after hours subsidies. These costs are borne by Commonwealth, state and territory health budgets.

Chart 5: Estimated total after hours primary care spend 2014-15 (%)



Source: IHPA – National Efficient Price Determination 2015-16; Medicare Statistics; AIHW; Australian Hospital Statistics

3.1.2 Primary care in the after hours period is provided by a variety of service providers. For the sake of completeness these include:

Emergency Departments:

- Emergency departments deal with a range of conditions triaged from Categories 1 to 5. Categories 4 and 5 are considered low acuity and in many cases can be dealt with by a GP, if available. These low acuity categories comprised 54% of ED presentations across Australia in 2005.¹³
- In the absence of access to after hours primary care options in the 2000s, attending EDs became the default option for many Australians. Consequently, this became a serious political issue and prompted a number of policy responses.

After Hours Clinic Visits:

- Daytime practices which extend their opening hours to, for example, 9:00pm or 10:00pm on particular days or open on a Saturday morning.
- Dedicated after hours clinics that open only at evenings or weekends (and include GP co-operatives).

After Hours Home and ACF Visits:

- Regular daytime GPs conducting after hours visits to their own patients at home and in ACFs. (This is a less common approach and where it does occur, is primarily in rural or remote areas where other options (e.g. MDSs) are not available.)
- Medical deputising services such as those represented by NAMDS; approved medical deputising services are accredited under the RACGP Standards for General Practice and are approved by the Commonwealth Department of Health to access doctor workforce under the Department of Health AMDS Program. These services provide the bulk of after hours home and ACF visits. NAMDS represents organisations that deliver approximately 65% of the services in this category.

13 Deloitte Access Economics, op. cit.

3.0 The Options for Provision of After Hours Primary Care

- GP co-operatives, where groups of GPs combine to provide after hours care to patients using a roster system and may include home and ACF visits. However, co-operatives tend to provide fewer home and ACF visits, which negatively impacts some patient groups who struggle to attend the clinic, such as the elderly or those with children who cannot be left home at night.¹⁴
- Other non-accredited after hours services (non-MDS services which do *not* rely on the AMDS Program for their clinical workforce). These are small services staffed with VR and non-VR doctors who may or may not provide patient reports back to the regular GP.

Telephone Triage Services:

- These comprise health information and advice services which may act as a front end triage process for patients to see a doctor after hours.
- The most prominent is that provided by the Commonwealth-sponsored Health Direct, which includes a nurse, helpline and a GP line (for patients in rural areas where the medical condition cannot be addressed by the nurse who handles the original call).
- Other telephone triage services are integrated with after hours clinics and to a very limited degree with actual home and ACF visits. Examples include GP Access in Tasmania and Hunter GP Access in the Hunter Region, NSW.

3.2 After Hours Medicare Item Numbers

- 3.2.1 Not all after hours item numbers are being reviewed by the MBS Review. We understand the Taskforce has been asked to review items 597, 599, 5023 and 5028. We understand the strong growth in use of these item numbers is the reason for the examination by the Taskforce.

The key Medicare items used by MDSs are:

- Item 597 – urgent attendance – after hours (M-F: 7:00am to 8:00am, 6:00pm to 11:00pm; Sat: 7:00am to 8:00am, 12 noon to 11:00pm; Sun/public holidays: 7:00am to 11:00pm).
- Item 599 – urgent attendance – after hours (11:00pm to 7:00am) – the ‘unsociable hours’.
- Item 5023 – non-urgent after hours home visits.
- Item 5028 – non-urgent attendance to aged care facilities.

3.2.2 Urgent Attendance After Hours (597/599)

- These items can only be used for the first patient seen on the one occasion. For the second and subsequent patients attended on the same occasion, standard (non-urgent) after hours items (e.g. item 5023) apply. If two patients are seen on the same day but at different times, then this must be noted on the Medicare claim as separate call-outs.
- The urgent after hours items can only be used where the patient has a medical condition that requires urgent treatment, which cannot be delayed until the next in-hours period. Further discussion is noted below.
- For clinic based consultations, it is necessary for the practitioner to return to and specially open the consulting rooms for the attendance.

3.2.3 Non-urgent After Hours Attendances (5023/5028)

- These items are for non-urgent medical services that are rendered after hours in a home, residential aged care facility, or institution (not hospital).

¹⁴ Comino, E.J., Zwar, N.A. & Hermiz, O., 2007, *The Macarthur GP After hours Service: A Model Of After hours Care For Australia*, Australian Health Review, 31 (2), pp 223-230.

3.3 After Hours Defined

3.3.1 MDSs provide after hours high value primary care services to patients in homes and in aged care facilities on behalf of the patient's regular GP. They provide care to patients under two basic circumstances:

- At the request of the GP when the patient's mobility issues inhibit attendance at the GP's practice (e.g. disability, frailty, those undergoing palliative care at home etc.) – this can include routine care activities performed on behalf of the GP; or
- At the request of the patient when regular GP services are unavailable during the defined after hours period and care is required on a timely basis for an acute and episodic condition.

There are a number of conditions associated with the 597/599 item numbers:

The face-to-face consultation must be conducted during the defined after hours period. The after hours are defined in the MBS based on the times when GP offices are typically closed. These times represent approximately 68% of the hours in an average week, i.e.:

- Weeknights from 6:00pm to 8:00am the following morning.
- Weekends from noon Saturday through to 8:00am on Monday morning.
- All day on public holidays.

The call for assistance must be initiated by, or on behalf of, the patient: patient initiated calls may be accepted from two hours prior to the after hours period commencing (but no sooner). This is to meet the Medicare objective that patients should attend to their own regular doctor during normal clinic hours whenever possible. Hence pre-booked or planned calls are not available, unless requested by the regular GP (e.g. a GP has an immobile patient requiring care and he/she is unable to attend to them; the GP can arrange for the MDS to provide this care at any time and is not restricted to the two hour window. Accordingly, GP referred calls may be accepted at any time, however any referrals made prior to two hours before the commencement of the after hours period cannot be billed as a 597 or 599 ('urgent') and must be billed at the lower non-urgent amount).

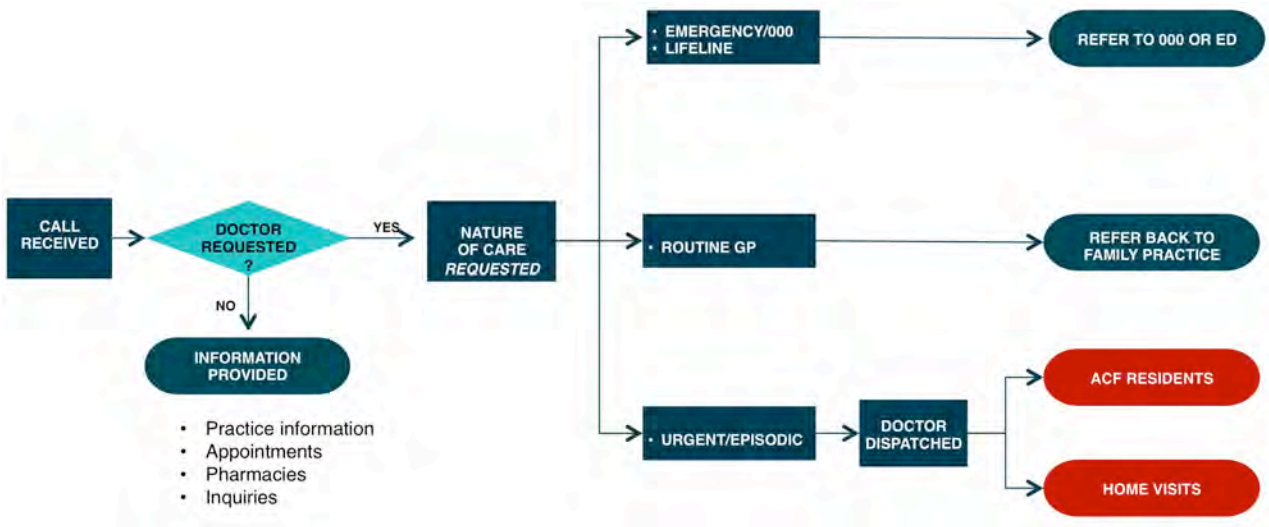
3.3.2 MDSs follow strict triage protocols to ensure that doctor visits are only made in appropriate circumstances. Calls received from patients are assessed and where there is a request for a doctor visit, symptoms are gathered and assessed against a triage scale determined by the relevant clinical leadership group in each organisation.

Calls fall into five broad categories, each with their own triage response:

- Information based calls (e.g. 'Where can I find a late night pharmacy?', or 'Can I book an appointment with my doctor?', or 'I thought I was ringing my doctor's surgery?') are handled by a medical receptionist with the requested information provided to the caller.
- Callers requesting a doctor, where the specific presenting symptoms are identified as a potential emergency requiring immediate referral to an emergency department for further assessment and treatment. Callers are advised to go immediately to their local emergency department or call 000. The presenting symptoms defined as 'emergency conditions' are set by the clinical leadership group in each MDS organisation.
- Callers requesting a doctor for non-urgent, routine care. These callers are directed to their regular GP.
- Callers requesting a doctor where the MDS holds specific patient instructions from the subscribing GP, for example, where the patient is receiving palliative care at home. A doctor visit is arranged as appropriate.
- Callers requesting a doctor where the presenting symptoms involve acute episodic care. Given that regular and obvious non-urgent calls are triaged out, this means by definition that MDSs typically have a much higher percentage of 'urgent' to 'non-urgent' items (having largely triaged out the non-urgent patients at the outset).

3.0 The Options for Provision of After Hours Primary Care

Chart 6: Triage process



3.3.3 Information obtained during the call includes:

- Patient details, address and Medicare details.
- Symptoms/basis for the call.
- Confirmation of the patient's regular GP to search for GP-initiated special patient instructions and to ensure continuity of care is preserved.
- Home or ACF access details.

3.3.4 Provided that the triage conditions identified above are met, patient requests are dispatched to doctors on the road. MDSs underpin continuity of care by providing a secure, comprehensive medical report of the consultation to the regular GP practice the following morning. Patients are advised to follow up with their regular GP if conditions persist, or where clinically appropriate.

3.3.5 It is a condition of accreditation that an MDS makes doctors available during the so called 'unsociable hours' from 11:00pm to 7:00am (in addition to the 'social' hours, i.e. the other hours in the after hours period). Resourcing the doctor workforce for the unsociable hours is a major challenge for MDSs, which puts their viability under pressure.

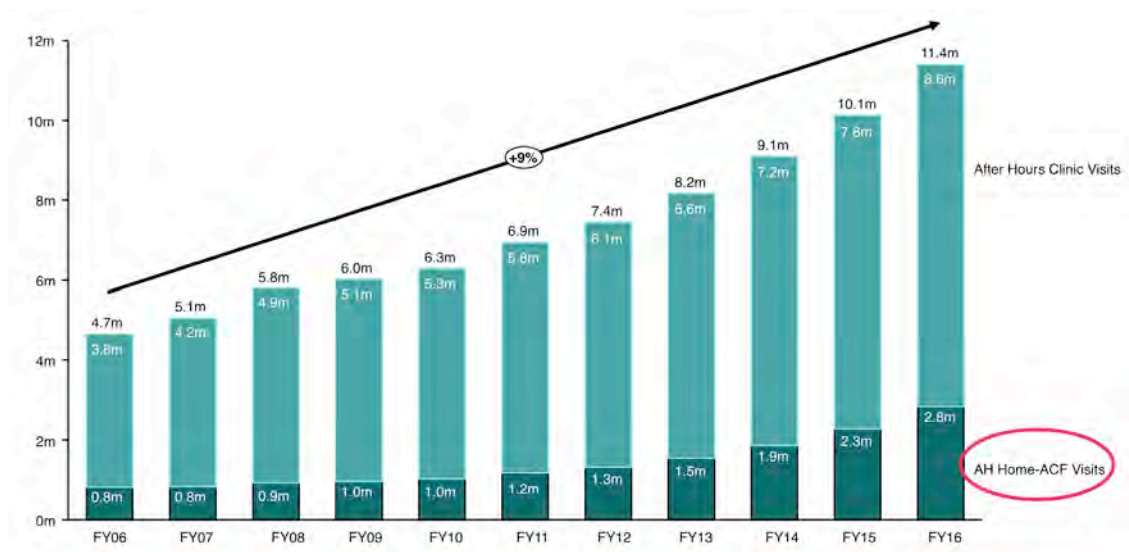
3.3.6 MDSs provide services on a very different basis than after hours clinics (for patients choosing between a service provided by an MDS or an extended after hours general practice that is not their usual general practice). There are several differences worth noting:

- After hours clinics are open limited hours and do *not* offer services in the unsociable hours.
- An after hours clinic is able to provide all medical care, *including the routine care normally provided by the regular GP. As such, a major feature of this care is the convenience to patients of being able to access a GP in the evenings and on weekends.* In contrast, MDSs triage convenience type requests back to the patient's GP. (Emphasis added.)
- After hours clinics effectively compete with regular daytime practices and have no obligations to provide patient notes to the regular GP, thereby often fragmenting care.

After hours clinics have also grown strongly over the last 10 years, delivering circa 8.6 million services at a cost of circa \$450 million in 2016, an increase of 4.8 million on the 3.8 million services delivered in 2006.

We do not challenge the merit of extended hours clinics but note their considerable cost, given the ongoing commentary about the \$230 million being expended for home and ACF visits.

Chart 7: Total # of consultations: all GP visits



Source: Medicare Database

4.0 About NAMDS and Medical Deputising Services

4.1 Membership

- 4.1.1 The National Association for Medical Deputising Services (NAMDS) was formed in 1993 and is an association of 10 member services which provide after hours care to over 18 900 000 Australians in the home and in aged care facilities.
- 4.1.2 There are a number of conditions that have to be met to qualify as an MDS, as set out in the NAMDS Guidelines.
- 4.1.3 There remain a further 87 AMDS Deeds (there may be multiple Deeds held by one organisation) as of 2016 which have received accreditation, but are not members of NAMDS. These are small providers (often 1-3 person operations) that have grown rapidly in number in the last few years and provide services via after hours clinics or as small competitors in the home and ACF visit space. As noted in the Jackson Review:

...The growth in MDSs has been reflected in the growth of the number of service providers approved under the Department of Health's Approved Medical Deputising Services Programme (AMDSP). The number of providers approved under the AMDSP has more than quadrupled from 16 in 2006, to 83 in 2014.¹⁵

Today there are 114 AMDS Deeds in place.

“Used this recently for my Mum who had decided to stop injecting her insulin! The doctor Dr Hanna was just so lovely, so thorough and able to convince my mum (82 yo) that she must let me take her to the hospital. Rang me a few days later to check in and my mum’s GP commented on the very thorough report she received from her. Great personal service! Thank you Dr Hanna!” Gloria, Online comment

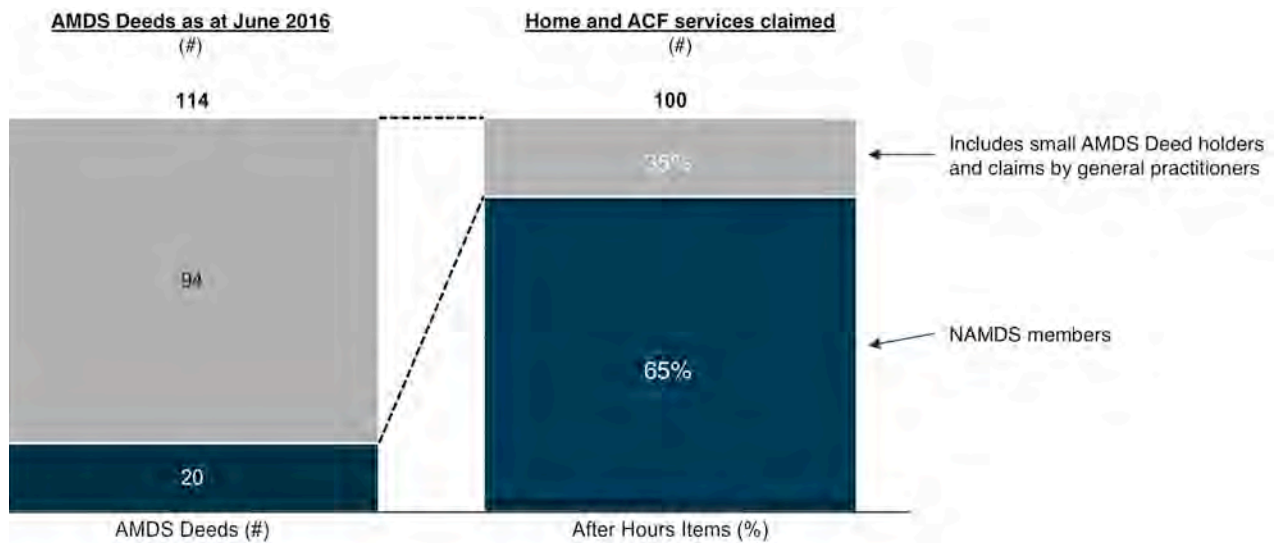
¹⁵ Jackson, op. cit.

Chart 8: AMDS Deeds vs volume



Source: Department of Health

Chart 9: AMDS Deeds (#)



Source: Department of Health; Deloitte Access Economics, November 2016

- 4.1.4 Tighter referencing of prospective providers against accreditation standards has seen the strong growth in AMDS Deed holders plateau after four years of rampant growth. Knowing the investment, effort and commitment required to meet the AMDS Program Guidelines set down by the Commonwealth Department of Health, it is probably not surprising that so many potential aspirants come into the sector only to quickly leave again. How they conduct themselves while trying to build a service is unknown.
- 4.1.5 There are other after hours providers which are not MDSs; these groups, along with GPs and non-NAMDS members providing their own after hours calls, represent the remaining 35% of the after hours home and ACF services.

5.0 History of After Hours Care – The Demise of the Home and ACF Visit

5.1 The Early Days (Pre-1990)

GPs traditionally had responsibility for 24/7 care of their patients. Home and ACF visits were a common element of general practice right through to the 1980s. GPs would typically do rounds of home and ACF visits in the morning, at lunchtime, or later in the afternoon and early evening. They would visit elderly and infirm patients and people who had difficulty getting to the surgery. This often included young families with children who had become ill later in the day.

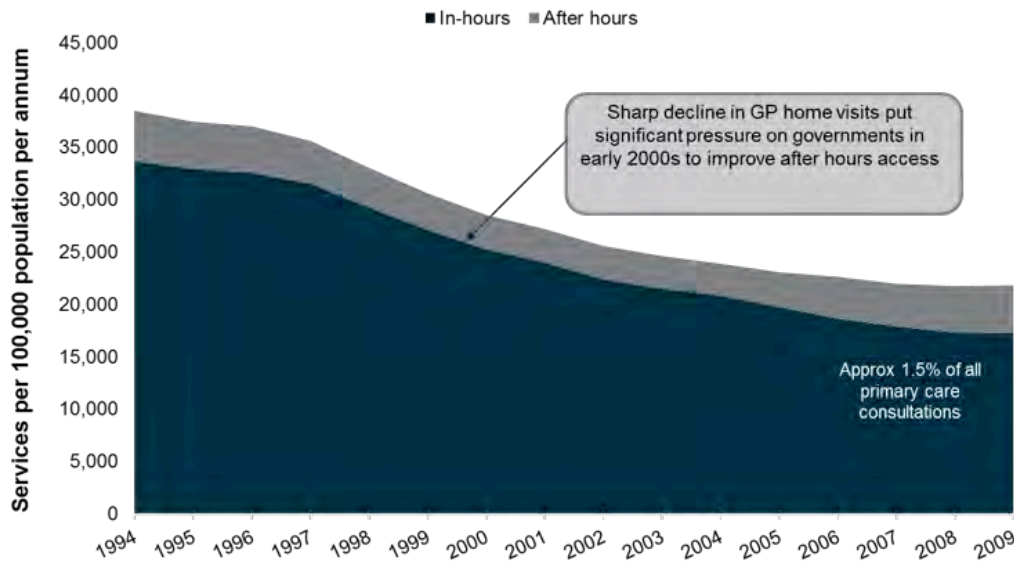
5.2 The Demise of Traditional GP House Calls (1990-2010)

5.2.1 As general practice began to change in the late 1980s and early 1990s, GPs began to make fewer house calls. Some GPs continued to do their own home and ACF visits both in-hours and out of hours, but between 1994 and 2010 the availability of home and ACF visits collapsed from 38.5 home and ACF visits per 100 people per year to only 21.2 home and ACF visits per 100 people by 2009. As a consequence, patients found it increasingly difficult to access after hours care. (It is important to note that 1994 does not represent the highwater mark for home and ACF visit needs but this is the most comprehensive MBS data available.)

“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 two calls a night. If they are far apart this takes a while and will give me \$130 per call.” GP

“I don’t want to be called at all hours of the night. It’s a lifestyle decision.” GP

Chart 10: GP's Medicare services per capita



Causes and Consequences of Declining Home Visits

- GPs historically responsible for 24/7 care of patients
- Changing GP workforce preferences and practices and changing practice economics saw decline in availability and patient expectations of home visits
- **Emergency Dept became default after hours option for urgent but low acuity issues**
- Growing community concern regarding pressure on EDs, waiting times and lack of alternative options

Notes: Home & institution visits: 4, 24, 37, 47, 58, 59, 60, 65, 20, 35, 43, 51, 92, 93, 95, 96

Source: Medicare

5.2.2 In the period leading up to 2007, community concerns regarding access to after hours primary care grew significantly in response to the declining availability of home and ACF visits. Patient needs however did not change and the ongoing requirement for access to after hours primary care placed increasing pressure on policy makers. For much of the 1990s and 2000s, improving access to primary health care after hours and reducing emergency department crowding were identified as key health policy issues. Commonwealth, state and territory governments promised and delivered helplines, co-located clinics, workforce strategies and improved rebates and incentives with the intention of improving access to care and reducing pressure on hospital emergency departments.

5.2.3 The need for health care reform in 2007 was summed up by Dr Martin B Van Der Weyden referring to the AMA 2007 Public Hospital Report Card:

Of prime concern to the public and health professionals is the systematic deterioration of our public hospitals, burdened as they are with ever-expanding waiting lists, reduced bed capacity, poorly coordinated clinical services, access block and overcrowded emergency departments...

...Indeed, there has already been a flurry of distressing reports cataloguing near misses and clinical mishaps in emergency departments across the nation.

General practice also has its share of problems. These include: increasing workforce shortages, especially in rural areas; the burden of red tape; inefficiencies in the interface between general practice and hospitals or community aged care; and numerous other issues related to continuity of care and access.¹⁶

16 Van Der Weyden, M.B., 3-17 December 2007, *It's Time For Change And Resolve*, Medical Journal of Australia, vol. 187, no. 11/12.

5.0 History of After Hours Care – The Demise of the Home and ACF Visit

5.2.4 In the context of today's debates around health care reform it is important to recall the significant level of concern and debate during the period 1998 to 2010 surrounding the lack of access to primary care in the after hours. Wave after wave of governments developed initiatives to address this issue, one that is so important to Australians. The range of government policy responses to the after hours crisis since 1998 include the following:

- 1998: introduction of after hours Practice Incentives Programme (PIP) payments to provide an incentive for GPs to provide or arrange after hours care for their patients.
- 1999: introduction of AMDS Program to help address workforce shortages.
- 2000-01: a sizeable increase (50%) in rebates.
- 2005: the Round the Clock Medicare policy meant more rebate increases (\$10 for after hours home and ACF visits from 8:00pm and \$10 per consult in consulting rooms from 8:00pm). In addition, the rebate was paid at 100% of the MBS schedule fee (rather than the 85% previously) with a \$5 bulk billing incentive item number 10990 for patients under 16 years and Centrelink recipients.
- 2007: rebate increases extended to the transition period of 6:00-8:00pm on weekdays.
- 2008: funding for super clinics.
- 2013: diversion of after hours PIP funding to Medicare Locals.
- 2015: abolition of Medicare Locals and the introduction of the new PIP After Hours Incentive.

“Thankfully I’ve seen a home doctor as I had a really bad sinus infection that if left a day later I would have been hospitalised...” Lola, Caboolture, Queensland

6.0 The Policy Response (1998 to Today) – Revitalising After Hours Primary Care

6.1. The Policy Framework

- 6.1.1 It is difficult to ascertain success of any given policy at a point in time. However, there was concern that emergency departments had become the default option for patients needing after hours care. The overall health policy objectives remained:
- The right care, right place, right time.
 - Respect continuity of care.
 - Avoid fragmentation.
- 6.1.2 Medical deputising has been in existence for several decades. Even as the traditional role of GPs in providing their own after hours care was waning over the last thirty years, MDSs operated to help fill the vacuum and address the unmet needs of patients. (Some NAMDS members have been operating for over 45 years and the core members have been in operation for over 30 years.) Historically, MDSs were small, sub-scale, localised organisations that often struggled to survive. Many would start up only to later close operations as the unpredictability of demand for services and difficulty in recruiting doctors, particularly with uncertain daily demand for services, presented real operating challenges. Early MDSs were entirely focused on delivering their support to general practices – allowing practices to hand over the demanding role of answering calls and attending to sick patients at night and on weekends. MDSs received ‘subscription’ payments from general practices for providing this service (typically a transfer of the PIP payment received by the practice) and also charged patients for attendances.
- 6.1.3 The introduction of Medicare in 1984 allowed MDSs to bulk bill patients for attendance, but MDSs remained largely reliant on subscriptions as a funding source until as late as 2013. These subscriptions subsidised the cost of overnight reception and medical coverage and the administration involved in reporting back to the regular GP. Following the 2015 change in PIP funding and on the back of increased competition within our own sector, these payments are generally retained by general practices and are not paid to their respective MDSs.

6.2 Medical Deputising in Development

6.2.1 By 2010, MDSs were starting to relieve the load on GP practices, but the sector was still relatively immature:

- **Access:** Access was patchy with some key metropolitan markets (in particular Sydney) and regional markets underserved or not serviced at all. Expanding access required investment.
- **Awareness:** Awareness levels were very low (and remain so today) – education and awareness was conducted largely via information coming from GP practices with disappointing results.
- **Systems:** Systems to support provision of care by MDSs, more comprehensive training and support for doctors on the road and to facilitate continuity of care to the GP practice were in their infancy and required investment.
- **Doctor supply:** The program to support supply of doctors in after hours – AMDS – was effective but competition for doctors remained a key concern.
- **Funding:** MDSs relied heavily on subscriptions from GP practices to support their viability.

6.3 Practice Incentives Programme

6.3.1 One policy step was the introduction of the Practice Incentives Programme After Hours Incentive in 1998. Payments were provided to incentivise Accredited General Practices to conduct after hours care or to *arrange* after hours coverage from an MDS.

6.3.2 The PIP After Hours Incentive's tiered arrangement resulted in most practices operating at Tier 1 – whereby they received an amount of money as an incentive for nominating an MDS to take care of their patients in the after hours period. The after hours payment was usually passed on to the MDS by the general practice in exchange for the MDS taking on this obligation. This was essentially a 'business-business' model. This allowed MDS coverage to grow, but typically only patients of subscribing practices would be seen. In essence, the cottage industry was being perpetuated.

6.3.3 Awareness of the availability of after hours services was largely left to general practices (some redirected their calls to the nominated MDS; others would place a sign in the window of the clinic informing patients of who to contact in the after hours). These efforts were not effective. Awareness levels by 2013 were still very low, with some capital cities at remarkably low levels. In the absence of patients knowing better, the emergency department remained the default option for after hours urgent needs.

6.3.4 PIP funding changed in 2013. As noted in the Jackson Review:

In 2013, the funding model for after hours care underwent significant change, with the redirection of all funding from both the PIP After Hours (PIPAH) incentive and the grants based General Practice After Hours (GPAH) to MLs (Medicare Locals). Under the revised arrangements, MLs administered funding to incentivise and support general practices to be available to deliver after hours services and more broadly to fill gaps in after hours primary health care services.¹⁷ (Explanations added in parentheses.)

6.3.5 The diversion of PIP after hours funding from general practice to Medicare Locals (MLs) in 2013 changed the subscription model available to MDSs. A portion of this funding went into MLs' building of community awareness of after hours options and a smaller portion subsidised MDSs for covering low density areas within the fringe areas of the ML. In most locations, however, funding from the ML to the MDS did not occur and MDSs became reliant on fee-for-service income for all revenue.

The response from the RACGP to the loss of PIP funding for general practice is noteworthy. As commented in the Jackson Review:

In July 2013, MLs became responsible for the coordination of after hours medical services within their local areas. In response to this, the RACGP adopted a new position in relation to Criterion 1.1.4 of the *Standards for general practice 4th edition* as follows:

¹⁷ Jackson, op. cit.

- Practices are required to demonstrate that they are aware of the arrangements in place for their patients to access after hours care; and
- Practices are required to have processes in place to alert their patients to these arrangements.

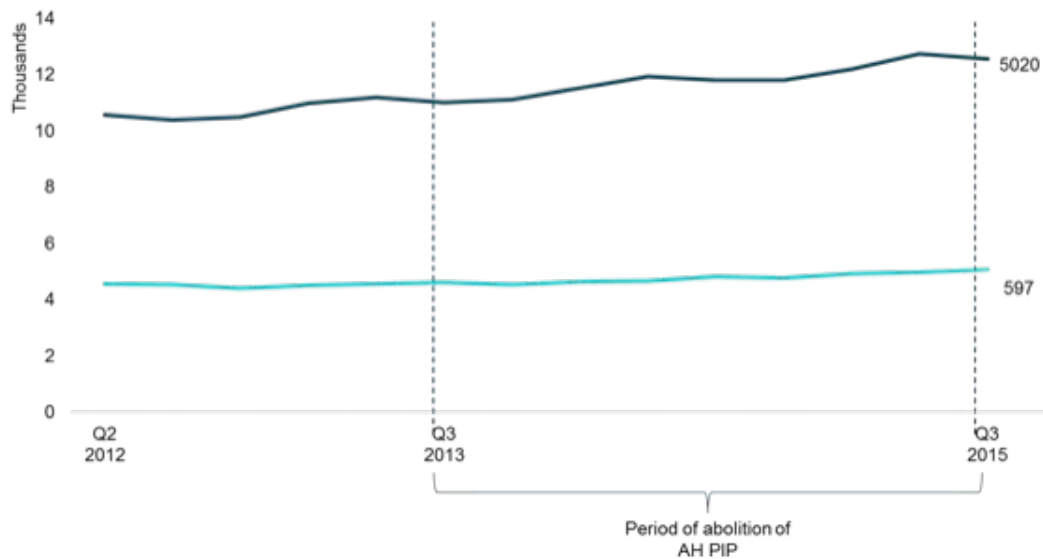
The change to MLs being responsible for the coordination of after hours medical services within local areas created a perception that after hours responsibility was with MLs and no longer with local general practices.

In effect, the traditional obligation of general practice to provide 24/7 care (in one form or another) was abandoned.^{18 19}

6.4 The PIP After Hours Incentive

- 6.4.1 In mid-2015, with the abolition of Medicare Locals, the Commonwealth Department of Human Services became responsible for delivering a revamped PIP After Hours Incentive to general practice. Most general practices now retain the PIP component of the funding and relatively few subscriptions are paid to MDS organisations for providing the after hours support. Primary Health Networks replaced the MLs but there has been limited grant funding made available to MDSs to provide coverage in low density, fringe areas.
- 6.4.2 In general, and looking at the profile of the \$104 million PIP payments, they have had little impact on the number of home and ACF visits being conducted by GPs. As an incentive, the Practice Incentives Programme has done little to change the behaviour of GPs.

Chart 11: Long-term claiming behaviour was unaffected by abolition of PIPAH



Source: Medicare Statistics

18 It is noteworthy that the sole issue raised by the RACGP in its submission to the Jackson Review concerning the provision of after hours primary care was the loss of PIP funding relating to after hours care.

19 The consequences of the abandonment by general practice of after hours care is borne out in an April 2016 communication from Medicare to MDS doctors engaged in after hours service. In that letter (and confirmed in a follow up letter from Medicare dated 27 September 2016), individual doctor's billing profiles were compared to that of a 'benchmark group' of doctors:

The graphs (*referring to the data presented in the April letter*) reflect data extracted between 1 July 2014 and 31 December 2015 for doctors who claimed urgent after hours items (597 and /or 599). Doctors identified as high billers of these items were provided with a graph compiled from their own claiming data, as a comparison.

Many of the billers of these items were identified as MDS doctors or doctors who worked solely in an after hours practice. (*Explanation added in italics*)

The claims for item numbers for this period for the benchmark group was as follows:

- 597 claims: 115 over a 78-week period, so the peer group did on average 1.5 visits per week.
- 599 claims: 16 over a 78-week period, so the peer group did on average 0.2 visits per week, or one visit during the unsociable hours every 5 weeks.
- The claim numbers included in the benchmark calculation *include* the claims by MDS doctors doing the bulk of the after hours calls and so the average is inflated. If doctors working solely in after hours services were excluded, the benchmark level of visits by regular GPs would fall even further.

These data demonstrate that general practice has effectively abandoned the provision of after hours home and ACF visits and is relying on MDSs to provide this care to their patients.

6.5 Critical Policy Response

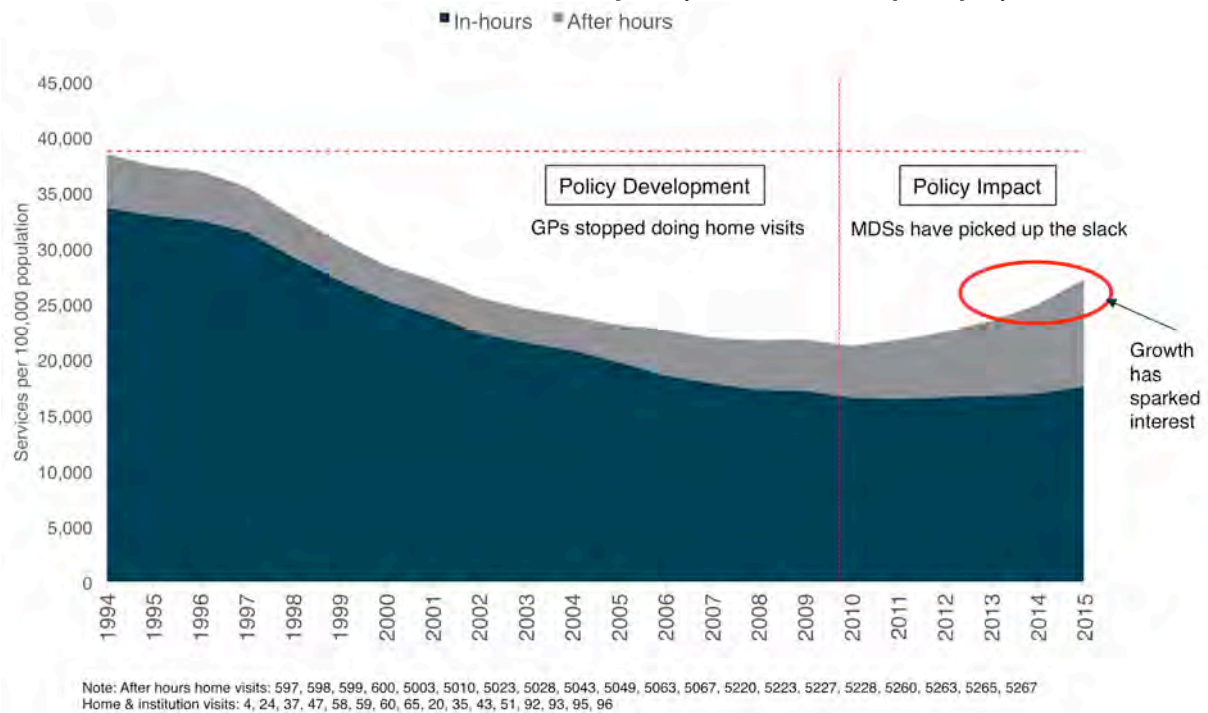
6.5.1 Beyond the importance of the 1999 AMDS Program to underpin availability of doctors (now under threat as discussed later), the most significant turning point for improved access to after hours care was the Howard Government’s Round the Clock Medicare package of 2005 and the ensuing MBS increase in rebates for after hours consultations in clinics and homes. In concert with the increase of the bulk bill rate to 100% of the MBS, this reform increased the compensation for after hours attendances and made fee-for-service operation more sustainable. This in turn encouraged ongoing innovation and investment by the private sector in technology, processes and clinical training and supervision to improve efficiency and quality.

In 2007, these increases were extended to the ‘transition’ period of 6:00pm to 8:00pm on weekdays. The structure of Medicare Benefits for after hours services has remained constant since then.

6.5.2 The shift to fee-for-service funding for after hours services has been effective in improving access. This reflects the appropriateness of using fee-for-service funding models to support acute episodic care.

6.5.3 The impact of these policy initiatives has been the revitalisation of this important part of the health care system. While home and ACF visit volumes still lag the level delivered in the 1990s, they do go a long way to meeting the needs of very vulnerable patient groups.

Chart 12: Home and institution visits by GPs (Medicare services per capita)



“The doctor knew exactly what was wrong and acted promptly. If we hadn’t seen the doctor our baby may have ended up in serious trouble.” Aidan, Gold Coast, Queensland

“This morning was the first time I used the after hours doctor service, I found the person on the phone very helpful and requested a doctor promptly. I found the service extremely valuable especially as a new mum to a 4-month-old baby (who needed to see the doctor). The service gave me reassurance that my baby was ok.

The service is extremely important and I hope the government and Medicare continue to support this service. I myself work in health care and knowing that my only other option if I was concerned would be to sit in an emergency department and put more stress and strain on my family and the hospital services. This service prevented me from doing that by giving me reassurance in a timely manner that my baby was ok.” Melissa, Mona Vale, NSW

7.0 Elements of a Successful Model of After Hours Home and ACF Visits

7.1 The Context for a Strong After Hours Sector

7.1.1 The context is best summed up by the Jackson Review:

When people become ill outside normal business hours they often need to access after hours health care services or advice. Choice of which service to access are influenced by a range of factors such as where they live, the time of day and the accessibility of health care services and mode of delivery. Primary health care is often the first port of call in meeting after hours health care needs across the country and in so doing reducing health inequity, lowering rates of avoidable hospitalisation and improving health outcomes.

Primary health care is considered to be the cornerstone of strong health care systems that produce better health outcomes at a lower cost. *The organisation and provision of after hours primary health care services is both an important element of the overall health care system and a challenging policy area. Access to primary health care, including after hours, is considered an important element of high quality health care.*²⁰ (Emphasis added.)

7.2 After Hours Model of Care

7.2.1 There are a number of stakeholders to consider when evaluating a successful model of after hours care. The starting point rests with patient need. Regardless of funding paradigms, doctor availability and the like, *patient need does not change*. The only question is how that need is met within an integrated health care system.

7.2.2 The critical elements of a successful after hours primary health care system are therefore as follows:

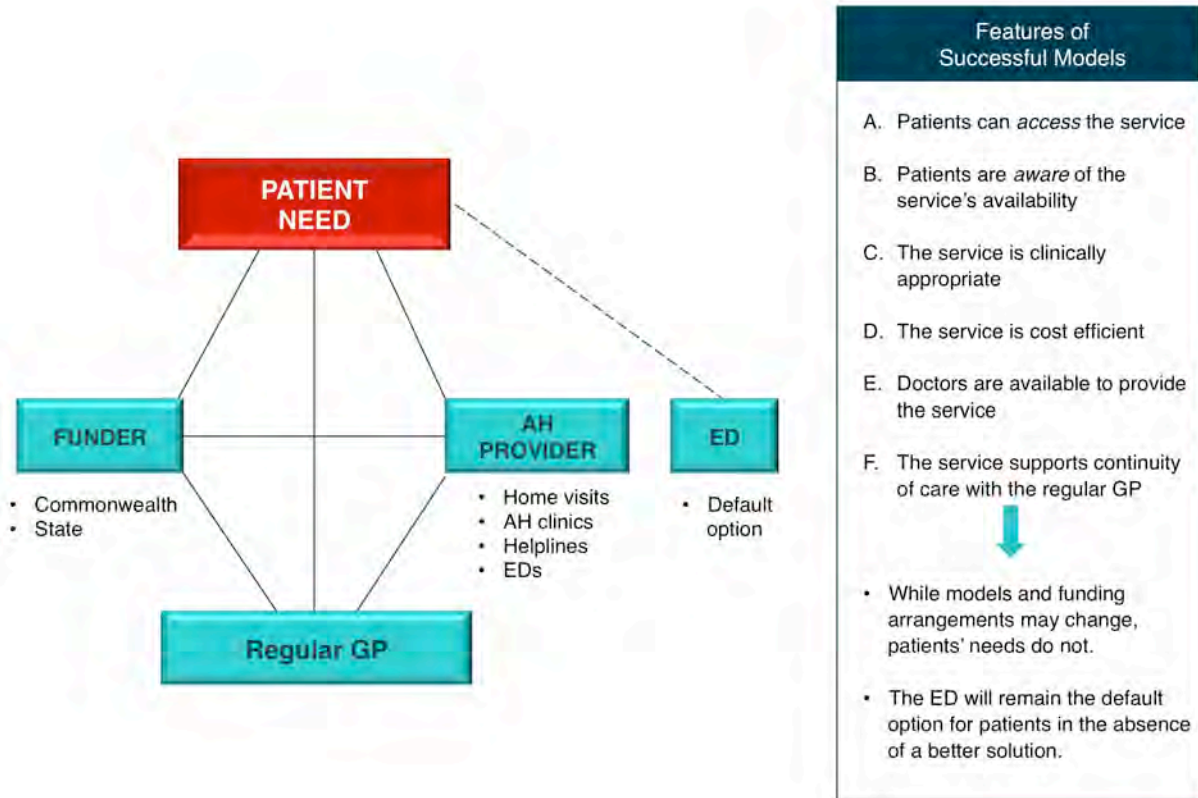
- A. Patients need to have *access* to appropriate care, i.e. it must be available, otherwise the default option will remain with the local hospital emergency department.
- B. Patients need to be *aware* of their options so they can choose the right care for their needs.
- C. The service provided must be *clinically appropriate* – the care provided must be quality health care and appropriate for the circumstances.
- D. The service must be *cost efficient*. After hours services are more expensive than patient care delivered in clinic during regular hours and thus must be carefully monitored to ensure cost effectiveness vis-a-vis other options. It must be used for appropriate circumstances and not as a replacement for daytime clinic visits.
- E. There must be *doctors willing and available* to support the service.

²⁰ Jackson, op. cit.

F. The fundamental relationship is that between the regular GP and the patient. It is critical that general practice *continuity of care* is supported. Ideally, this involves systems/processes and governance to ensure clinical handover occurs (between the general practice and the after hours provider) and continuity of care is maintained (from the after hours provider to the regular GP).

On all dimensions, the AMDS Program (1999) and the ensuing Guidelines and the Round the Clock Medicare policies (2007-09) were the most effective policy initiatives adopted to reinforce these elements to the extent they relate to MDS.

Chart 13: Model for after hours care



7.3 Access

7.3.1 The Jackson Review commented on the underlying issue of universal access to after hours primary care:

A number of national strategic documents over recent years have discussed the challenges of providing efficient, accessible and appropriate after hours services for all Australians. Australia's First National Primary Health Care Strategy *highlighted the significant disparity in the level of access to after hours primary health care across Australia and the importance of achieving the right balance of financial incentives and funding arrangements to deliver effective and flexible services at the local level.* The National Strategic Framework for Rural and Remote Health reflected on the role of after hours strategies to improve recruitment, retention and distribution of rural GPs.²⁰ (Emphasis added.)

7.3.2 While it took a few years for the effect of the improved funding for after hours items to be felt, access to after hours services began to expand more consistently from 2010 onwards. Up to this point, most support provided by MDSs was in the major metropolitan areas of Melbourne, Brisbane, Adelaide and Perth, and limited coverage in Sydney.

21 Jackson, op. cit.

7.0 Elements of a Successful Model of After Hours Home and ACF Visits

Regional coverage as at 2013 included:

- Geelong.
- Albury-Wodonga.
- Wollongong.
- Gold Coast.
- Sunshine Coast.
- Rockhampton.

At that point, MDS services were available to approximately 11.6 million Australians or just 53% of the population.

Since 2013, there has been a 71% increase in the number of Australians who have access to an MDS. This expansion of access is the single largest contributor to the increase in volume over this period. While access to an MDS was limited to approximately 11.6 million Australians in 2013, today 19.8 million have access to this vital service. *Usage of this service per capita has stayed flat with a usage rate of 0.13 per capita in 2013 and 0.14 per capita in 2016.*

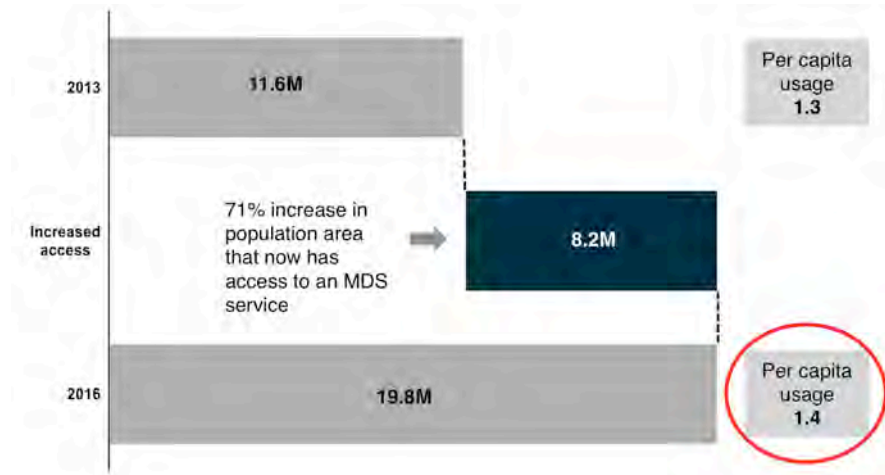
Regional towns now covered by an MDS that had no access in 2012 include:

VIC	Ballarat	NSW	All of Sydney
	Bendigo		Armidale
	Shepparton		Ballina
QLD	Bundaberg		Byron Bay
	Cairns		Central Coast
	Coolangatta		Cessnock
	Gladstone		Coffs Harbour
	Hervey Bay		Gosford
	Mackay		Kiama
	Maryborough		Lake Macquarie
	Toowoomba		Lismore
Townsville	Maitland		
WA	Bunbury		Newcastle
	Mandurah		Port Macquarie
	Rockingham		Tweed Heads
TAS	Hobart		ACT
	Launceston	NT	Darwin
SA	Gawler		

The net result is an increase in access to 18.9 million Australians. Today, MDSs provide after hours home and ACF support to approximately 82% of the population.

- 7.3.3 The increase in basic access is not a trivial issue. Australia's health care expectations are underpinned by a strong sense of equity. Universality and access are recognised as key principles of an effective health care system.

Chart 14: Access – communities with access to MDS services (population – millions)



Sources: MBS; Australian Hospital Statistics; Jackson Review; Industry Statistics

7.3.4 Much of the increase in use of the relevant MBS item numbers rests in Australians now almost uniformly having access to after hours services, unlike 2012. This growth is appropriate and consistent with broad health care objectives that universal access should be provided to Australians wherever possible. Comments made by industry observers about 'exploding numbers' in after hours care look at usage in isolation of the increased access.

7.3.5 Three additional points are worth noting when examining growth in usage:

- Firstly, there has been strong growth in other after hours health care services, including after hours clinics.

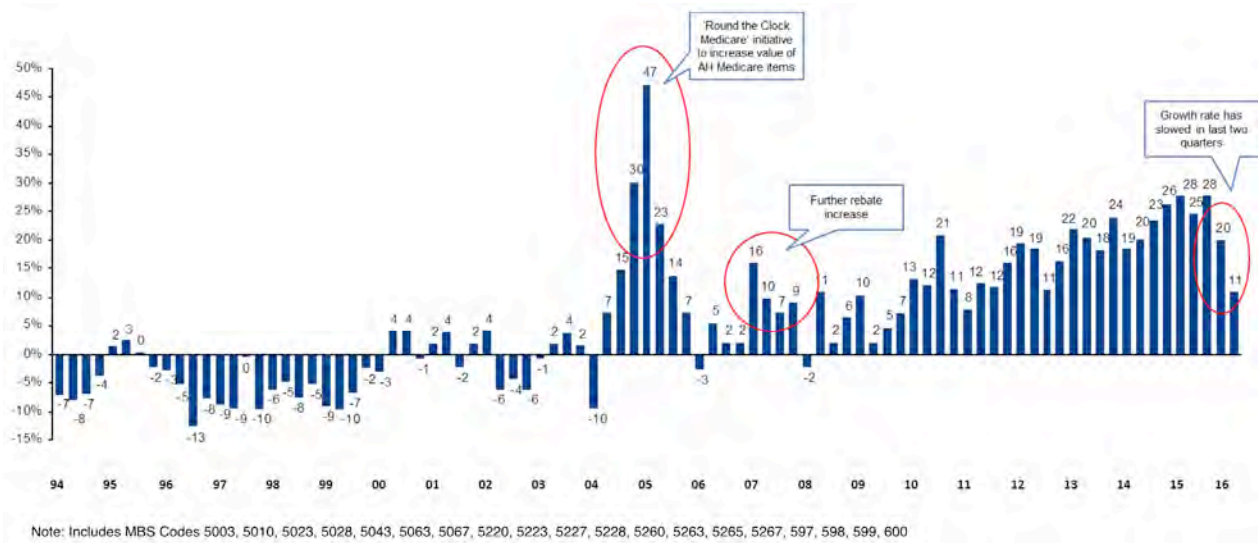
Although after hours clinics only provide services in a smaller portion of the after hours period compared to MDSs (and none in the unsociable hours), there was an increase of 4.8 million services from FY06 to FY16, at an average cost to the system of \$93 per service versus an increase of 2.0 million services (at \$128 per service) in the full after hours period in home and ACF services.²²

It is perplexing and frustrating that MDSs attract so much attention when the increase in services provided by after hours clinics was almost double the number of after hours visits, especially as clinics are not limited to providing care only for urgent and episodic matters and, in fact, compete head on with daytime general practice.

- Secondly, growth through increased access is evident in the use per capita observed in 2013 and 2016, which has remained relatively flat at 0.13 uses per capita and 0.14 respectively.
- Thirdly, much of this growth in home and ACF visits represents one-off growth as communities and regions that previously had no after hours support took it up for the first time. Not surprisingly, unmet needs are addressed once a new service opens in, for example, a regional centre but then tails off. A declining quarterly growth rate over the last two quarters is evident as new areas for expansion decline in number.

²² Deloitte Access Economics, op. cit.

Chart 15: Quarter on quarter growth in MDS billing: all MDS codes – 1994-2016 (%)



7.3.6 Most MDS services are typically 100% bulk billed, which ensures access for those who need after hours care, particularly the elderly, young families and concession card holders. Over 70% of patients are eligible for the bulk billing incentive payment.

7.4 Awareness

7.4.1 Prior to 2013 building awareness of the availability of after hours home and ACF visits was primarily the responsibility of general practices. Awareness building was through a combination of clinic signage, notices on clinic websites or messages on a practice’s after hours answering machine directing patients when necessary to either the emergency department or an MDS after hours service. In some cases, calls to the practice in the after hours were automatically transferred to the MDS. Awareness levels amongst Australians developed on this basis were disappointing.

Unprompted awareness of MDSs as an option for accessing after hours primary care was on average a very low 17% in 2013. The level of awareness ranged from 10% in Sydney up to 35% in Adelaide, where there was a tradition amongst patients of being able to contact ‘the locum service’. These low levels of awareness were the result of general practices having largely sole responsibility for building awareness with their patients over a 15-year period.

This is not intended as criticism, but it reflects the nature of the sheer volume of information GPs are expected to convey to their patients on the back of a consultation.

“I had no idea this home visit service was available. I’ve raised three kids and had the same GP throughout and it never came up. I can’t believe the number of trips to North Shore (ED) this would have saved me. Why was it a secret?” Mother, Sydney, 2013

7.4.2 As noted in the Jackson Review:

Most respondents indicated that *consumers often had limited knowledge of the variety of services available* to them and how to best utilise them to access the most appropriate after hours care. Consumers also expressed the need for better integration and coordination of existing services.

Better health literacy around which after hours services to use and how to access them would increase consumer knowledge, accessibility, appropriateness and efficiency. (Emphasis added.)

Later in that same report:

An appropriately designed, targeted and implemented PIPAH incentive would greatly simplify current arrangements, reduce reporting burden, target most desirable practice after hours support and provide financial certainty to general practices who provide holistic care.

Of equal importance, is a clearly-articulated approach to link consumers appropriately with the myriad of options for local after hours support, particularly in urban areas. This would encourage much greater consumer awareness and choice, minimise unnecessary administration costs and increase effectiveness and appropriateness of available after hours care. This should be accompanied by appropriate consumer awareness initiatives, locally and nationally. (Emphasis added.)

Again, in the Jackson Review:

Consumer awareness of available after hours services is essential to appropriately meet the after hours health care needs of patients and to ensure that after hours resources are utilised effectively and efficiently. After hours utilisation is influenced by many factors including *knowledge of available services*, availability of the right kind of care and accessibility issues, including cost, time and resources required to access.²³ (Emphasis added.)

7.4.3 Clearly, the level of awareness evident at the time of the Jackson Review in 2014 after 15 years of general practice based awareness was insufficient.

7.4.4 There was a collective view across the many stakeholders in the sector that levels of awareness had to be dealt with. Awareness has grown over the last three years as a result of various campaigns by:

- Medicare Locals.
- PHNs.
- Governments: For instance, ACT Health posts on its website:

For ongoing comprehensive health care for everyone, including those with acute problems, children under two years and those with complex medical problems, see this listing of GPs by suburb. If you or family need a doctor on a weeknight, weekend or public holiday, you can also call an MDS.

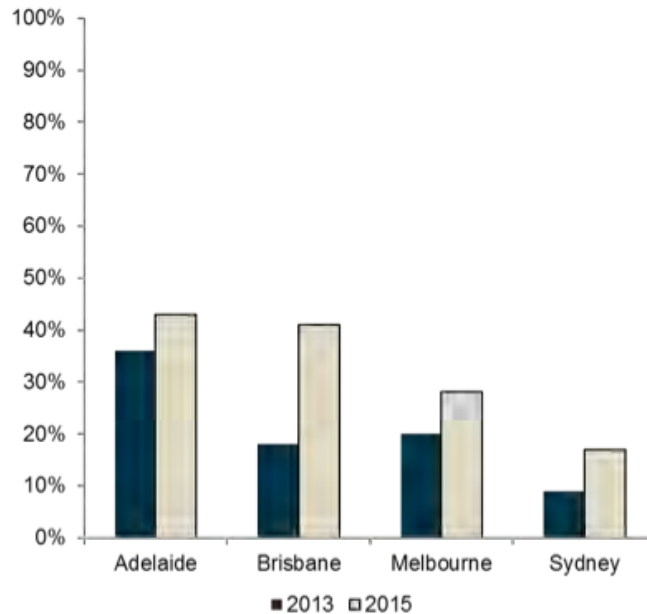
- Private Health Insurers: For instance, Health Partners posts on its website:

If you need a GP on a weeknight, weekend or public holiday, a locum service like an MDS may be helpful.

- Emergency departments.
- MDSs running their own awareness/media campaigns.

7.4.5 The result of the last four years of combined campaigns is an increase in awareness amongst patients of the availability of after hours home and ACF visits when appropriate. This is a good thing, although awareness remains sub-optimal.

Chart 16: Unprompted awareness of after hours home visiting services – 2013 vs 2015



Source: MBS, Australian Hospital Statistics, Industry Statistics

7.4.6 Notwithstanding these campaigns, awareness is still low. In data drawn from an October 2016 Galaxy Poll, awareness was still only 54%.²⁴

7.4.7 In general there is broad support for increasing informed user choice principles in the health care sector. Awareness of options for care is a fundamental component of user choice. As noted by the RACGP in its submission to the Productivity Commission on 21 July 2016:

It is important to note that it is difficult for consumers to make genuinely informed choice regarding healthcare services beyond the measures of out-of-pocket costs and access.

More specifically, vulnerable groups may not have the capacity to exercise informed choice or may not benefit from an increase in choice, competition or contestability.

All people must be protected and supported to continue to access high quality healthcare services.

Increased awareness by Australians (both patients and carers) can only assist in this area.

7.4.8 The objective of building awareness of health care options is not without challenges. There is significant work required to build awareness of health service offerings. As an example, Rosemary McKenzie writes in her assessment of the After Hours GP Helpline (AGPH):

Nationally, 28% of the respondents were aware of the AGPH when prompted with a list of telephone services providing health advice. There was little unprompted mention of the AGPH; <1.0% mentioned it as a telephone service for advice and support, and 2.0% identified calling the service as an action to take when a doctor is not immediately available.

Limited awareness most probably reflects the contained approach taken to marketing the service via posters, magnets and keyrings distributed through health services, and very limited mass media promotion.²⁵

²⁴ October 2016, *Galaxy Omnibus Poll*.

²⁵ McKenzie, R., 2016, *Consumer Awareness, Satisfaction, Motivation and Perceived Benefits From Using An After hours GP Helpline – A Mixed Methods Study*, The Royal Australian College of General Practitioners, vol. 45, no. 7.

- 7.4.9 Views expressed by some that advertising should not be allowed to build awareness amongst patients and carers of after hours options fly in the face of user choice and the need to educate patients on the most appropriate form of care to seek. Limiting awareness is a retrograde step. As outlined in the *Better Outcomes For People With Chronic And Complex Health Problems* report of the Primary Health Care Advisory Group in December 2015:

Patients can and should be supported and encouraged to be more active and effective partners in their health care. The concept of “patient activation” goes beyond person-centred and holistic approaches to service delivery and is about patients having the knowledge, skills, and confidence to manage their health. An increasing body of research is showing that improving patient activation has great potential as a means to improved health outcomes.

More broadly, the impact of improving patient activation on the organisation of health systems should not be underestimated. *Improving information available to patients and better recognising their importance in directing their own care can have a significant effect on how teams of providers work together with patients to pursue improved health outcomes.*²⁶ (Emphasis added.)

And in one of the Case Studies presented in the Report, a sufferer of a chronic condition, noted:

“I don’t have a huge support structure outside of hospital...There’s a lot in the community if you can source it, but it’s hard because most people don’t know what’s available.”

- 7.4.10 The role of broad based media in communicating awareness of health options is important. The RACGP for instance launched its first campaign in many years in 2015. As referred to in the RACGP media release of 14 December 2015:

The campaign earlier this year, our first in 45 years, focussed on the special bond GPs establish with many patients...

...Now it’s time to tell the story of general practice, of the highs and lows faced by GPs and their patients, and in doing so it’s important that we don’t hide from the stark realities of the tough issues that GPs and patients frequently experience...

...The national media campaign will include TV, cinema, digital and social media components, and material for RACGP members to display in their practices.²⁷

- 7.4.11 NAMDS applauds these efforts. Patient awareness of health issues, the importance of having a regular GP and the role patients play in addressing health issues in a timely and appropriate manner are critical for dealing with the long-term pressure facing our health care system. Again, as noted in the Jackson Review:

Community awareness of after hours services was identified as a common issue, often the first reaction in a medical emergency is to call an ambulance or present at a hospital emergency department, although there is variability across the country. Health literacy regarding after hours care across the community is generally considered to be poor, *with significant opportunities existing to better educate consumers on which after hours services are available and when to access them.* This includes which services to utilise and in what order.

Some MLs pursued information campaigns to improve community awareness on local after hours services, but this was not universally undertaken. *Improving community awareness enables consumers to make informed decisions about appropriate after hours utilisation.* Ultimately consumers need awareness of all entry points to after hours services to ensure the right service is delivered by the right person, at the right time and in the right place.²⁸ (Emphasis added.)

26 Primary Health Care Advisory Group, December 2015, *Better Outcomes For People With Chronic And Complex Health Problems*. ISBN: 978-1-76007-252-0, <<www.health.gov.au/internet/main/publishing.nsf/Content/76B2BDC12AE54540CA257F72001102B9/\$File/Primary-Health-Care-Advisory-Group_Final-Report.pdf>>

27 14 December 2015, RACGP’s ‘*The Good GP*’ Campaign Highlights Diversity In General Practice, media release, << www.racgp.org.au/yourracgp/new/media-releases>>, Royal Australian College of General Practitioners.

28 Jackson, op. cit.

- 7.4.12 A policy to limit awareness to those with a GP excludes a large segment of the population who have no regular GP and mocks the concept of universal access. The legacy of this antiquated approach is a challenge, as reported in the Jackson Review:

Consumers generally were seen to have limited awareness of the services available to them in the after hours period or how to access the most appropriate care. In part this is associated with a 'need to know' basis of after hours services. The 'default option' for consumers is often to go to the hospital or call an ambulance.²⁹

There is no credible case to keep patients and carers in the dark about after hours services for acute episodic illness. The 'need to know' model of relying on GPs to inform patients does not work and is harmful to patients, carers and the health system. It assumes a capability by general practice to take on even more responsibility for communication in addition to what is an already full agenda.

7.5 Appropriate Quality Care

- 7.5.1 Medical deputising focuses on acute, episodic care. The after hours services provided by NAMDS members are focused on patients with acute episodic conditions where the patient needs to be seen on an urgent basis. Unlike general practice, after hours doctors do not manage chronic disease; chronic disease management requires ongoing comprehensive care and this properly falls within the purview of general practice. The same rule applies to all matters that should and can be dealt with by the regular GP. MDSs act as an extension of general practice, not as a replacement.
- 7.5.2 Data captured by the industry show that the mix of patients seen in the after hours, and the reasons why they make contact, are very different to the typical mix of patients and symptoms presented in a regular daytime GP practice:
- One in four (24%) patients are children under 4 years, which is 3.5 times the proportion typically seen in general practice.
 - One in seven (14%) patients are over 75 years. Of these, 13% are in residential aged care facilities, which rises to 30% in Melbourne. These are higher percentages than seen in typical general practice.
 - A high proportion of patients also have other disadvantages, such as carer responsibilities and mobility issues and other disabilities.
 - Over 60% of calls to MDSs are made by carers such as parents, family members or aged care nurses, rather than by the patient themselves. It speaks to the issue of 'urgency' that it is typically a carer (not the patient) who has formed the view that the symptoms require medical attention today. This is not surprising: the Australian Bureau of Statistics identified 4.3 million Australians living with a disability in 2015, representing 18.3% of the population. Over 2.7 million Australians were informal carers in 2015 supporting those with a disability. Of this group over one third of primary carers reported having disability themselves. This is an incredibly vulnerable group.³⁰
- 7.5.3 Interestingly, the mix of patients seen by MDSs is markedly different to that seen in daytime practice and by after hours clinics, reflecting the weighting towards the very young and the very old.

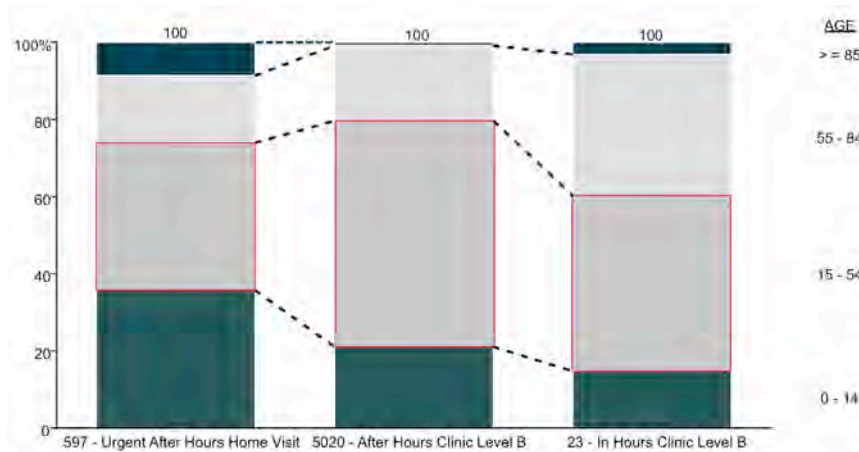
“My parents are elderly and lack mobility and as a family member it gives me peace of mind that if they need medical attention there is someone to call for support.”

Family member, Blacktown, NSW

²⁹ Jackson, op. cit.

³⁰ Australian Bureau of Statistics <<www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0>>

Chart 17: Claims by age of patient – January 2015 to December 2015 (%)



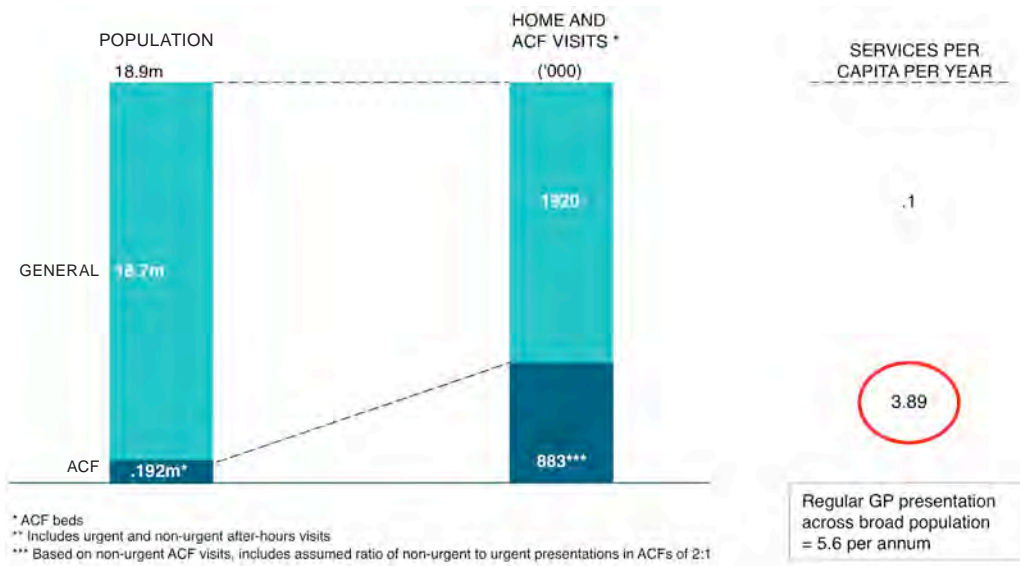
Source: Medicare Statistics, 2015

7.5.4 In the Jackson Review, residents of aged care facilities (RACFs) were singled out for special mention:

RACFs were consistently identified as experiencing significant difficulties achieving timely access to after hours GPs for their residents and for placing demand pressure on after hours services, *in particular, hospital emergency departments*. Many consider after hours demand from RACFs to be a consequence of broader systematic failure of access to in-hours GPs which has the potential to be better managed to contain health system costs. Anecdotally, a high proportion of after hours episodes from RACFs are for advice, prescription orders and the implementation of treatment plans rather than emergency care. Some RACFs also contribute to after hours demand through their limited availability of appropriately trained medical personnel and the engagement of lower skilled workforce. *Many RACFs have a risk averse culture where the appropriate after hours response is to call an ambulance for issues that could be managed out of hospital.*³¹ (Emphasis added.)

7.5.5 There is an additional flow-on effect from ACF patients who have needs during business hours but are not able to receive care from their regular GP. This speaks to the difficulty of a daytime GP attending ACF residents during an otherwise busy clinic day. There is a corresponding increase in after hours demand. Not surprisingly, a disproportionate share of the increased volume is directed at ACF residents.

Chart 18: Population covered and usage – 2015



Source: Medicare Statistics

We suggest there is a compelling argument to revisit the NAMDS proposal to extend services to ACF during daytime hours in some circumstances. See Appendix B.

“It’s the ACF patients and frail aged at home patients that are causing the problem and it’s growing. MDSs are now essential as this demand can’t be triaged off or ignored.”

GP

7.5.6 The issues of awareness and access are particularly important for parents of sick children as there is often a ‘knee-jerk’ response when a young child is ill to present to an emergency department. Professor Gary Freed looked at this in recent research:

Despite growing concern about the cost burden of unnecessary ED visits, Professor Freed said the magnitude of the very young patient group went under the radar because policy makers were preoccupied by the demographics of older patients.

“No one had even bothered to look at the children,” Professor Freed told The Medical Republic. “They had the blinders on, only thinking about the problems of the elderly.”

Research led by Professor Freed found that 90% of very young patients (aged 0-4) who presented at EDs across Victoria met the criteria for a “primary care-type visit”, compared with 70% of all patients, during the 2002-13 review period.

Even as their proportion of the population declined, the very young accounted for a higher proportion of ED visits than any other group (followed by 20-24 year-olds). They also made up the greatest absolute number of ED presentations across the state and territories, increasing their visits by 29%.³²

32 Freed, G.L., Allen, A.R., Turbitt, E., Nicolas, CC., Oakley, E., April 2016, *Parent Perspectives And Reasons For Lower Urgency Paediatric Presentations To Emergency Departments*, <<www.ncbi.nlm.nih.gov/pubmed/26879127>>

7.5.7 In summary, the patients who benefit from MDS services include:

- Mothers with young children.
- The elderly in aged care facilities.
- The elderly living in the community.
- The disabled.
- Those undergoing palliative care at home.
- Families and ACF residents in regional centres.

“The waiting time until the doctor arrived was very quick. Very professional. Great experience and really grateful to have this service available otherwise I would have had to go to an emergency dept and wait for hours for a severe UTI that just needed urgent antibiotics, not a wait at a hospital due to no clinics being available after hours.”

Rebecca, Brisbane, Queensland

“The doctor was very good. The process for getting the appointment was easy and the way we were kept informed about when doctor would arrive was very helpful. We would have been in a bind if we had not been able to access a doctor in this way because my father was unable to walk and we were trying to avoid calling an ambulance and having him end up in hospital emergency.”

Theodore, Eatons Hill, Queensland

“Patient has special needs, dr has wonderful bedside manner and patience. My son (patient) comfortable and easily responded to clear questions by doctor on holiday weekend.”

Jacob, Grange, South Australia

7.6 Type of Conditions

7.6.1 As you would expect and as a result of the triage process, MDS doctors see a different mix of conditions compared to those in daytime practice. Any *convenience based* requests (e.g. request for referrals, script repeats, etc) are triaged to the patient’s regular GP unless there is an urgent medical need or the matter has been referred by the patient’s GP.

Table 1: Major presentations – medical deputising (top 15)³³

Diagnosis/ Problems	%	Ranking among GP presentations
Acute Respiratory Infections*	38.2	3
Viral disease (other)	12.6	-
Combinations of the gastrointestinal system [^]	11.5	-
Skin and Soft Tissue Infections	7.1	-
Musculoskeletal conditions	4.2	9
Rash and its various causes	3.9	-
Urinary Tract Infections	3.3	-
Eye Complaints	2.5	-
Exacerbation of Asthma or COPD	1.8	14
Dental	1.2	-
Anxiety and Mental Health issues	0.9	4 / 15
Migraine and other causes of Acute Headache	0.5	-
Acute hypertension	0.5	1
Verification of Death/ Life extinction certificate	0.5	-
Acute appendicitis	0.1	-

Table 2: Major presentations – general practice (top 15)³⁴

Diagnosis/ Problems	%	Treated by medical deputising?
Hypertension	5.7	No (Yes acute)
Immunisation	4.2	No
Acute URTI	3.3	Yes
Depression	2.9	No
Diabetes: non-gestational	2.3	Yes
Lipid disorders	2.1	No
General check-up	1.9	No
Osteoarthritis	1.7	No
Back complaint	1.7	Yes
Prescription	1.6	No
Oesophagus disease	1.6	No
Female genital check-up	1.5	No
Acute bronchitis/bronchiolitis	1.5	Yes
Asthma	1.3	Yes
Anxiety	1.2	Yes

Notes: *Acute Respiratory Infections - Influenza, pharyngitis, tonsillitis, otitis media, acute bronchiolitis, croup, viral respiratory infections, lower respiratory infections including pneumonias

[^]Conditions associated with varying combinations of the following gastrointestinal symptoms - vomiting, nausea, diarrhoea, abdominal pain, bloating

³³ Industry data.

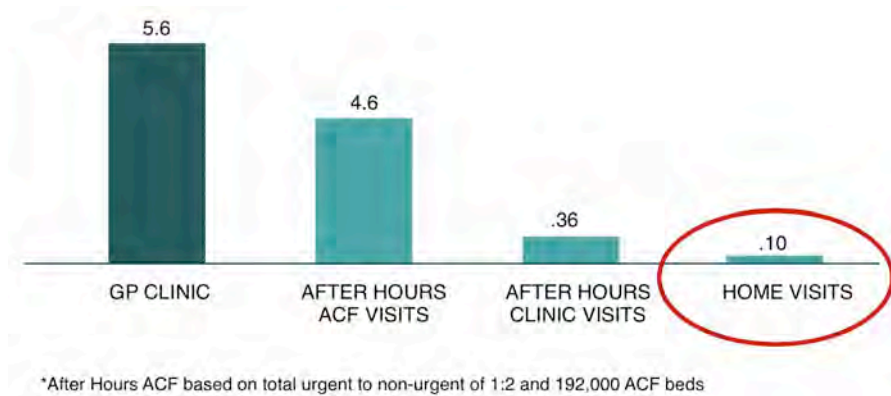
³⁴ Australian Physician, 2013, *Common General Practice Presentations And Publication Frequency*, Vol. 42 No. 1-2.

7.6.2 Specific triage protocols are developed by the clinical leadership teams within each MDS to ensure the focus on urgent and episodic conditions is respected.

7.6.3 The result of these protocols is a very low repeat patient usage. A medical deputising service using these protocols reports:

- Attendance rates of 0.10 uses per capita; this compares to 0.36 uses of after hours clinics and 5.6 visits per year across all GP daytime attendances.
- Attendance rates for after hours and ACF visits increase to 4.6 per capita per year.

Chart 19: Attendance rates per capita



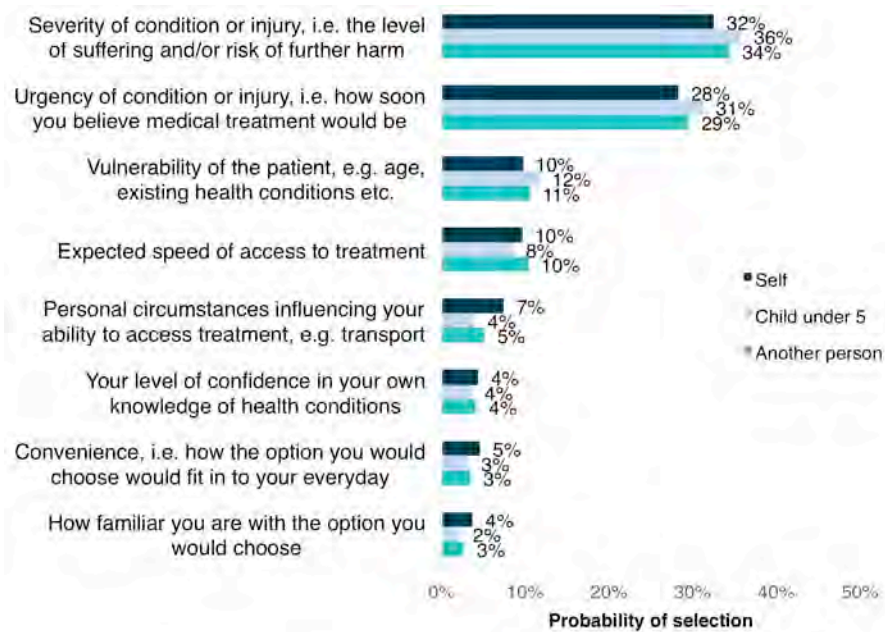
Source: Medicare Statistics; NHPA

7.7 Patient Motivations

7.7.1 Contrary to the view of some observers that patients are motivated to use after hours services for 'convenience', patient research by AMR reports that over 90% of callers to their service believe they (or the person they provide care for) need medical attention before their GP will re-open. The results of a 2016 AMR Survey of home doctor users shows that patients are motivated by *severity of condition* and *urgency*; convenience was not the predominant driver of use. Many of those patients contact an MDS after calling their regular GP to get an urgent appointment late in the day or on a weekend, or having called a nurse helpline and then being redirected to see a doctor urgently. Convenience ranks as a lower influencer to:

- Severity of condition or injury.
- Urgency of condition or injury.
- Vulnerability of the patient.
- Expected speed of access to treatment.
- Personal circumstances (e.g. mobility issues).
- Confidence in your own knowledge.

Chart 20: Stated preferences: by relationship with last patient



Base: All respondents whose first action would be to contact a home visit service or GP, n=1,913
 Q28. Please select which of the following two factors would have THE GREATER INFLUENCE on your decision to take action, if the exact same most recent medical issue occurred again over the next six months.

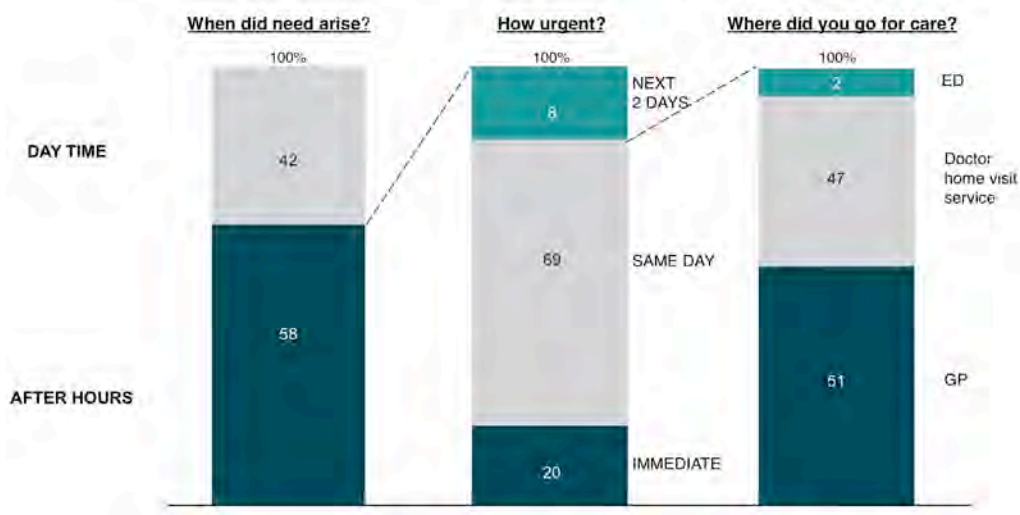
Source: AMR

7.7.2 The same research examined the options considered by patients when they reached a point where, in their view, medical intervention was warranted for themselves or their child or someone for whom they had carer responsibilities. When this group of users was asked about the last time they used the service, the findings are interesting:

- 58% said they reached the view that medical intervention was required at a point in the day which fell within the after hours period.
- When that view was formed, 89% said they were of the view attention was needed ‘that day’ (69% said ‘that day’ and 20% said ‘immediately’).
- Having reached these two thresholds, the first response of 51% of respondents was to try to contact their GP, 47% to contact an after hours service and only 2.0% to go to ED.

The data demonstrate the appropriateness of responses of patients who are aware of options and how decision making takes place.

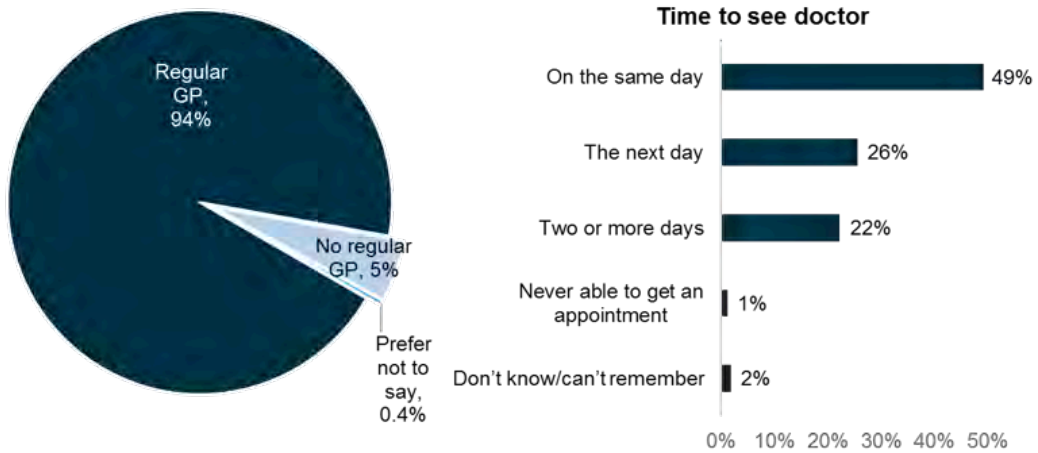
Chart 21: Patient usage process of those who used home visit service



Source: AMR Patient Research, 2016

7.7.3 Despite the influx of new medical graduates, about half of home doctor patients still report difficulty seeing a GP on the same day. Moreover, 23% say they have to wait two or more days.

Chart 22: Medical access

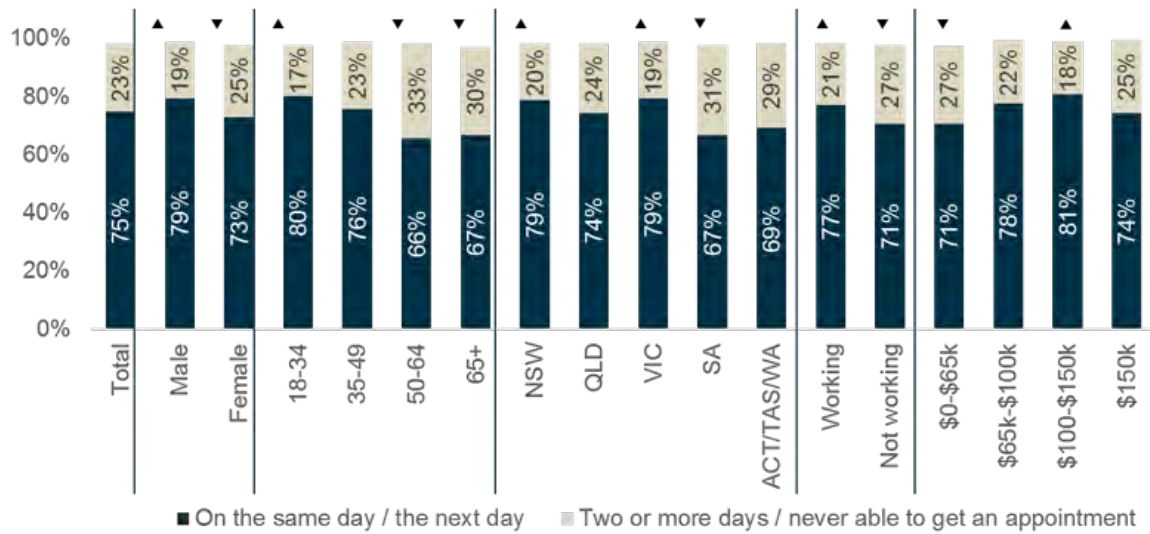


Base: All respondents, n=2,585;
 Q7. Is there one doctor, or doctor's group, health center, GP practice/general practice or clinic you usually go to for most of your primary medical care and/or the primary medical care of someone for whom you are responsible?
 Q8. Last time you or someone for whom you are responsible was sick or needed medical attention, how quickly could you get an appointment to see a doctor? Please do not include a visit to the hospital emergency department.

Source: AMR

7.7.4 These findings are consistent across demographics.

Chart 23: Medical access – time to access a GP, by demographics



Base: All respondents, n=2,585;
 Q8. Last time you or someone for whom you are responsible was sick or needed medical attention, how quickly could you get an appointment to see a doctor? Please do not include a visit to the hospital emergency department.

Source: AMR

7.7.5 These findings are consistent with the Commonwealth Fund International Health Policy Survey released in November 2016 that said 31% of Australians did not get a same or next day appointment the last time they needed care.³⁵

Chart 24: Did not get same or next day appointment last time you needed care



Source: 2016 Commonwealth Fund International Health Policy Survey, November 2016: Survey Size: Australia (5248), Canada (4547)

7.8 Quality

7.8.1 There are many different aspects of quality of care: from the perspective of the patient, the experience of the doctor providing the care and the experience of the regular GP whose patient is being attended. By all measures quality of care is very high.

35 Commonwealth Fund, November 2016, Commonwealth Fund International Health Policy Survey, <<www.commonwealthfund.org/interactives-and-data/surveys/2016/2016-international-survey>>

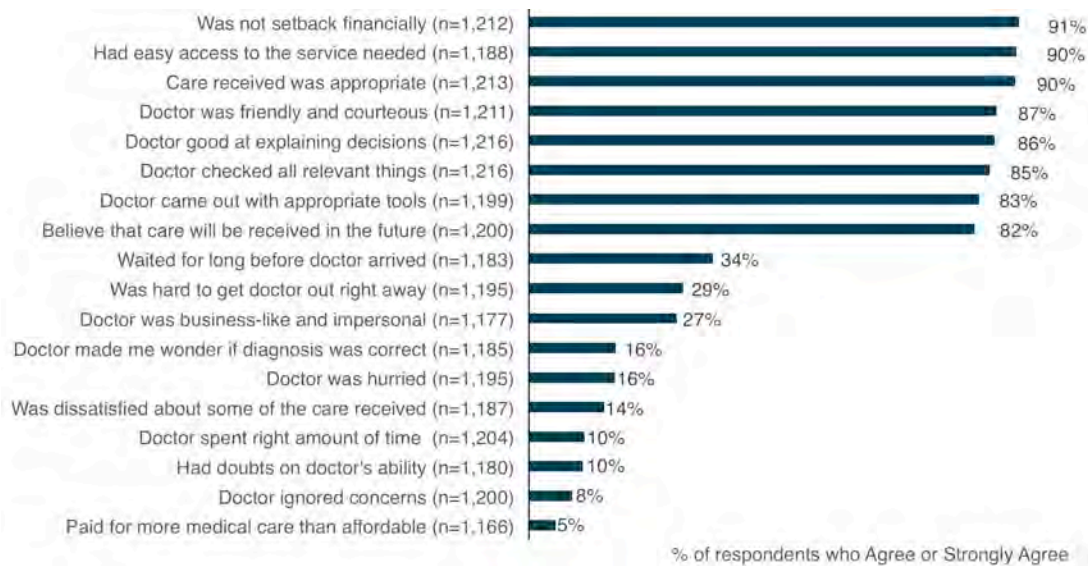
7.8.2 Quality from the patient's point of view

7.8.2.1 There are a number of measures that can be examined which indicate patient views on quality of care. Individual service organisations capture patient feedback on a regular basis and use it to monitor communications, doctor responsiveness and the perceived value of clinical care. Many of our member organisations capture this information on a daily basis, which provides them with a real time measure of performance. Meaningful patient feedback is captured from over 300,000 patients per year. The feedback received from patients on quality of care and communication is typically very high. Patients are deeply appreciative of the service and speak of elements that go well beyond 'convenience'.

7.8.2.2 Beyond patient feedback collected by various MDSs, a recent peer-reviewed study on patient feedback (sample size of 1228) addresses the patient view on the quality of MDSs in Australia. In the paper 'Levels and predictors of patient satisfaction with doctor home-visit services in Australia' the researcher found:

Based on the reasonably high levels of patient satisfaction on all seven scales (range of 72.9% – 87.4%), one can conclude that Australians are generally satisfied with AHHC (*after hours home care*). This is a commendable finding, and an argument can be drawn between this and the report of a recent publication *Quality in Australian after hours doctor home visits: exploring the clinical, professional and security supports available to involved practitioners*, which found that about two-thirds of Australian AHHC practitioners feel well supported clinically and professionally. Such a reasonably decent level of support for doctors can be expected to translate to some good quality care, which can in turn result in a high level of satisfaction among the patients they treat.

Chart 25: Satisfaction items for patients seen by after hours house call services



In addition, it was noted:

It is pleasing to find a high level of satisfaction on the communication aspects of AHHC (after hour home care) given that published studies...have established the positive relationship between communication and patient satisfaction.³⁶

36 Ifediora, C.O. & Rogers, G.D., 2016, *Levels And Predictors Of Patient Satisfaction With Doctor Home-Visit Services In Australia*, Family Practice, 1-8 doi:10.1093/fampra/cmww092.

7.0 Elements of a Successful Model of After Hours Home and ACF Visits

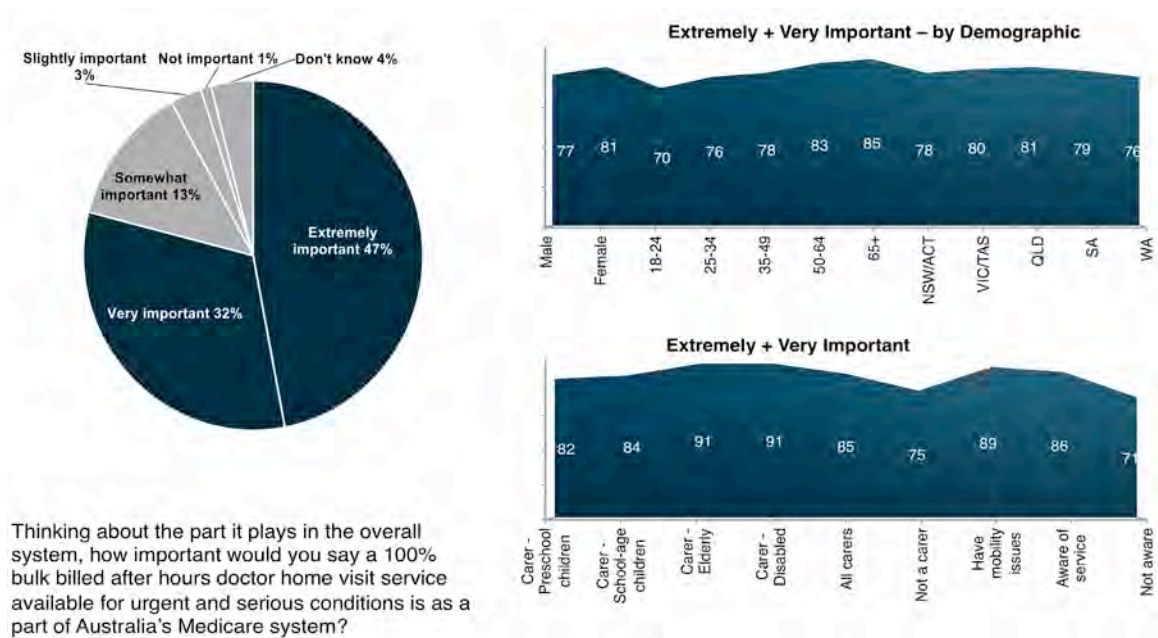
The only comparable Australian general practice survey to our findings focused on satisfaction among patients who utilized regular-hours, practice-based services. Patients in our study appeared to be more satisfied than practice-based patients (85.2% 'satisfied' or 'very satisfied' on the General Satisfaction scale, compared with 68.6%) but this comparison should be treated with caution since the two studies utilized different instruments.

The General Satisfaction level from our study is also higher than the 66.2% reported in a 2013-14 national survey of general practitioner patients seen by OOH (out of hours) services in England.

This study concludes that satisfaction in Australian AHC is high on all scales but recommends that the service providers should aim to attend to patients within 4 hours of their initial calls.³⁷ (Explanation of acronyms added in parentheses.)

- 7.8.2.3 Other comments reflect patient appreciation that after hours home or ACF visits are an intrinsic part of what they see as a valued Medicare system.

Chart 26: Doctor home visits – seen as a very important part of Australia's Medicare system

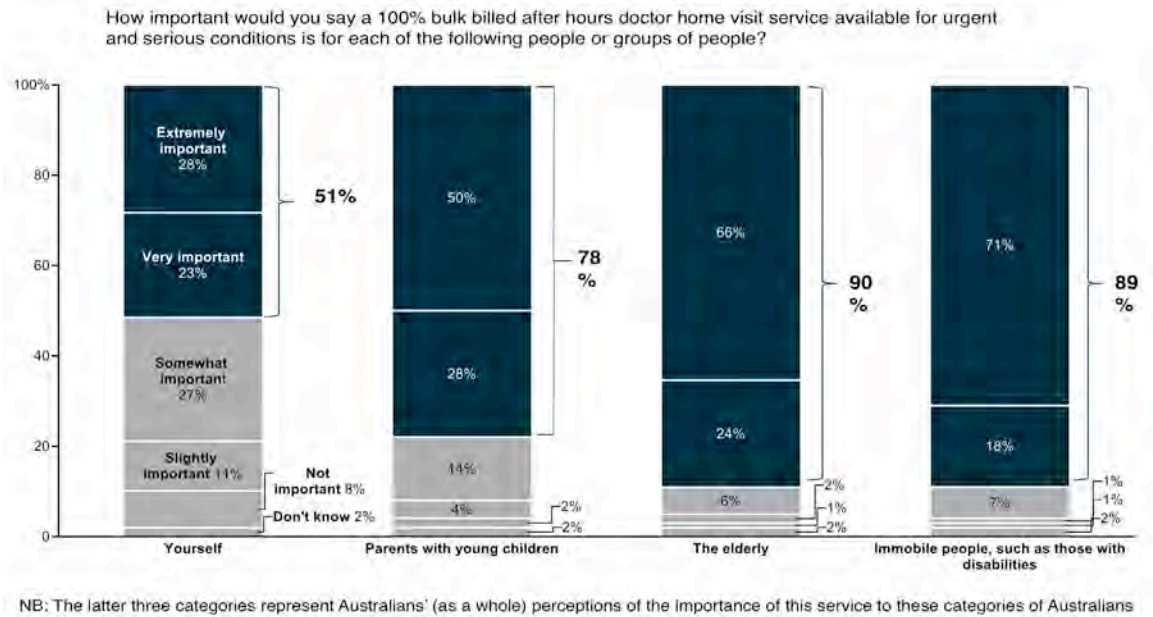


Source: Galaxy Poll, October 2016

- 7.8.2.4 The perceived importance of these services is valued by users and is even stronger in terms of how users perceive the value for other groups such as the elderly, immobile people and parents with children.

37 Ibid.

Chart 27: Perceived importance for specific community groups



Source: Galaxy Poll, October 2016

7.8.2.5 Negative feedback tends to fall into comments about frustration with the waiting time between requesting a doctor and when the doctor arrives. This is particularly evident on holidays and weekends when there is already a shortage of regular GPs. Additional constraints are felt when doctors are sitting GP specialist exams. Comments on actual clinical issues are rare and all service organisations have strict clinical feedback processes to address these.

7.8.3 Quality from the point of view of the doctors providing the care

7.8.3.1 A survey of 300 doctors engaged in after hours care assessed the level of burnout in the doctor sample group over a 12-month period from October 2013 to September 2014. Of the 300 doctors, 168 returned survey questionnaires. The findings were as follows:

This study concludes that the levels of burnout among primary care doctors involved in after hours house calls in Australia are mainly low-level across all dimensions of Emotional Exhaustion, Depersonalisation, and Perceived Personal Accomplishment. The level of Perceived Personal Accomplishment among doctors in AHHC is either at the same level, or better, than, levels among GPs elsewhere...

...An analysis of the frequencies of the experiences of the eight individual items in the PA (Personal Accomplishment) dimension...indicate very high percentages for each. The concerned items are the feelings of "being effective with the patients' problems", "having positive influences on the patients", "easily creating relaxed atmospheres with them", and "being calm with their emotional problems". Other items include the feeling of "easily understanding the patients", "feeling energetic", "feeling exhilarated when dealing with patients", and a feeling of "accomplishment of worthwhile things while on the job".³⁸

38 Ifediora, C.O., 2016, *Quality in Australian after-hours doctor home visits: exploring the clinical, professional and security supports available to involved practitioners*, Journal of Evaluation in Clinical Practice, doi: 10.1111/jep.12605.

7.0 Elements of a Successful Model of After Hours Home and ACF Visits

7.8.4 Quality from a GP's perspective

7.8.4.1 Feedback is also regularly sought from subscribing GPs. Examples of the sort of feedback received is set out below:

“We use the MDS to relieve ourselves from having to do it. It is terrific for us as it really reduces our burden.” GP

- Prompt, LEGIBLE, informative feedback reports delivered digitally for ease of review and direct inclusion in patient file.
- Seem to be timely and GPs appear to be of high standard.
- Our perception is that you are punctual, responsive and provide a level of care that our patients would get if they came to us.
- You can support us when the practice is closed.
- Having subscribed to your service for many years we have had minimal negative feedback from our patients. Have had nothing but good feedback from patients who have required your service.
- Have heard excellent reports from our patients re after hours care.

7.8.4.2 It is worth noting that MDSs hold themselves up to *daily* detailed review of the care they provide on behalf of the regular GP. This takes place in the form of overnight clinical reports. It is difficult to imagine any other area of primary care where a doctor's assessment, diagnostic and treatment decisions are held up to as much daily scrutiny by another doctor. A senior Medical Director within the MDS addresses any issues or concerns raised by a subscribing GP. These concerns do not arise regularly.

7.8.4.3 Assessment of long-term *clinical* impact is difficult to determine. By definition, ongoing care appropriately rests with the regular GP. Any positive longitudinal impact will be due to having an effective ongoing relationship with a regular GP. There is a deep pool of research indicating the merits of such a relationship. We as MDSs actively encourage patients without a regular GP to form a relationship. We see our role as ensuring patients are taken care of in the after hours period so that, wherever possible, matters are dealt with at a primary care level rather than in hospital. Our role is to return the patient to the regular GP for ongoing care.

7.9 Quality of Care

7.9.1 By any measure, as perceived by patients, doctors delivering the care or the regular GP, MDSs deliver appropriate and high quality care.

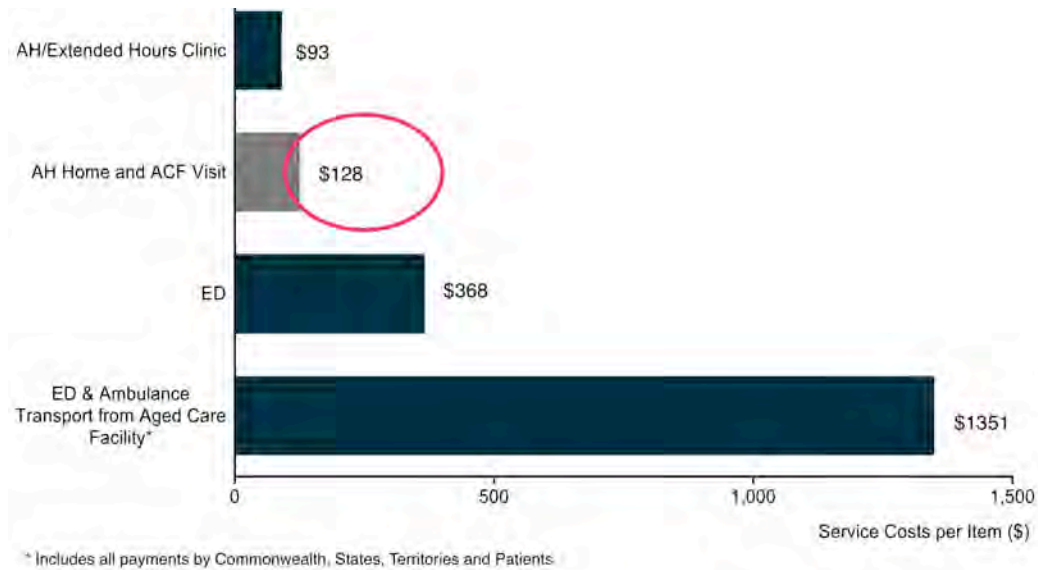
7.10 After Hours Services are Cost Effective

7.10.1 The taxpayer benefits when the less costly service is chosen after hours. The weighted average cost of a low acuity emergency department presentation is \$368. This increases to over \$1351 if an ambulance is used, which occurs in 23.7% of all low acuity presentations (2014-15). The average weighted cost of a home and ACF visit is \$128.³⁹

The difference is significant.

³⁹ Deloitte Access Economics, op. cit.

Chart 28: Service cost per item (\$)*



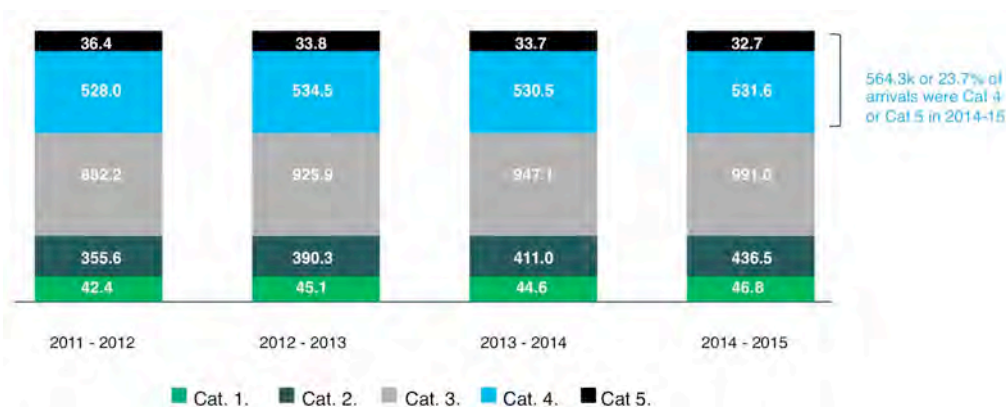
Source: MBS; Australian Hospital Statistics; Jackson Review; Deloitte Access Economics, November 2016

7.10.2 The costs, assessed by Deloitte Access Economics, include ambulance carry costs, where appropriate. As found by Deloitte, these costs are a significant burden on the health care system and more evident in low acuity presentations than most people would realise:

The majority of ambulance transports end at emergency departments, including a large number of patients triaged as categories 4 and 5 at the emergency department. Since 2011-12, arrivals have increased 3.4% per annum (CAGR). This growth is largely attributable to categories 1 to 3 growing at 3.4%, 7.1% and 4.0% (CAGR) respectively – all at or above the overall annual growth rate. Categories 4 and 5 have grown at a slower rate over the same period. Category 4 has increased at 0.2% while category 5 has declined at 3.5%.

Although growth has been lower in low acuity presentations, they comprise a significant number of the total number of presentations arriving by ambulance. In 2014-15 patients triaged as either category 4 or 5 were 23.7% of the total number of presentations arriving by ambulance or over 564,000.⁴⁰

Chart 29: Patients arriving by ambulance to emergency departments by ATS triage category ('000s)



Source: AIHW (2011-2015), Emergency department care: Australian hospital statistics.

40 Deloitte Access Economics, op. cit.

7.0 Elements of a Successful Model of After Hours Home and ACF Visits

- 7.10.3 A useful way to interpret competing data and to assess appropriateness is to gauge the level of use by different patient groups.

Using the average GP visit rate of 5.6 appointments per year as a benchmark, the data illustrates that the elderly, particularly those living in aged care, require substantial primary care. After hours visits to these ACF residents equalled approximately 31% of all after hours home and ACF visits, or 4.6 visits per year. Visits per year to after hours clinics was only 0.36 visits per year and even lower for home visits at 0.10 per year.

- 7.10.4 A more comprehensive assessment of the economic benefits of a strong after hours sector is set out in Section 8 below.

7.11 Doctor Availability

- 7.11.1 Availability of doctors willing to engage in after hours work is a critical element in a robust after hours primary care model yet remains the most challenging aspect of this part of the health care system. As noted in the Jackson Review:

GP Workforce was consistently highlighted as the biggest challenge in the provision of after hours primary care arrangements, particularly finding GPs who are willing to provide after hours services on a regular basis.⁴¹

- 7.11.2 This problem is not unique to Australia; access to high quality health care outside of usual working hours is a major issue in many developed countries. In addition to emergency and hospital services at weekends, primary health care is often the first point of contact for patients 'after hours', and historically patients would expect to be seen at home by their GP.

Though this is still the case in many rural communities, shifting work-life balance expectations have changed the provision and nature of after hours services provided by GPs. In most developed countries, after hours care is usually delivered in a variety of organisational models involving GP provision. The most common organisational models include deputising services (such as we have in Australia), co-operatives or roster arrangements, and practices or clinics with extended hours during evenings and weekends.

In the past few decades, many countries have faced serious challenges in the provision of after hours care due to shortages of GPs who are willing to provide regular after hours services. In primary care the decision by GPs to provide after hours services is important, as the provision of after hours care can potentially alleviate the burden on the hospital sector by reducing utilisation of more expensive emergency department, out-patient and in-patient care, though the evidence here is largely descriptive.⁴²

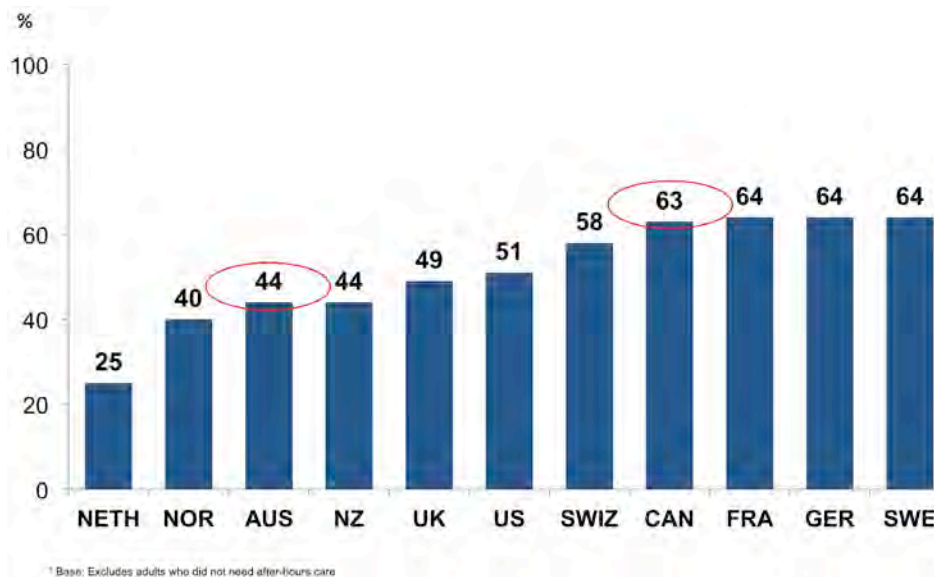
- 7.11.3 In the UK, the requirement for GPs to provide 24-hour care was removed from their contracts with the National Health Service (NHS) in 2004.
- 7.11.4 In Canada, provision is made in provincial funding arrangements for GPs to provide after hours care but few take it up. The greater difficulty in accessing after hours care in Canada compared to Australia is marked and in turn impacts emergency department usage. In Canada propensity to use the emergency department is significantly greater than in Australia. (See Case Study C, Section 8.7, p65.)

⁴¹ Jackson, op. cit.

⁴² O'Malley, A.S., December 2012, *After hours Access To Primary Care Practices Linked With Lower Emergency Department Use And Less Unmet Medical Need*, doi: 10.1377/hlthaff.2012.0494 Health Aff January 2013, vol. 32, no. 1, 175-183.

Chart 30: Difficulty getting after hours care

Percent who said it was somewhat or very difficult to get after hours care without going to the emergency department



* Base: Excludes adults who did not need after-hours care

Source: 2016 Commonwealth Fund International Health Policy Survey, November 2016; Survey Size: Australia (5248), Canada (4547)

- 7.11.5 Australia’s first National Primary Health Care Strategy highlighted the importance of achieving the right balance of financial incentives and funding arrangements to deliver efficient, accessible and appropriate after hours services.⁴³ As described above, between 1999 and 2009 there was a large fall in home visiting rates by GPs in Australia and the delivery of after hours care has been shifting from individual and group GP practices with local after hours on-call schedules toward larger-scale deputising services or networks.
- 7.11.6 These trends are also associated with changing demographics and work-life preferences of the medical workforce, with more young doctors, including female doctors, entering the profession who are often less inclined to provide after hours care and need to be more substantially incentivised. After hours calls and being on-call have been consistently ranked as the most important job characteristics that GPs in the UK and Australia would be willing to pay a large proportion of their annual incomes *to avoid*.
- 7.11.7 These findings are consistent with contemporary research from the University of Melbourne. Using detailed survey data from a large sample of Australians GPs, researchers were able to estimate a structural, discrete-choice model of labour supply and after hours care. The findings were informative and not surprising:⁴⁴

Among doctors overall, men and women increase their daytime-weekday working hours if their hourly earnings in this setting increases, but only to a very small extent. Men’s labour supply elasticities do not change if their family circumstances change, but for women the small behavioural response disappears completely if they have preschool-aged children. Doctors are somewhat more likely to provide after hours care if their hourly earnings in that setting increases, but again the effect is very small and only evident in some sub-groups. Moreover, higher earnings in weekday-daytime practice reduce the probability of providing after hours care, particularly for men. Increasing doctors’ earning appears to be at best relatively ineffective in encouraging increased provision of after hours care, and may even prove harmful if incentives are not well-targeted.

43 Australian Commonwealth Government 2010.

44 Broadway, B., Kalb, G., Li, J. & Scott, A., 2016, *Do Financial Incentives Influence GP’s Decisions To Do After hours Work? A Discrete Choice Labour Supply Model*, Melbourne Institute Working Paper Series, Working Paper No. 12/16, Melbourne Institute of Applied Economic and Social Research, ISBN 978-0-7340-4410-5.

7.0 Elements of a Successful Model of After Hours Home and ACF Visits

7.11.8 The AMDS Program created in 1999 was designed to provide a specific response to the fact that general practice does not wish to engage in after hours care to any material degree. As Professor Anthony Scott of the University of Melbourne wrote in June 2016:

...Regular GPs do not want to provide after hours care. And our research shows that practice-based GPs cannot be persuaded to provide more after hours care by financial incentives.

In fact the RACGP's own standards were changed in 2013 where the duty of GPs to provide care 24/7 was removed as the then new Medicare Locals took over some of the funding for afterhours care.

So deputising services that are accredited according to RACGP standards are filling an unmet need. It is also possible they are seeing patients who would otherwise be presenting to emergency departments, saving the health system money.⁴⁵

7.11.9 It is clear from the economic modelling done by Scott et al that financial incentives will do little to draw daytime practitioners into after hours work:

Several important policy implications can be drawn from this study. First, while a policy that increases the hourly earnings for AHC (after hours care) is likely to increase participation in AHC, the effect will be relatively small. We can quantify the simulated response in the provision of AHC in the Australian context: since there are in total about 11,000 female GPs and 15,900 male GPs in Australia, and about 32.46% of female doctors and 55.12% of male doctors currently provide some after hours care, our estimated elasticity indicate that a 10% increase in AHC hourly earnings would increase the number of GPs providing after hours care by 37 female GPs and 134 male GPs. This provides a cautionary note for any future policy reform that purely relies on higher hourly earnings for after hours care as the cost of such a reform will be quite high. Second, given that an increase in earnings for regular working hours actually decreases the probability of after hours care provision, if the policy goal is to improve the provision of after hours care, it is important to specifically target financial incentives to after hours care services while holding the earnings from regular working hours constant. If regular hourly earnings and after hours earnings are increased at the same time, it is important to maintain the relativity between them to keep the current level of GP participation in after hours care. Lastly, to the extent that the earnings elasticities for after hours care vary across gender, family circumstances, and practice size and locations, financial incentives are unlikely to be equally effective across GPs with different family circumstances and GPs working in different locations.

7.11.10 The current 75:25 mix of AMDS doctors to non-VR and VR doctors in MDSs within NAMDS illustrates this point perfectly.

7.11.11 The 2016 Magin study referred to earlier raises concerns about the "increasing reluctance of graduating cohorts of GPs to perform home visits".⁴⁶ The Commonwealth Department of Health-funded study shows that not only is there a scarcity of GPs for home and ACF visits, the medical graduate cohort is not going to improve this unless there is a policy change that works. The study holds the hope that this may change over time as the GP assumes a "fuller" role within general practice and it argues the case for optimising trainee exposure to home, ACF and nursing home visits.

7.11.12 Any policy position that contracts or limits the effectiveness of the AMDS Program will mean a profound reduction in the available workforce and a commensurate impact on patient care and increase in demand for ED services.

⁴⁵ Ibid.

⁴⁶ Magin, P., et al, op. cit.

7.12 Continuity of Care

7.12.1 The importance of maintaining and enhancing the relationship between the regular GP and the MDS providing the care on behalf of the GP cannot be understated. The fundamental and timely exchange of patient information (both in terms of special patient information or instructions provided by GPs to the MDS and effective clinical handover of the patient back to the GP) provides for the best care and ensures continuity of care rests with the regular GP. This exchange of information is not typically available between the GP and an (often competing) after hours clinic, or ED, or helpline. In the Jackson Review it was noted:

Continuity of care was identified extensively in the consultation process, noting that improved coordination and integration of services should be put in place to ensure that when a practitioner other than an individual's regular GP provides after hours services, notification of the event should be communicated back to the regular GP as soon as possible to facilitate follow-up and continuity of care.

Later in the Review:

The extent to which continuity of care is achieved varies considerably across after hours service providers. *Examples were provided of practices referring patients to MDSs and receiving patient reports the next morning, whereas in contrast, patient contacts had with (Health Direct Australia) and the AHGPH (After Hours GP Helpline) did not provide this continuity.*⁴⁷ (Emphasis added.)

7.12.2 Examples of the type of special patient information or instructions provided by GPs to MDSs to be placed on patient files are:

- Existence of chronic conditions and existing treatment plans.
- Ongoing medication.
- Instructions re palliative care (and appropriateness of pain relief).
- Carer details.
- Drug seeking behaviour.
- Disability and mobility issues.
- Instructions on notification process to GP in the event of patient death.

Even in the absence of electronic health records, MDSs today have invested in systems that allow for GP patient-specific instructions to be held securely and transmitted to the doctor conducting the house or ACF visit.

7.12.3 The strong and productive relationships, including clinical reporting, between most GPs and their medical deputising providers points to the high value of the Australian medical deputising model. In the *Review of Primary Care Out-of-hours Services in the UK National Health Service*, Professor Trish Greenhalgh and Dr Fraser Macfarlane found:

There is presently no capacity in the UK to provide to the after hours provider important clinical information in advance of the attendance. *This is not the case in Australia*, where most medical deputising services have perfected special patient files detailing important GP clinical information.⁴⁸ (Emphasis added.)

⁴⁷ Jackson, op. cit.

⁴⁸ Greenhalgh OBE FRCP FRCGP FFPH FSB, T., & Macfarlane BSc MBA PhD, F., October 2012, *A Review Of Primary Care Out-Of-Hours Services In The UK National Health Service*.

7.13 The Commitment of NAMDS to Continuity of Care

7.13.1 Another benefit of the policy changes between 2010 and 2016 is that the professionalism of the MDS sector improved. After hours services and specialist home and ACF visiting services were historically small and fragmented. Larger, technology enabled services have since emerged with significant local scale in each major city. These services blend the personal touch of a doctor making a house call to a sick patient, with efficiency and consistent quality enabled by modern communications technologies and rigorous clinical governance frameworks.

7.13.2 Specific processes underpin continuity of care between the MDS and the regular GP:

- More sophisticated triage processes – emergency and regular appointments screened.
- Secure reporting back to regular GP.
- Training and clinical support of doctors on appropriate services.
- Patient feedback sought and delivered to MDS doctors to aid continuous improvement.
- Active monitoring of patients who are overusing the services (via contact with the regular GP seeking clarification on use).

7.13.3 In this regard, the sector has already addressed one of the concerns raised in the Jackson Review:

A consistent theme which emerged from respondents was that the key infrastructure to support after hours service provision is often already in place, however refinement is necessary as well as much better coordination between the existing services. Gains could be made by better linking Commonwealth and state/territory programs across populations as well as *improved* community promotion of these services. In particular:

- improved promotion and better integration of Healthdirect, the NHSD, nurse and GP helplines with the aim of facilitating more appropriate patient access to available services, particularly lower acuity options where appropriate.
- *appropriate triaging to ensure patients do not use after hours home and ACF visiting services for convenience and services are only provided for urgent need. Improved key performance indicators, monitoring and audit could also better target the use of these services for urgent care.*⁴⁹ (Emphasis added.)

7.13.4 MDS support for the GP is paramount. This is particularly evident in the demand for MDS spiking at those times when regular GPs are not available, such as peak holiday times. Today, MDSs are often generally known as 'after hours home and ACF visit services', reflecting the service they provide to patients as well as to GPs. Nonetheless, the responsibility to general practice remains a core commitment for all quality MDSs.

7.13.5 It is NAMDS' view that the following elements are essential to underpin a robust after hours home and ACF visit service: access, awareness, appropriate care, doctor availability, continuity of care and cost effectiveness. While there is always scope for improvement, we believe that as a sector we already deliver on these dimensions to a very high standard.

⁴⁹ Jackson, op. cit.

8.0 Policy Outcomes: After Hours Primary Care is a Medicare Success Story

8.1 After Hours Primary Care is a Medicare Success Story By Any Measure

8.1.1 By any measure, after hours primary care is a Medicare success story and reflects the foresight of the initial government policy makers:

- Patients truly value this part of Medicare, which supports urgent matters being addressed in their own home when such care is appropriate.
- Residents in ACFs are being better supported without the need for ambulance carries.
- GPs are supported in daytime practice and continuity of care is enshrined.
- Emergency departments are seeing the benefit of a reduced mix of low acuity patients presenting in the after hours period.

8.2 Role of Primary Care in Reducing Low Acuity Emergency Department Presentations

8.2.1 On 5 February 2015, the RACGP issued a press release that stated:

Dr Jones (*then President of the RACGP*) said well-resourced primary health care led to an almost 50% cut to the number of emergency hospital visits and when patients were admitted, the length of stay was halved...

...GPs are cost effective and reduce hospital admissions, saving the system money and improving patient health outcomes. (Qualification added.)

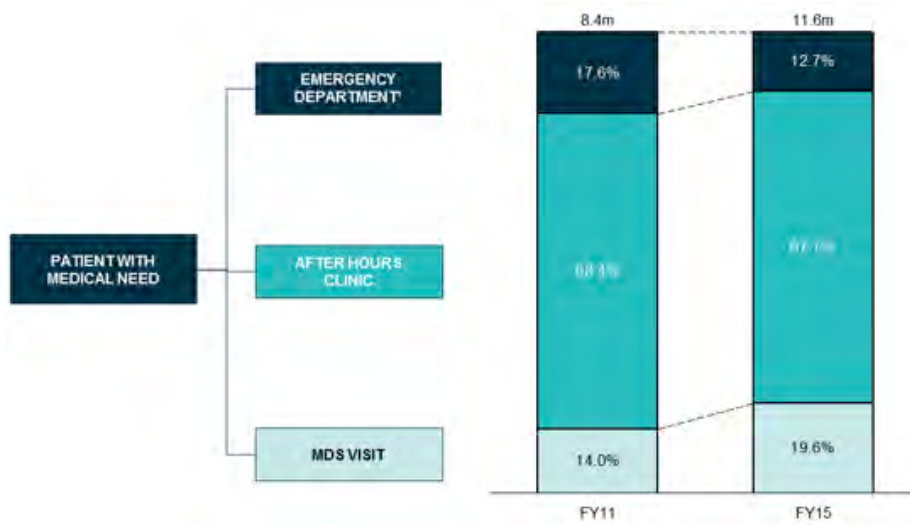
We agree with these comments.

8.2.2 There is compelling evidence that a strong primary care sector helps minimise unnecessary hospital presentations. Expansion of after hours home and ACF visiting services extends primary care to homes and aged care facilities and reduces the pressure of low acuity presentations on hospital emergency departments, saving taxpayers money across the system while still delivering good clinical care.

Patients with a low acuity medical issue in the after hours period are increasingly choosing to be treated via an MDS rather than a hospital emergency department. In FY11, 17.6% of people with a low acuity medical issue in the after hours period chose a hospital emergency department, while 14.0% used an MDS. In FY15, only 12.7% chose an emergency department, with most of this volume transferring to MDSs (19.6% of patients).

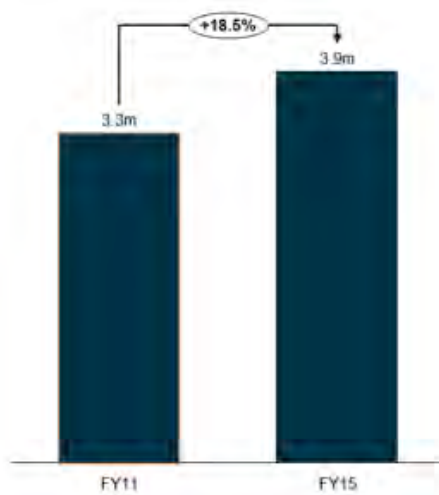
GP *clinic* attendances is by far the most highly used option for patients in the after hours period. The proportion of patients selecting an after hours GP clinic was flat across this period at around 68%.⁵⁰

Chart 31: Patient pathways in after hours care: FY11 to FY15



This shift in volume has corresponded with a slower rate of growth in low acuity emergency department categories compared to high acuity categories. Between FY11 and FY15, total high acuity emergency department presentations in Australia grew by over 600k presentations or 18.5% (3.32 million to 3.94 million).⁵¹

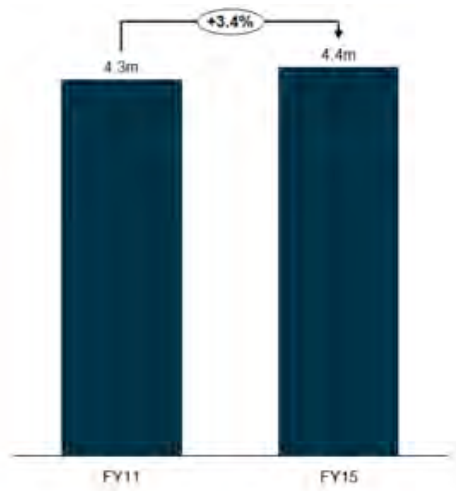
Chart 32: Growth in high acuity emergency department presentations: FY11 to FY15



In contrast, low acuity categories increased by just 100,000 cases or 3.4% over the same period (FY11 to FY15), from 4.3 million presentations to 4.4 million presentations.

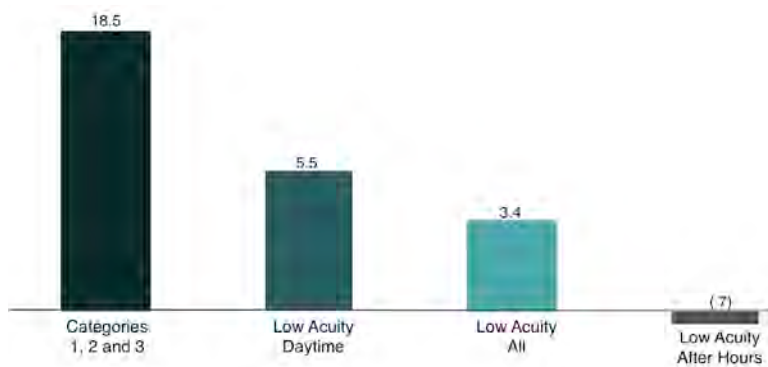
⁵¹ Ibid.

Chart 33: Growth in low acuity emergency department presentations: FY11 to FY15



- 8.2.3 This lower rate of growth in low acuity presentations is entirely due to the falling number of patients presenting to hospital emergency departments with low acuity conditions in the after hours period.
- 8.2.4 It is important to note that the impact MDSs have on low acuity presentations in emergency departments pertains only to those patients who would present to emergency departments during the after hours period. This may appear obvious, but looking at the 'time-of-day' impact is insightful. When growth rates across the hours of the day are examined, it is observed that MDSs are having a particularly meaningful impact on emergency department presentations when they are seen by patients as being a viable option.
- 8.2.5 In terms of total patient volumes, low acuity presentations in the after hours period have been flat at approximately 1.5 million presentations (-0.7% growth), while the standard hours period has grown by 150,000 presentations (+5.5% growth).

Chart 34: Emergency department growth rate (%) FY11-FY15



8.0 Policy Outcomes: After Hours Primary Care is a Medicare Success Story

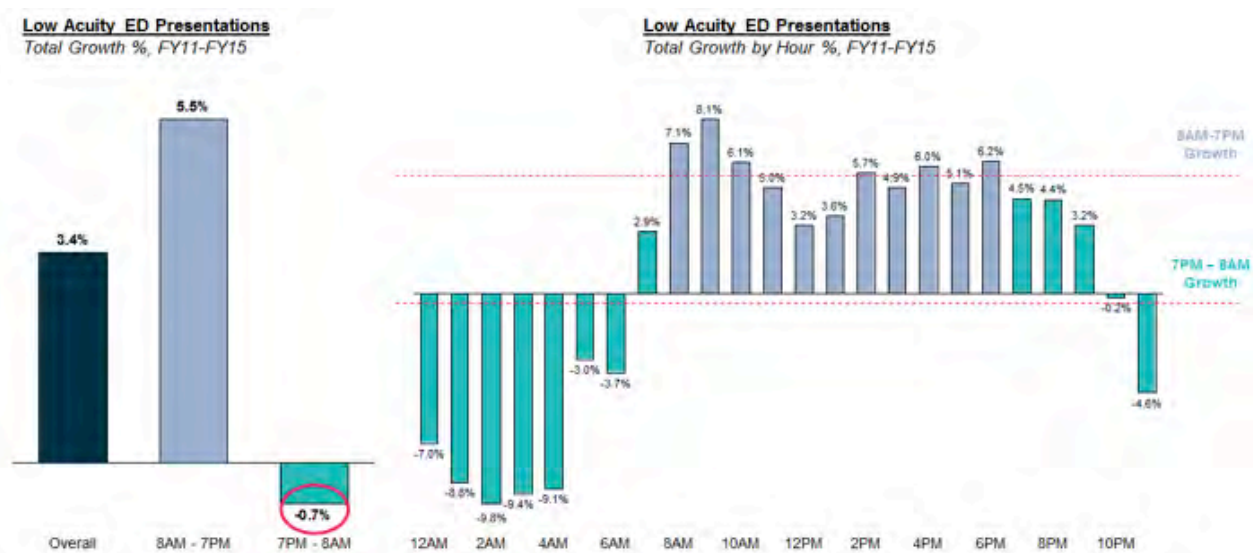
We agree with the view of the RACGP when it states in its submission to the MBS Review Taskforce:

Reduction in emergency department presentations, hospital admissions and readmissions could indicate that patients have access to evidence-based, high quality care through a greater number of patients being managed effectively in the community.⁵² (Emphasis added.)

We agree with various commenters that MDSs *cannot* impact all low acuity emergency department presentations as the data show that most low acuity emergency department presentations were made between 8:00am and noon on weekdays, when those patients could be seen by a regular GP. Clearly this cohort is not one that can be supported by MDSs.

The growth rate of low acuity presentations during the daytime, when the patient *could* have seen a regular GP is 5.5%. For some reason these patients continue to attend emergency departments rather than GP clinics; this may be due to perceived issues with accessing a same day appointment. What is compelling, however, is that where an MDS can support a low acuity patient, the growth rate in emergency department presentations is markedly lower. Presentations in the *after hours* period actually declined by 0.7% between FY11 and FY15. This can be seen when growth rates in low acuity presentations by hour of the day are examined.

Chart 35: Growth in low acuity emergency department presentations by time of day: FY11 to FY15



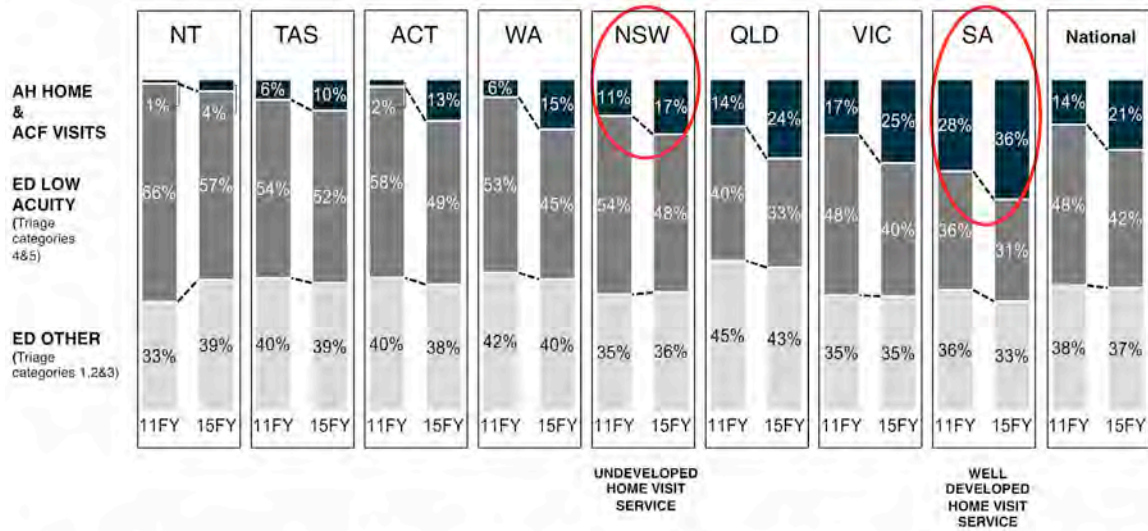
REFERENCE: Australian Institute of Health and Wellness, Australian Hospital Statistics: Emergency Department Statistics; Medicare Statistics Database.

The use of appropriate pathways is a significant issue when the health system costs are examined. Any policy activity which replaces an expensive emergency department presentation with a lower cost care alternative is good policy.

- 8.2.6 A state by state and territory comparison shows a clear relationship between an increase in after hours home visits and a decline in low acuity emergency department presentations on a per capita basis. The data show that states with greater use of home visits show fewer low acuity emergency department presentations. Due to historical reasons, use of after hours home and ACF services in, for example, South Australia and Queensland are higher than in than in NSW, the ACT and Tasmania. Conversely, South Australia and Queensland demonstrate a lower use of emergency departments for low acuity presentations than NSW, the ACT and Tasmania.

⁵² RACGP Submission To The Medicare Benefits Schedule (MBS) Review Taskforce, <<www.racgp.org.au/download/Documents/Reports/MBS-review-taskforce-submission-Final-November-2015.pdf>>

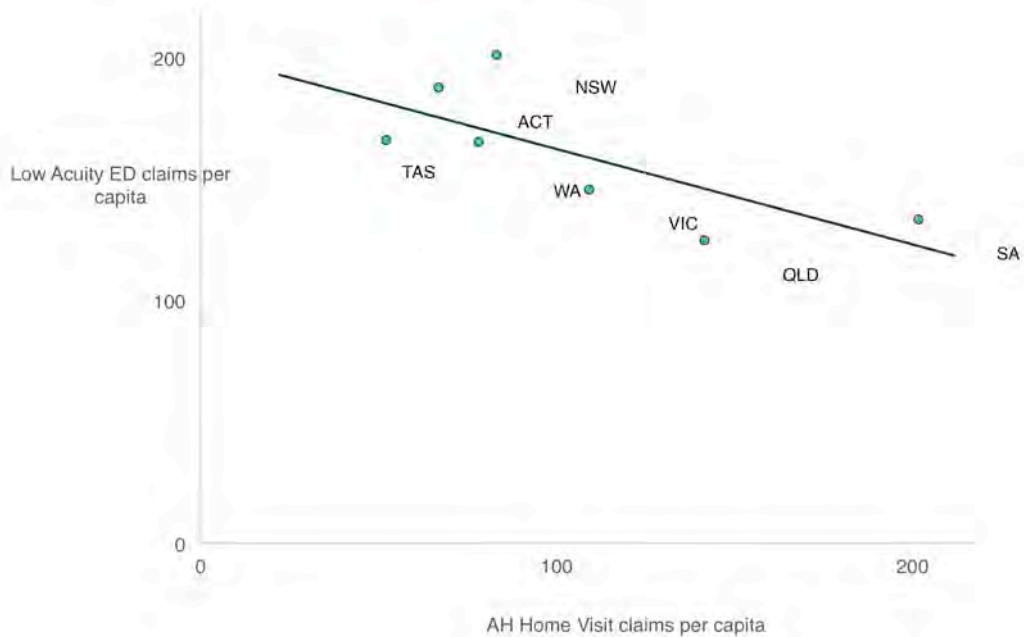
Chart 36: Mix of after hours visits and emergency department presentations 2011-15 (%)



Notes: ED low acuity numbers are across 24 hours; 43% of low acuity presentations occur in daytime when AH services cannot displace them. ED presentations grossed for population % covered in report. AH Home & ACF items – 597, 598, 599, 600, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263, 5265, 5267

Sources: Australian Hospital Statistics 2010-11 and 2014-15; MBS Statistics

Chart 37: Emergency departments low acuity claims vs after hours home visit claims per capita ('000) 2014-15



Notes: ED Low Acuity population adjusted for coverage

Source: Medicare Statistics; Australian Institute of Health and Welfare

8.3 Growth has Delivered High Value Outcomes for the Health System

8.3.1 The combination of improved awareness and regional access, enhanced professionalism, larger scale systems and technology utilisation has resulted in high value outcomes for the health system. Australia has seen a shift in low acuity patient presentations from emergency departments to after hours providers with significant economic and clinical benefits for the system.

Government policy was developed and designed to encourage focus and investment by the private sector to deliver a positive response for the community. By any measure, these policy initiatives have been successful.

8.4 Determinants of Growth

8.4.1 The Jackson Review commented:

MDSs are recognised as having a critical role in meeting after hours needs, providing valuable support for GPs already working long hours, access to home visits and in many cases good continuity of care.

MDSs provide an important service to people in need, however it is considered that existing policy, regulatory and financial settings may not encourage judicious or targeted use of such services. *Anecdotally, views presented suggest some MDSs are overzealous in turning calls into home visits.* The expansion in utilisation of MBS items and the value for money for government from MDSs is unclear.⁵³ (Emphasis added.)

The sector's response to these questions is clear and provides evidence to counter any anecdotal observations. Growth in medical deputising has been due to two factors: the service expanding into regions and cities previously not serviced at all, and by increased adoption of the service as a cost effective means to deal with an urgent matter.

8.4.2 A NAMDS-commissioned report by Deloitte Access Economics on the cost of alternative pathways demonstrates the broader health system cost implications of after hours primary care:

After hours pathways have different roles and ensuring the most appropriate pathway is utilised has significant benefit to the health system.

- The lowest cost pathways for patients seeking after hours primary care are extended and 'after hours only' clinics (\$93) and after hours home and aged care facility (ACF) visits (\$128). Emergency departments is the most expensive at \$1,351 if arriving by ambulance and \$368 if self-presenting.
- In 2012-13 AIHW estimated that 2.12 million presentations to emergency departments were avoidable, GP-type presentations, of which 63% occur after hours. If this quantum of presentations occurred today, the cost would be approximately \$0.8 billion. If a quarter of the AIHW estimated number of the GP-type presentations were diverted to either extended and 'after hours only' clinics or home and ACF visits, the net benefit to the health system would be \$81.8 million to \$93.5 million nationally.
- Further, a study of 50,000 patients who utilised home and ACF visits showed that 94% would seek care using an alternative pathway if the service did not exist. Based on the preference information, the cost to the health system would be \$181 million higher compared with after hours home and ACF visits.⁵⁴

From a system-wide point of view, appropriate use of lower cost care pathways is clearly preferential.^{55 56}

Three case studies demonstrate different aspects of these findings:

⁵³ Jackson, op. cit.

⁵⁴ Deloitte Access Economics, op. cit.

⁵⁵ Impact on Access Block: It is important to distinguish the difference between the economic value associated with avoiding the high costs of treating low acuity patients in EDs vs the more entrenched issue facing EDs of 'access block' or 'bed block'. Access block occurs when there is excessive delay in access to appropriate inpatient beds (> 8 hours total time in ED). Access block for admitted patients is the principle cause of overcrowding, and is mainly the result of a systemic lack of capacity throughout health systems. While a well supported home and ACF visit sector sees patients treated more effectively and at lower cost in the home than in an ED, we are not arguing that it represents the panacea for addressing access block.

⁵⁶ Richardson, D.B. & Mountain, D., 2009, *Myths Versus Facts In Emergency Department Overcrowding And Hospital Access Block*, Medical Journal of Australia, 190(7): 369-374.

8.5 Case Study A: Melbourne Emergency Department Profile

8.5.1 The situation in late 2008 is best reflected in a study by Lowthian et al. of whether the then current models of emergency and primary care were failing to meet community needs.⁵⁷ The study, published in 2012, examined a retrospective analysis of public hospital emergency department data for metro Melbourne for 1999-00 through to 2008-09. The review indicated an average annual increase in the rate of presentations of 3.6% (across all triage categories) over ten years. The key findings were:

- The rise in presentation numbers and presentation rates per 1000 person-years over 10 years were beyond that expected from demographic changes and there was a persistent rise in emergency department demand. Of all the age groups represented, older people presented at the highest per capita rate:

Our results here are also consistent with our recent study demonstrating increasing and accelerating demand by older people for emergency ambulances. Given projected trends in population ageing, the trends shown in our study are likely to have a dramatic impact on all aspects of emergency and hospital care. An ED visit for an older person is a sentinel health event that can lead to substantial functional decline and other adverse outcomes. In 2008-09 most patients were classified as semi-urgent or non-urgent...the data showing they could have been managed appropriately in community-based settings.

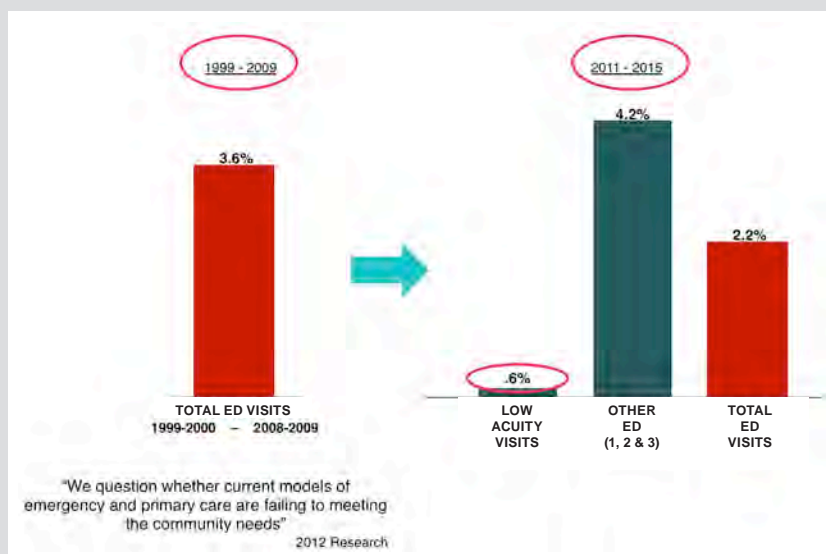
ED attendance by lower acuity patients could be related to changes in primary care service delivery. An association has been reported between ED utilisation and reduced general practitioner accessibility and increasing GP co-payments. Furthermore, EDs may appeal to people of working age, with the convenience of 24-hour, hospital based care...

- The authors noted that government and service providers have progressively responded to demand for emergency health care but increasing efficiency alone is unlikely to meet this demand.
- In summary, they noted:

We question whether current models of emergency and primary care are failing to meet community needs. This is a major cause for concern, considering the investment that has been made to date in the many interventions targeting demand.

8.5.2 These case study findings are in stark contrast to the data for the period 2010-15

Chart 38: Melbourne/Victoria emergency department growth profile



Source: Med J Aust, 2012, 196 (2): 128-132; Australian Hospital Statistics 2011-12 and 2014-2015

57 Lowthian, J.A., Curtis, A.J., Jolley, D.J., Stoelwinder, J.U., McNeil, J.J. & Cameron, P.A., 2012, Medical Journal of Australia, <<www.mja.com.au/journal/2012/196/2/demand-emergency-department-front-door-10-year-trends-presentations?inline=true; http://emj.bmj.com/content/early/2010/10/20/emj.2010.099226.short>>

8.0 Policy Outcomes: After Hours Primary Care is a Medicare Success Story

While the period from 1999 to 2009 demonstrated growth in total emergency department presentations of 3.6% (a rate that concerned the researcher), the period from 2011-15 showed remarkably slower growth of circa 2.2%. Categories 1, 2 and 3 continued to grow at an even higher rate of 4.2% but these were offset by remarkably lower growth of just 0.6% (essentially flat) in lower acuity categories 4 and 5. Increased use of home and ACF visits in Victoria by carers and patients was observed over this period.

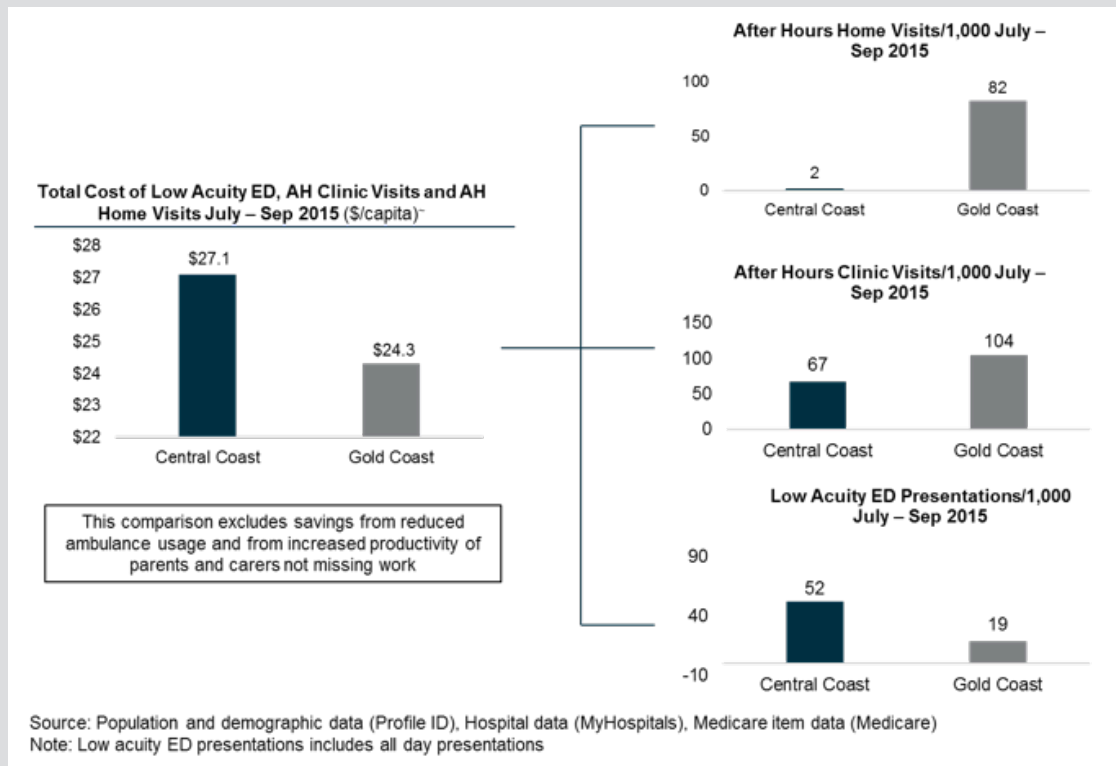
8.6 Case Study B: Gold Coast vs Central Coast

8.6.1 Data reviewed by Deloitte Access Economics for the quarter 1 July to 31 September 2015 comparing the Central Coast, NSW and the Gold Coast, Queensland provide an interesting comparison. The two areas present similar demographic profiles, with access to two major hospitals yet markedly different take up of after hours home and ACF visits.

While home doctor visits are commonplace on the Gold Coast (a mature market in terms of after hours use), there is lower availability and accordingly, less usage of home and ACF visits on the NSW Central Coast. The data show a number of compelling conclusions:

- Central Coast residents were more than two and a half times more likely to visit the emergency department for a low acuity issue.
- Gold Coast after hours primary health costs per citizen (excluding cost savings from avoided ambulance carries) were 10% lower than the Central Coast.

Chart 39: Central Coast NSW and Gold Coast Queensland, home visits July to September 2015



8.6.2 With regards to the Gold Coast experience, the anecdotal view expressed by some GPs is that patients being seen in the after hours are impacting daytime GP numbers. This anecdotal view is not borne out by the data. When the difference in regular GP presentations between the Gold Coast and Central Coast are examined, there is a virtually identical level of visits to daytime practices per capita. This is consistent with a view that after hours services displace emergency department presentations rather than daytime GP services.

8.7 Case Study C: Canada vs Australia

- 8.7.1 A robust model of medical deputising should not be taken for granted. In Canada, which has a similar publicly funded health care system with after hours telephone health advisory systems and an incremental fees structure to incentivise GPs to work after hours, the situation in emergency departments is dire. The Jackson Review says:

Canada also uses public hospital emergency departments as a service provider and as a result public hospitals are over-run, with long wait times.⁵⁸ (Emphasis added.)

A 2014 Canadian study adds:

What is more, the rate of seniors' visits to hospital emergency departments is actually increasing over time...Ironically this group is least likely to benefit from what a hospital can offer. Research has documented the increased risk of pressure ulcers, deconditioning, delirium, and iatrogenesis associated with hospital admission of frail seniors.

And later:

If a family medicine resident happens to have a preceptor who still does home visits or nursing home work, he or she might get some exposure to this important clinical activity... Otherwise, our training programs are failing to meet the needs of this vulnerable and growing population. This of course is not by design but rather a possible unintended consequence of the past decade of primary care reform.

...If a preceptor does not make housecalls or nursing home visits, there is no such "system backup." It is time to build this...

Family Physicians are well suited to play a key role in access, continuity, and coordination of primary care for Canada's frailest seniors. It is time to implement these goals. Let's take our trainees to the "coal face" where these seniors reside, and teach them how to make housecalls and visit nursing homes, so that the next generation of family doctors can develop confidence in this increasingly important work.⁵⁹

- 8.7.2 The challenge in Canada was summed up in a 2013 article which studied doctor attitudes towards house calls in Victoria BC, Canada. Of the sample of 73 doctors surveyed, only 12 made house calls once a week and 11 at least once per month:

Not surprising were the physicians' reasons for not doing more housecalls. An overwhelming 90% listed lack of time as a factor, and about half listed unsatisfactory remuneration and travel distances as factors. Additional comments left by physicians echoed this. Physicians reported that by the time they finished seeing patients in the office, managing patients in hospital, and attending to paperwork, they no longer had the time, energy, or desire to do housecalls.⁶⁰

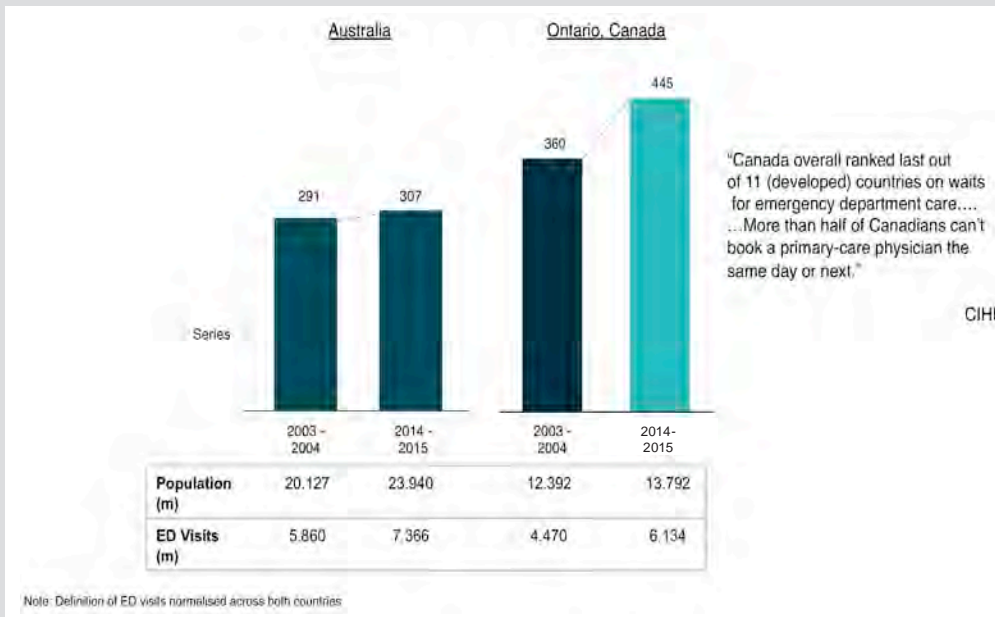
- 8.7.3 The almost complete lack of after hours primary care in Canada has a disturbing and worsening impact on ED utilisation.

58 Jackson, op. cit.

59 McGregor MD CCFP MHSc, M.J. & Slone MD FCFP, J., August (Aout) 2014, *Realigning Training With Need*, Canadian Family Physician (Le Medecin de Famille Canadien), vol. 6.

60 Hammett MD CCFP, T., January (Janvier) 2013, *What Do Victorian Family Physicians Think About Housecalls?*, Canadian Family Physician (Le Medecin de Famille Canadien), Peer reviewed by Canadian Family Physician 2013;59:e33-8.

Chart 40: Emergency department visits per capita ('000)



Source: Canadian Institute of Health Information; Australian Institute of Health and Welfare Database

While the profile of emergency department presentations in Australia grew from 291 visits per 1000 to 352 visits between 2003-04 and 2014-15, the situation in Ontario, Canada, where there are few after hours primary care options, grew from an already high usage rate of 360 visits per 1000 in 2003-04 to over 445 per 1000 by 2014-15.⁶¹

As commented by the Jackson Review:

The administration and delivery of health care in Canada are the responsibility of each province (state) or territory. Canada has thirteen provincial and territorial health care systems that operate within a national legislative framework, the Canada Health Act 1984.

Canada defines after hours care, in the context of family practice, as providing care to all practice patients outside of normal office hours. While there are no legal requirements for GPs to work after hours, there is an incremental fee structure to incentivise them. *Canada also uses public hospital emergency departments as a service provider for after hours and as a result public hospitals are over-run, with long wait times.*⁶² (Emphasis added.)

8.7.4 The Canadian ED experience reflects a poignant example of where an otherwise well intentioned health care system fails to provided adequately for primary care in the after hours.

61 Canadian Institute for Health Information, 2005, *Understanding Emergency Department Wait Times*, ISBN 1-55392-676-5; Canadian Institute for Health Information, *Sources of Potentially Avoidable Emergency Department Visits*, ISBN 978-1-77109-320-0; and Canadian Institute for Health Information, January 2015, *How Canada Compares: Results From The Commonwealth Fund*, ISBN 978-77109-336-1.

62 Jackson, op. cit.

8.8 Work to Reduce Emergency Department Presentations is Far From Over

8.8.1 Work to reduce presentations to emergency departments is far from over. As recently as winter 2016 stories abounded about emergency departments being swamped with low-level presentations:

The Royal Children's Hospital in Melbourne has recently been pleading with parents of children with minor ailments to see GP's (sic) after demand for its emergency department reached a record this year, causing some people to wait more than eight hours to be seen.

On Thursday 7 July 2016 Victorian Health Minister Jill Hennessey said the hospital would receive extra funding to deal with the spike and to create a new 10-bed ward for low-priority patients. She urged parents to visit their GPs for low urgency problems.

In recent Facebook posts, the hospital said as many as 290 children a day were attending its emergency department to enter queues as long as 83 deep.

Professor Gary Freed, an American pediatrician who has been studying Australia's health system for five years at the University of Melbourne, warned that if the trend continued it would "break" the health care system.

"In a decade, your system will break. It's already fracturing," he said.⁶³

Similarly, a Queensland PHN launched the Emergency Alternative campaign in June 2016 after an audit of after hours emergency department data by the Brisbane North Primary Health Network revealed 'shocking misuse of hospital services'. Deputy chairwoman of the Brisbane North PHN, Dr Anita Green, said the group found one in three after hours visits to EDs were for illness or injury that could have been treated by a GP. Meanwhile, 75% of the patients admitted to never accessing an after hours GP.

Dr Green commented:

"What we are seeing are more young adults in our EDs as many are no longer engaged with a regular GP and are unaware of the after hours service they provide."⁶⁴

8.8.2 As the RACGP commented in a media release dated 29 September 2016:

On Monday the RACGP called for the government to keep evidence-based care at the forefront whilst undertaking the MBS review.

We agree with this view. In this case evidence is compelling. The appropriate use of after hours home and ACF visits can alleviate the pressure of low acuity presentations to emergency departments. This is a prime example of 'right care, right place, right time'.

"... I used it for my son. He has bad allergies, lung issues, skin issues. So for when clinics are shut and we don't need a hospital or ambulance but he needs to be seen it's great. It's so nice not getting home at 3 am with a toddler and then having to be up at 6am for work!" Patricia, Carindale, Queensland

63 Medew, J. & Spooner, R., *Worried Parents Swamp Emergency Departments With Coughs And Colds*, <<www.theage.com.au/victoria/worried-parents-swamp-emergency-departments-with-coughs-and-colds-20160707-gq0y56.html>>

64 Courier Mail, 28 June 2016, <<www.couriermail.com.au/news/queensland/queensland-hospital-emergency-departments-clogged-up-by-people-with-nonurgent-ailments/news-story/47670a19e272c5d88aeaa00ab288c9>>

9.0 Workforce Supply is Key to a Sustainable After Hours Sector

“GP work force was consistently highlighted as the biggest challenge in the provision of after hours primary care arrangements, particularly finding GPs who are willing to provide after hours services on a regular basis.” 2014 Jackson Review

“I can’t recruit GPs to my practice unless I have an arrangement with an MDS. Doctors just aren’t interested in after hours care.” GP

9.1 The Doctor Workforce is Insufficient for After Hours Home and ACF Visits

9.1.1 The doctor workforce available for after hours home and ACF visits is insufficient to meet the genuine patient need. While government programs to expand the pool of doctors available for home and ACF visits have been successful, at the same time, the number of GPs providing home and ACF visits has continued to decline and is now at a record low.

More than 80% of GPs report that they do no home visits and GP training pathways fail to recognise and support young GPs to gain such experience. This is at odds with government policy to migrate care from higher cost settings into the home. This risks creating a ‘lost generation’ of GPs that neither do nor have experience of home and ACF visits.

9.2 History

9.2.1 The Approved Medical Deputising Service (AMDS) Program was established in 1999 under section 3GA of the *Health Insurance Act 1973* in response to concern about the shortage of doctors providing after hours home and ACF visits. The purpose of the AMDS Program is to expand the pool of available doctors who provide after hours services including home and ACF visits during the whole of the Commonwealth-defined after hours period:

The Australian Government recognises that the provision of after hours medical services is an area of workforce shortage. The principle behind the AMDS Program is to improve public access to after hours medical services provided by MDS, including home visits, during the whole of the defined after hours period.”

- 9.2.2 Such doctors are eligible to provide a restricted range of professional services for which Medicare benefits are payable, provided they work in an approved MDS. To be approved, an MDS must be accredited and meet both the RACGP Standards for General Practice and the requirements of the AMDS Program.

The AMDS Program guidelines incorporate the NAMDS definition of a medical deputising service. Working with a reputable MDS ensures such doctors have access to Quality Improvement and CPD activities to maintain a qualified workforce and deliver quality care. The AMDS Program is also a pathway for non-VR doctors to achieve RACGP fellowship on the back of stringent education and mentorship requirements.

9.3 Today

- 9.3.1 As noted above, the AMDS Program, in supporting Australian government policy to migrate after hours care out of hospital emergency departments and into the community, has been a policy success. Access to after hours home and ACF visits has increased and home and ACF visits are currently provided by a qualified workforce that includes Vocationally Registered (VR) GPs, GP Registrars and other non-VR doctors working their way towards fellowship of the RACGP or ACRRM.

“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

- 9.3.2 However, at the same time, VR GPs have continued to withdraw from home and ACF visits and non-VR doctors have become even more essential to care in the after hours, now providing over three quarters of all doctor home and ACF visits in Australia:

- **GP home and ACF visits have declined by over 60% in the past 15 years:** This per capita decline is based on Medicare data and primarily due to the ageing of the workforce, with younger VR GPs demanding more work-life balance and higher remuneration in clinic settings.
- **80% of VR GPs now report doing no regular home and ACF visits:** According to multiple studies and surveys, there is only a small minority of VR GPs still doing home and ACF visits.
- **Young GPs are even less likely to do home and ACF visits, creating an increasing gap:** GPs under 35 years of age are only half as likely as GPs over 50 and one-third as likely as GPs over 65 to do home and ACF visits. As older VR GPs retire, there will be an increasing unmet need for home and ACF visits.

9.4 New GPs Receive No Exposure to Home and ACF Visits

- 9.4.1 A recent study by the University of Newcastle attributed the low involvement in home and ACF visits by new VR GPs to the absence of any requirement to do home and ACF visits as part of RACGP Vocational Training. According to the researchers:

At present, there is no program-wide requirement in the Australian GP vocational training program for trainees to undertake nursing home visits or home visits...If you can get GP Registrars comfortable seeing patients in their homes and nursing homes, they are far more likely to undertake this work as established GPs...Exposure to these visits should ideally be a core part of GP training, so our GP workforce can meet the future needs of an aging population.”⁶⁵

The same authors commented that nearly 95% of the respondents who currently do home and ACF visits were taught to do these as part of their GP training, and those who visited nursing homes as a registrar were ten times more likely to continue doing this as an independent GP. Dr. Simon Morgan, one of the researchers, commented in Medical Observer:

If you can get GP Registrars comfortable seeing patients in their homes and nursing homes, they are far more likely to undertake this work as established GPs.⁶⁶

The same Medical Observer article identified that older Australians and patients receiving palliative care are particularly vulnerable to the trend away from visits.

9.5 Non-VR GPs Receive Little/No Recognition for their Efforts in Performing Home and ACF Visits

- 9.5.1 Notwithstanding that the community now depends on non-VR GPs to provide one in two home and aged care visits, such doctors receive little formal recognition for this experience. Until recently, non-VR GPs working as home and ACF visiting doctors could access a pathway to fellowship with RACGP (the Experience or Practice Eligible Pathway). However, following changes by RACGP earlier this year, this pathway has been dismantled and replaced with another training pathway capped at 50 non-VR doctors per annum.⁶⁷ One of the consequences of this change is that it is now even less attractive for young doctors to work or specialise as a home and ACF visiting doctor.

9.6 Outlook

- 9.6.1 While the overall outlook for the Australian GP workforce is positive, with increasing numbers of graduates and fellows, home and ACF visits will continue to be an area of workforce shortage as long as incentives and RACGP training pathways remain disconnected from Australian government policy.

Without change, there will be increasing unmet need for home and ACF visits as older GPs retire and are replaced by young GPs who have had no exposure to home and ACF visits nor any formal recognition or encouragement to specialise in home and ACF visits.

- 9.6.2 We argue there is a real need to strengthen the available doctor workforce for after hours home and ACF visits. Alignment of GP training programs with the long-term need for home and aged care visits is critical.

GP training must be connected to government policy objectives of moving care out of higher cost settings and into the community (e.g. the Medical Home, palliative care in the home, ageing in home). Without any exposure to home and ACF visits as part of GP training, recent studies point to a ‘lost generation’ of GPs that do no home and ACF visits or aged care visits whatsoever.

65 Magin, P., Catzikiris, N., Tapley, A., Morgan, S., Holliday, E.G., Ball, J., Henderson, K., Elliott, T., Regan, C. & Spike, N., 2016, *Home Visits And Nursing Home Visits By Early-Career GPs: A Cross-Sectional Study*, Family Practice, 1-6. <<fampra.oxfordjournals.org/content/early/2016/09/14/fampra.cmw099.abstract>>

66 Medical Observer, 20 September 2016, We Don't Deliver: GPs Avoid Home Visits Unless Taught, <<www.medicalobserver.com.au/blog/we-don-t-deliver-gps-avoid-home-visits-unless-taught-0>>

67 RACGP website <<www.racgp.org.au/becomingagpp/imgaus/pep/ >>

In addition, the unintended consequence of the recent RACGP change to the Experience Pathway is that it is now even less attractive for young GPs to engage in home and ACF visits.

To help address this, we suggest home and ACF visits become a formal part of the GP training curriculum and have vocational recognition.

- GP registrars to complete a set number of home and aged care facility visits as part of vocational training either via their practice or while working with an MDS.
- GP registrars to be offered a 3-6 month special skills placements with an approved MDS as part of their clinical rotations.

9.6.3 The RACGP policy for assessment of general practice experience applicable for the General Practice Experience (Practice Eligible) pathway changed unexpectedly in December 2014. Since 1 January 2015, the level of GP experience recognised is determined by the time working in an accredited MDS multiplied by 50% to a maximum of 2.5 years. This policy change made it more onerous for doctors wishing to work for an accredited medical deputising service to pursue this pathway.

We suggest that it should revert, as a minimum, to being counted as 100% up to a maximum of 2.5 years, as it was prior to 1 January 2015.

10.0 A Robust Model for Medical Deputising is Needed for the Future

10.1 A Robust Medical Deputising Model is Needed in the Future

10.1.1 A robust medical deputising model is needed in the future to support a wide range of progressive health care initiatives:

- The Medical Home.
- Palliative care in the home.
- Aged care in the home.

10.2 The Medical Home

10.2.1 This is an approach to providing quality patient care where each patient has a stable and ongoing relationship with a general practice that provides continuous, coordinated and comprehensive care throughout all life stages.

10.2.2 We endorse the view of the RACGP with respect to the importance of the patient-centered medical home model (the Medical Home) as set out in its *Vision for general practice and a sustainable health care system* dated September 2015.

The Medical Home features five key attributes that closely align with the role of general practice in the Australian health care system including *accessible care, available to patients easily, when it is needed and in responsive settings*.⁶⁸ (Emphasis added.)

10.2.3 The RACGP goes further in its Vision and argues that the more service is available within the community, the less patients will need to rely on more expensive secondary and tertiary hospital care. A payment to general practice highlights the type of work required to make the Medical Home comprehensive:

The payment to a practice would be based on an agreed range of measures for comprehensive service provision. This would include undertaking work such as:

- Routine undifferentiated care.
- Acute care.
- Preventative healthcare.
- *After hours care*.
- Immunization.
- *Home visits*.
- Women's health.
- Men's health.
- Child health.
- Minor procedures (e.g. fractures, lacerations and abscesses).
- Aboriginal and Torres Strait Islander health services.
- Structured care for chronic disease management and mental health care.
- *Aged and palliative care*.⁶⁹ (Emphasis added.)

68 RACGP, op. cit.

69 RACGP, op. cit.

10.2.4 The Medical Home framework assumes a robust model exists to provide the type of care set out above, not just during clinic opening hours, but 24/7. To this end, and as emphasised above, MDSs play a critical role to reinforce the very tenets of the Medical Home that define its success.

10.2.5 These views are reinforced in the Primary Health Care Advisory Board *Better Outcomes* report:

...people with chronic and complex conditions often access a variety of clinical and non-clinical supports and services managed by care coordinators through other funding mechanisms. Effective coordination of these supports is important to enable the Health Care Home to meet the complete care needs of patients...

...Of particular importance is identifying opportunities to enable patients to receive care in the most appropriate environment. *Service provided to support patients to receive care in their home or residential care facilities, where appropriate, could enhance their experience of care and reduce the burden on the hospital system.* (Emphasis added.)

And further it stated:

Care within the Health Care Home is supported by better integrated community and acute care within the broader health system. This allows the patient, family and health care team to more readily access important care within their own community. This might be a specialist opinion or visit, videoconference or *additional home service* to avoid a preventable hospitalisation. (Emphasis added.)

And later:

The average cost of a single hospital admission for heart failure or chronic obstructive pulmonary disease without any other complications is around \$5,500. While not all hospital presentations for chronic or other conditions can be prevented through primary health care interventions, it may be possible to prevent many:

- In 2013-14, 48% (285,000) of potentially avoidable hospitalisations were for chronic conditions; and
- *Nearly a quarter (23%) of people who visited an emergency department felt their care could have been provided by a general practitioner.* (Emphasis added.)

And later again:

The Health Care Home should also include access to after hours support including advice or care for enrolled patients to avoid unnecessary emergency department and hospital admissions out of hours.⁷⁰

10.3 A Robust Medical Deputising Model is Needed in the Future to Support Palliative Care in the Home

10.3.1 The argument for supporting more palliative care in the home is well understood. On all measures, clinical support, compassion, family support and cost, a robust system to support palliative care is required. And yet, despite all this, the option to die at home is not commonly available to Australians. One of the vexing problems to address is how to coordinate the doctor and community nurse support required for home based care. Overseas studies confirm that GPs conducting home and ACF visits resulted in more cancer patients dying at home:

We believe that this study is the first to show, on a population level, that GP home visit in the last week so of end-stage cancer patients' lives...has an important impact on elements of quality of end-of-life care, i.e. staying at home and dying at home...⁷¹

⁷⁰ Primary Health Care Advisory Group, op. cit.

⁷¹ Aabom, B. & Kragstrup, J., (Research Unit for General Practice, University of Southern Denmark, Odense), Vondeling, H., (Research Unit of Health Economics, University of Southern Denmark, Odense), Bakketeig, L.S., (Research Unit of Epidemiology, University of Southern Denmark, Odense) & Stovring, H., (Research Unit of General Practice, University of Southern Denmark, Odense), *Does Persistent Involvement By The GP Improve Palliative Care At Home For End-Stage Cancer Patients?*, <<www.pubpdf.com/pub/12964936/Palliative-care-at-home-general-practitioners-working-with-palliative-care-teams>>

10.4 Outcomes

10.4.1 While various models and funding approaches have been explored, three outcomes are clear:

- Patient needs do not change.
- In the absence of an after hours service that patients *are aware of* and *can access*, the emergency department will remain the default option for after hours primary care for low acuity patients.
- The availability of a strong after hours home and ACF service is the most compelling option that has emerged.

11.0 Recommendations

Growth and sophistication of after hours home and ACF visits is very much a Medicare success story.

To further strengthen the sector and ensure it continues to deliver high quality care, cost effectively, NAMDS recommends the following:

1. NAMDS, the Commonwealth Department of Health and other key stakeholders collaborate to create an *industry wide* **Code of Conduct** with guidelines for:
 - A standard triage profile for emergency conditions that will be directed to the emergency department (and not warrant a home or ACF visit).
 - A standard triage profile for regular health care needs that will be referred to the patient's regular GP (and not warrant a home or ACF visit).
 - Standard protocols for addressing 'frequent user' requests and other complex patients: this would include adopting a standard protocol for monthly monitoring of frequent users/complex patients to determine if such patient behaviour is appropriate; any decisions about supporting such patients would be made in conjunction with the patient's regular GP.
 - Standard protocols for an MDS to receive special *patient* instructions from the GP with respect to any specific patient.
 - Standard protocols for accommodating medical *practice* instructions (e.g. practices that may be open evenings or Saturdays) and rules for informing a patient of their regular practice's opening hours when those practices are open in the otherwise defined after hours period.
 - Standard protocols for encouraging patients without a regular GP to form a clinical relationship with a GP.
 - Standard protocols to address attempted use of the service by individuals with a substance or drug dependency and other dangerous circumstances to ensure safety of all MDS doctors.
 - Agreed language to use in all awareness campaigns to ensure services are used appropriately.
2. **After Hours Taskforce:** The Deloitte Access Economics report is the first serious economic analysis of the best pathways for after hours for the health system.⁷² It is an opportunity to work together for the optimal model of care. We suggest a Taskforce be formed with your department, NAMDS, peak patient groups, PHNs and other stakeholders with a remit to identify broader solutions for after hours care across the health system.
3. **Standard protocols to improve clinical handover and continuity of care:** NAMDS to work with the Royal Australian College of General Practitioners (RACGP) to identify ways to increase the breadth of clinical handover to aid MDSs in conducting home and ACF visits and to identify further ways to ensure continuity of care between an MDS and the regular GP.

⁷² Deloitte Access Economics, op. cit.

11.0 Recommendations

4. **Adopt digital health records:** NAMDS to engage with the Commonwealth Department of Health and the Australian Digital Health Agency to:
 - Enhance the transfer of secure clinical communications between deputising services to subscriber general practices and to the My Health Record.
 - Develop improved methods of access to the My Health Record for out of hours deputising GPs.
5. **Define ‘urgency’:** NAMDS recommends the MBS Review Taskforce maintains the existing MBS item values and adopts the attached guideline for the definition of urgency. NAMDS has sought to clarify the meaning of urgency. Following consultation, advice has been drafted and approved by a conference of NAMDS members (see Appendix A).
6. **Medicare training for doctors:** NAMDS to engage with the Commonwealth Departments of Health and Human Services to:
 - Develop improved guidelines and case examples regarding the appropriate use of relevant item numbers used by deputising doctors.
 - Support the role of deputising doctors in prescribing, including use of the PBS and the Prescription Shopping Programme.
 - Support the usage of Medicare online platforms such as HPOS.
7. **Peer group benchmarks:** NAMDS to collaborate with the Commonwealth Departments of Health and Human Services to set robust benchmarks for appropriate Medicare peer groups for after hours doctors. It has become apparent that Medicare “understands some providers have specialised roles in the community and that means they may be claiming a large number of urgent after hours items”.⁷³ It is of high concern, however, that the peer group for after hours being used for comparison is not the providers with specialised roles (i.e. medical deputising services) but those 20% of regular GPs who may do one or two home and ACF visits a week. We recommend a like-for-like peer group be established for appropriate benchmarking.
8. **Awareness campaign regarding options in an emergency:** growing community awareness of after hours services will improve access and reduce low acuity emergency department presentations. As awareness remains sub-optimal, there is significant scope for further cost savings. We recommend a national awareness campaign be launched in collaboration with state and territory governments.
9. **Council of Health Ministers (COHM) study into opportunities for better ambulance triage:** better triage of low acuity ambulance callers is possible. NAMDS is currently working with Victorian and NSW ambulance services to develop processes for referring more low acuity callers to more appropriate services. We recommend the benefits of the program be explored by COHM.
10. **Commonwealth Department of Aged Care Working Party:** NAMDS recommends that such a party be established with the Department of Health, NAMDS and other key stakeholders including state and territory governments to identify better ways to ensure residents of ACFs have an after hours plan in place. Many residents enter a facility with a regular GP but do not have after hours plans established with their GP; patient expectation is that their GP is accessible, but often this is not the case. The current impact on ambulance and emergency department services is significant and extremely costly to the health system and clinically detrimental to the patient experience.
11. **MDSs should be allowed in-hours access to ACF patients** to treat urgent episodic illness at the specific request of the regular GP. Currently some GPs schedule regular visits but many will not attend an ACF for just one patient. With ambulance carries and treatment costs in the vicinity of \$1351 per patient, this is a significant and often unnecessary impost on the cost of our health system and a stressful experience for elderly patients (see Appendix E).
12. **Palliative Care in the Home Working Party:** a working party should be established with the Commonwealth Department of Health, RACGP, Palliative Care Australia, NAMDS and other key stakeholders including state and territory governments to identify ways to increase access to palliative care in the home. According to Palliative Care Australia, 70% of Australians say they wish to die at home but only 14% do so. We recommend a working party be established to develop a position paper to address current shortcomings. We note this is one of the areas identified for reform by the Productivity Commission in its latest inquiry regarding human services.

73 April-August 2016, Medicare Letter To Practitioners.

13. **After hours introduction to a GP:** many (and a growing number of) after hours patients no longer have a regular GP. We recommend NAMDS develops a system in conjunction with the RACGP and Australian Medical Association for the active introduction of after hours patients to GP clinics looking to expand their patient base.
14. **Accreditation standards and guidelines of the Approved Medical Deputising Service (AMDS) Program should be transparent and subject to collaboration and agreement from all relevant parties including NAMDS.**
15. **After hours support for rural and regional Australia:** under the current Medicare after hours items, medical deputising is not sustainable for smaller population centres. Funding is sought for a pilot program in regional Australia to support alternative models of after hours doctor services where the current Medicare items for after hours are too low to be sustainable.
16. **Alignment on continuity of care and other standards:** after hours providers who are not approved MDSs draw on the relevant MBS after hours item numbers but are not obligated to meet the conditions of, for example, continuity of care with the regular GP. We recommend the Commonwealth Department of Health be charged with formulating a means to ensure doctors engaged in after hours care (regardless of whether they are working within the auspices of an MDS or not) meet these standards.

After hours medical deputising is high quality, high value for the patient, high value for the health system, beneficial for GPs and has grown in line with clear policy objectives. It is a Medicare success story.

Rather than changing the existing Medicare Benefits Schedule structure and or item values related to after hours, which will have an immediate detrimental effect on the community, doctors and the health system, measures should be adopted to strengthen the success of previous government policies and the positive outcomes those policies are delivering to Australians nationwide.

NAMDS, December 2016

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APPENDIX A: DEFINITION OF URGENCY

Preamble

This advice has been prepared to assist doctors working in Medical Deputising to provide guidance on the use of Urgent After Hours MBS Items. It is critical to note that this is only a guidance based on our best understanding and that all doctors are personally responsible for their own billing decisions. Substantiation of your decision through your clinical notes is essential.

Department of Health Advice

All doctors should familiarise themselves with published advice from the Department of Health, which can be found at <http://www.health.gov.au/internet/main/publishing.nsf/Content/hpg-sub-urgent-atten-after-hrs>.

We are aware that in various correspondence from the Department it has been made clear that it is appropriate for a doctor to make a prospective assessment of whether a patient requires urgent treatment and that doctors are not required to make a retrospective assessment of the urgency of treatment following examination. See for example <http://www.mdanational.com.au/Resources/Blogs/Fair-billing>.

Guidance

All NAMDS members operate under a Model of Care that is consistent with the definition of a Medical Deputising Service as set out in the Approved Medical Deputising Service Guidelines. This involves trained staff taking requests for medical attendance and recording the symptoms described by the patient or carer initiating the request. Symptoms requiring emergency treatment are directed to appropriate emergency services. Requests for routine medical care should be referred back to the GP. Generally, only patients with acute, episodic symptoms that are seeking urgent care should be passed through to doctors to attend, with the exception of those calls referred by the Principal GP to the deputising service.

Following the attendance, the deputising doctor should make their own assessment regarding urgency by considering the question – “did the patient’s symptoms and status prior to the face to face consultation support the medical opinion that a face to face examination, assessment and treatment was required in the current after hours period?”

This analysis should be informed by:

- Any telephone triage performed by the doctor prior to attendance
- The degree of patient or carer concern or anxiety
- The severity of symptoms
- Whether symptoms had changed or worsened in the after hours period
- The possible serious conditions or risks that could not have been excluded over the phone and would have required face to face assessment to exclude, especially when taking into account the vulnerability of the patient (age, underlying health status, etc)
- General triage protocols that apply for same day access in general practice
- Whether treatment (including reassurance and advice) was actually required on an urgent basis

It is critical to remember that all doctors are personally responsible for their own billing decisions and substantiation of decisions through clinical notes is essential.

APPENDIX B: EXTENSION OF MDS SERVICES TO DAYTIME ACF

Daytime Aged Care Support

Concerns continue to be raised in the community about the paucity of residential medical care during the daytime for both aged care residents and the frail elderly living at home.

By no means should this be construed as a criticism of daytime general practitioners. NAMDS acknowledges and supports the role of general practice to provide initial, continuing, comprehensive and coordinated care. NAMDS, however, recognises that, from time to time, daytime GPs struggle with their practice based patient volumes and they find it difficult (especially in metropolitan Australia) to battle through traffic to home visit their aged care and housebound patients.

Notwithstanding the successes achieved to date, NAMDS believes the scale of the problem is increasing and the isolation of these patients is growing.

One of the principal stumbling blocks to quickly responding to daytime needs is NAMDS' concern that any home visiting service provided by our members in no way competes with, nor confuses the prime patient management role for these patients by regular daytime GPs. We propose a practical set of recommendations for the Minister of Health to consider. These are:

- The government expands the role of MDS in Australia to cover GP referred daytime home visiting of the frail aged who are either house-bound or living in accredited aged care facilities.
- That DOHA creates a new item number accessible to deputising general practitioners working for accredited MDSs in the period 8:00am to 6:00pm Monday to Friday, and 8:00am to noon on Saturdays.
- This new item number could only be used where the MDS receives a written/electronic referral letter from the patient's regular GP requesting a daytime attendance. The GP referral would need to form part of the medical record and thus be auditable by Medicare Australia.
- That the level of rebate, which applies to this item number, be the same as item 597.
- MDSs are required to transmit the completed patient report to the regular daytime GP within 12 hours of the attendance being completed to strengthen and maintain the oversight role of the regular GP.
- Additionally, there would need to be some minor regulatory adjustments to allow AMDS Program and 19AB exemption doctors to attend referred patients and the frail aged housebound during daytime hours and a corresponding amendment to the definition of a medical deputising service.

If this was to lead to a reduction in Australia's unacceptably high rates of RACF and frail and elderly patient hospitalisation, then the net costs to the Commonwealth would be zero. If ambulance and state and territory government costs were included, the result would be substantially beneficial.

NAMDS contends that the greatest benefit of our proposal would be to empower regular GPs to recommence their care of ACF residents and housebound frail elderly patients. Under the NAMDS proposal, daytime doctors can (where they opt to do so) refer their daytime home visiting care when they have no spare capacity. This, we believe, will lessen the present concerns of GPs and re-invigorate their long standing and compassionate care for this needy group of housebound Australian patients.

APPENDIX C: 'A NIGHT IN THE LIFE OF AN AFTER HOURS DOCTOR'

By Umberto Russo MBBS (ADELAIDE) FRACGP

As a career after hours doctor of 26 years' duration I have continued in the role because I enjoy the variety, challenge of assessing and providing care for acute conditions and the knowledge that I am providing quality care to patients who place a high value on the availability of such a service.

I have been fortunate to see the remarkable progress of after hours services during this time. From the early days when calls were vetted very little and the use of information technology was limited, to the present where the incremental improvement of technological systems used for receiving calls, triaging and information management have led to deliver safe, quality care for patients in need of acute care during the after hours period.

The characteristics of patients on a typical night are as follows:

1. The request from a mum to see her young child with a known history of Asthma presenting with cold symptoms of 2 days' duration. After consultation, a diagnosis of Exacerbation of Asthma/Viral URTI is made and the treatment includes the addition of prednisolone liquid. We do not always know the nature of the problem until a face-to-face consultation is conducted.
2. A request from an aged care facility for an elderly man who has been confused for the day. Attempts to get his GP to visit had been unsuccessful and the GP requests that the ACF call the AH (after hours) service. The consultation is conducted with the patient's concerned daughter present. Further enquiry and examination confirms a diagnosis of UTI most likely and antibiotics are commenced. The patient's daughter comments about how wonderful it is to have a back-up doctor when her father's GP is unavailable. The availability of primary care for acute episodic illness in the absence of the patient's GP should never be underestimated – day or night.
3. A middle-aged man calls with muscular aches and pains, minor cold symptoms, high temperature and headache of 2 days' duration. He has been progressively getting worse and calls the AH service. After further history and examination, I diagnose influenza. He is mildly dehydrated and treatment includes advice about fluid intake to improve his hydration status. This intervention is important to minimise the risk of dehydration and the need for an ED visit for IV fluids.
4. An elderly woman in an aged care facility with vomiting. After further enquiry and examination there are no signs to establish a definite diagnosis. A urinalysis is normal. Further management includes IM Maxolon and instruction to try and increase fluid intake. Instructions are provided on the recommended follow up with instructions for the GP to review the next day. My clinical notes are completed electronically and sent by fax to the ACF immediately and to the GP to ensure effective hand-over.
5. I visit a four-and-a-half-year-old boy with an earache. Mum expresses concern that her son has had a cold for several days but the earache has only come on since late afternoon and her son has been crying because of the pain. Panadol has not helped the pain and the child is unable to sleep. After further history and examination, I decide to provide a stat dose of Painstop and, due to the toxic nature of the presentation, commence Amoxycillin liquid. It is extremely stressful for parents to have children suffering during the night and feel helpless about the situation. Availability of AH care provides comfort to parents when in a helpless situation such as that described above.
6. I see a 45-year-old man who had acute lower back and L leg pain after bending to pick up his 7-year-old son. He has a history of lower back pain but it has never been as bad as this and usually settles within several days. He is agitated by the pain and his mobility is quite restricted. The pain is particularly burning down his lateral hip and he has pain around his anterior shin consistent with L4 nerve compression. Examination confirms L4 nerve root compression with a positive femoral nerve stretch test. He has had minimal relief from Panadol. I decide to treat him with regular ibuprofen in addition to regular Panadol and provide other symptomatic advice with instructions to be reviewed by his GP when he is able to get into his car to drive. The option of using Tramal as a pain medication was discussed if pain was unresponsive to the Panadol/ibuprofen. Access to after hours home visits for patients with acute mobility limitations are important.

7. I attend a call where mum explains her 14-year-old daughter has had increasing sore throat for 2 days but her temperature now is 39 degrees and she is not eating. She called her general practice at 3pm but there were no appointments available that day, so an appointment was made for the next day and she was advised to call the practice's AH service for a visit that night if she felt a consultation could not wait until the next day. Mum becomes increasingly concerned about the symptoms and decides to call the AH service later that night as her daughter was experiencing considerable pain. After history and examination, a diagnosis of acute tonsillitis is made and phenoxymethylpenicillin commences in addition to other symptomatic advice. The patient was provided with samples of phenoxymethylpenicillin until a prescription could be filled the next day.
8. A mother states her 12-month-old child has had cough and cold symptoms for 2 days. Mum is extremely concerned because Panadol is not reducing the fever and her child has not been taking much fluid and is refusing food. After examination, I diagnose a viral URTI. Panadol doses were inadequate for the child's weight so this was adjusted. I was concerned about the child's fluid intake so educated mum about some possible techniques to increase fluid intake and the quantity to give, to prevent complications. The treatment plan for each patient is individualised depending upon the circumstances. The importance of ensuring optimum intervention to aid in quicker or uncomplicated recovery, if possible, should always be observed.
9. I receive a call for a 60-year-old non-insulin dependent diabetic complaining of headache, fever, rhinitis and generalised aches and pains of only 4 hours' duration. Upon further history and examination, I diagnose influenza. Notwithstanding the controversies surrounding Tamiflu, the timing is right for early commencement and I proceed with the Therapeutic Guidelines recommendation of commencing Tamiflu. I provide him with 2 tablets as samples to cover the next 24 hours until he can fill a prescription. Timely access to primary care in this instance will provide the best opportunity for the patient to benefit from early intervention and prevent complications.
10. A mother had taken her 13-month-old child to her GP in the morning with a high fever and some irritability with some reduced fluid intake of 2 days' duration. Mum reported an occasional cough and slight runny nose over the preceding week. The GP diagnosed a viral URTI and provided mum with an AH service telephone number if she was concerned regarding worsening symptoms after hours. Later in the day mum called Health Direct and after a detailed discussion was instructed on symptomatic measures to help her child and told to see her GP for further follow-up. Mum was extremely concerned about the lack of improvement in her child. The symptoms I received late in the night were 'fever, cough, irritable for 2 days'. Additional information I received from mum during the consultation was the fever was still present, there was continued irritability and the reduced food and fluid intake continued but she thought she was providing adequate quantities. The child's stools were runny but not more frequent than usual. Examination findings included a temperature of 39.1 Celsius, obvious dehydration, localised inspiratory crackles and slightly reduced air entry of the right lower lung, tachypnoea (55 breaths/minute) and an oximetry of 92%. Given the clinical signs and my diagnosis of pneumonia, an ambulance was called to transfer the child to ED. Although this type of case is not frequent – I may see one child every 3-4 weeks that requires transfer to ED – it highlights the mismatch between symptoms provided by a parent and the examination findings during a face-to-face consultation. Based on the symptoms provided, a common presentation I might add, I would not have expected this outcome. It is cases like this which make me feel proud of the good I do via my contribution to ensuring patients have access to quality acute episodic care during the AH period.

I take care in completing my clinical notes, knowing that these are provided to the patients' GPs to ensure continuity of care. My name and the company I work for are displayed on these notes and I have always valued the feedback I have received from GP colleagues who have contacted me to discuss my management of their patient – whether positive or negative. I also look forward to receiving my Net Promoter Score each month which provides me with valuable feedback from patients regarding their experience of my consultation. My average Net Promoter Score is very high but then again most of my peers' scores are very high also.

It is uncommon for me to receive requests for obvious non-urgent matters as these are triaged back to patients' GPs by the call centre. All requests are for sick patients – no routine management of diabetes, HT, requests for immunisation etc. Of course, I receive some requests where, after the consultation, the condition did not require urgent treatment and therefore attracts a non-urgent MBS item number. An obvious case is a child with diarrhoea only to find out during the consultation that mum's or dad's motive was the need for a clearance certificate for child care. Urgency can be very difficult to assess when the patient requests a visit but becomes more obvious during the consultation. As a guide, consultations attracting non-urgent MBS items number approximately 20-25%.

It is extremely uncommon for me to request investigations for patients unless absolutely necessary. This is usually for a segment of patients with a suspected urinary tract infection requiring an MSSU as per the Therapeutic Guidelines Antibiotics V15. As the requester, I understand I am ultimately responsible for the result but will always ensure a copy of the results are forwarded to the patient's GP. In the case of a significant result where further intervention is needed, I take my responsibility seriously by ensuring the patient organises review with their GP.

With the sophistication of the handling of drug seekers or other types of problem patients, I rarely get these calls except for the first presentation. I know that when I flag such a patient with the call centre, it normally results in further action via the comprehensive Problem Patient Policy and Procedure, which may result in severe restrictions for further visits or a management plan in collaboration with the patient's GP. Knowledge of this important process is one of the significant contributions I can make to the safety of other doctors or safe delivery of care in the future to these types of patients.

I hope this provides a greater understanding of exactly what it is like to be on the frontline as an after hours doctor. I welcome anyone sceptical of the value of the service we provide to vulnerable Australians, to spend an evening with me and discover it for themselves first hand.

