



5th August 2013

Dr Liz Marles FRACGP
President
Royal Australian College of General Practitioners
100 Wellington Parade
East Melbourne
VIC 3002

Dear Dr Marles,

I refer to the recent changes to the RACGP's position regarding after hours requirements in Criterion 1.1.4 *Care outside normal opening hours*. NAMDS was disappointed not to be consulted in advance of the RACGP changes, now implemented.

In justifying its decision the RACGP states it 'has recognised the current environment and circumstances regarding planning and funding of after-hours care has caused uncertainty about the after-hours requirements under the Standards.' As members of the TWG, NAMDS was in agreement with the RACGP, AMA and all other medical groups that the government's proposals to shift financing of after-hours care from direct to practices and instead to Medicare Locals was impractical and would lead to a triangulation and fragmentation of the continuous and comprehensive patient/doctor relationship in Australia. NAMDS empathises with the frustration felt by your members about these foolish and naïve reforms.

Irrespective of this however, NAMDS believed that the patient centric and continuous care and coordination of patients' 24/7 primary medical care would continue to be the standard that would guide the RACGP's policy positions on these matters. Additionally, we expected that this would continue to be the foundation on which the concept of the GP centric Medical Home would be based, as it is unlikely that a medical home concept could be credibly promoted, just in day-time practice opening hours.

Historically, the RACGP standards for after-hours care have been patient centric and comprehensive and facilitated a collaborative approach between general practices and AH providers (including medical deputising services) to encourage seamless integration of patient care. Such an approach ensures that the patients regular daytime GP maintains their pivotal role in the continuing, comprehensive and coordinated care of patients. Hence, General Practices which had agreements with medical deputising services were able to provide seamless access to AH GP services throughout the whole of the defined after hours period, linked back to daytime care coordinated by the patients regular GP.

Sadly, the interpretation of the new RACGP standard by accreditation agencies allows general practices to opt out of direct 24/7 patient care and transfer this patient care responsibility to others

such as Medicare Locals, public hospitals, call centres and others. All NAMDS members confirm significant numbers of practices adopting the new RACGP standard and abandoning their previous after-hours patient care responsibilities.

In unilaterally implementing this new and dramatically lower standard there has been, in our view, a substantial and regrettable change to the patient centred role of the College, the consequences of which significantly diminish 24/7 patient care standards in Australia and endanger the role of medical deputising general practitioners in supporting general practice.

Some examples of these emerging systemic failures include:

A The interpretation of the new RACGP after-hours standards facilitates the transfer of after-hours patient care authority from general practice to various parties. This has meant that practices can choose to no longer have a documented arrangement with an MDS nor any after-hours cover, other than a referral to some other service.

When a medical deputising doctor attends a patient of a non-engaged practice how then does the MDS transfer patient reports in accordance with the Commonwealth Privacy Act?

More importantly, what medico-legal responsibility does the day-time practice have in following up clinical matters identified by the after-hours doctor? Who then takes responsibility for the continuity of patient care now where the patients' clinical conditions require intervention that spans day-time and after-hours practice?

B NAMDS members are reporting that practices that opt out of 24/7 patient care responsibility cannot be contacted for supporting after hours care of their patients. The previous standard provided for a collaborative approach between MDS and GPs to enable information sharing or special instructions to enhance the management of patients, especially those with complex medical problems or for those requiring a more coordinated approach to care such as patients who have a mental illness or where chronic pain requires detailed management. Was the safety of these patients and their treating after hours doctors considered when the RACGP decided to sever the bilateral relationship which existed between MDS and general practices?

C A Practice that opts out of 24/7 patient care responsibility cannot be contacted concerning urgent pathology, radiology, nor their willingness to sign death certificates or the need for rapid clinical follow-up. Who then is responsible for the patient's care coordination when addressing these crucial matters?

Now that the Australian Primary Medical Care has been fragmented and triangulated by both the ill-conceived after-hours roles of Medical Locals and the now diminished new after-hours RACGP standards, NAMDS members are considering how best to advise our 600 after hours doctors regarding follow-up care of patients. The advice of the RACGP on these matters is sought.

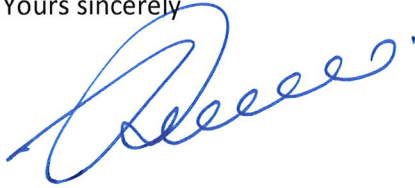
NAMDS contends that the RACGP's strong support of high quality, coordinated and continuous after-hours care of Australian patients should not have been changed lightly. The present change in the standard, together with the new interpretation of the standard by the accreditation agencies has facilitated the fragmentation of Australian in-hours and after-hours patient care, reduced patient and after hours doctor safety and increased 'silos' between primary medical care providers.

It remains the view of NAMDS that Australian patients want a continuing relationship with a regular day-time practice and doctor that they trust and this is, in turn, is strengthened by GPs having a formal relationship with an AH provider who can deliver face-to-face care including home visits

where clinically warranted. New standards which diminish the central role of general practice in the provision of 24/7 continuous and coordinated primary healthcare are, in our view, unsatisfactory.

NAMDS would appreciate your advice on what actions it should take regarding these various matters.

Yours sincerely



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