NAMDS National Association For Medical Deputising

Presentation by Mr Stuart Tait, FAICD
NAMDS President

"A brief master class on Australian after-hours primary medical care services."

1

NAMDS

Getting after-hours care in Australia right is a substantial challenge and a huge responsibility for all of us here today.

NAMDS

Presently, authority, accountability and responsibility for after-hours is vested with 23,000 Australian General Practitioners.

Medicare Local reforms may inadvertently transfer clinical responsibility and patient care accountability from Australian General Practitioners caring for patients in the community to Medicare Locals.

This is potentially a momentous change in the Australian primary healthcare system that is being implemented at an unprecedented and courageous pace.

For the purpose of this presentation, I have divided Australia into two zones:

Zone 1

Metropolitan and MDS serviced urban areas

Zone 2

Sub-regional, Rural and Remote Australia

NAMDS

Sub-regional, Rural and Remote Australia

For MLs covering this zone, there is no alternative than to keep remunerating GPs for their onerous 24/7 patient care responsibilities.

NAMDS believes that sub-regional, rural and remote MLs should commence negotiations with the RDAA to clarify and complete these funding mechanisms ASAP.

NAMDS

Metropolitan and MDs and serviced urban areas

Medical Deputising Services exist in all Australian capital cities, with around 650 deputising GPs working after-hours.

Australian MDS care for a national population of around 17,500,000 people.

Australian MDS have a combined capital value in the vicinity of $125 million.

NAMDS

Additionally, MDS services are required to meet a Commonwealth regulated MDS definition and must be accredited to the RACGP standards.

Some MDS are also quality assured to ISO 9001.

Definition of a Medical Deputising Service

Preamble:

An organisation will be deemed to meet this Definition of a Medical Deputising Service if it is accredited to the current Royal Australian College of General Practitioners Standards for General Practice, including supplementary materials for after-hours care services **AND** is accredited to confirm it meets all the additional criteria set out below.

10

Definition

1. A Practice Principal is a registered medical practitioner (vocationally recognised or not, full-time or part-time), who undertakes the continuing care of patients in a medical practice.

The Practice Principal has a responsibility to arrange comprehensive care of patients 24 hours a day and engages the MDS.

11

Definition *(continued)*

2. A Medical Deputising Service is an organization which directly arranges for medical practitioners to provide after hours medical services to patients of Practice Principals during the absence of, and at the request of, the Practice Principals.

12

Definition *(continued)*

3. A Medical Deputising Service is a means whereby a Practice Principal may externally contract out the after hours components of both continuous access to care and continuity of care to practice patients.

Definition *(continued)*

4. A Medical Deputising Service utilises facilities and processes which ensure continuous access to care and continuity of patient care.

Definition *(continued)*

5. A Medical Deputising Service comprises a physical facility which incorporates a control / communications / operations capacity, administrative services and, where applicable, a clinic.

Definition *(continued)*

6. A Medical Deputising Service must provide home visits and may also provide clinic and telephone triage and medical advice services.

Medical Deputising Services must ensure that they are always in a position to provide home visits as required for significant medical reasons or as requested by Practice Principals, throughout the entire after -hours period.

16

Definition *(continued)*

7. A Medical Deputising Service responds to patient or principal-initiated calls only and must not provide planned or routine patient services unless agreed with the patient's principal practitioner.

17

Definition *(continued)*

8. A Medical Deputising Service must not schedule appointments beyond the after hours period in which the patient request was received.

18

Definition ***(continued)***

9. A Medical Deputising Service is required to operate and provide uninterrupted access to care, including home visits, for the whole of the after hours period.

The defined after hours periods that must be covered by the Medical Deputising Service are: any time outside 8am - 6pm on weekdays and all day weekends and public holidays.

Definition ***(continued)***

A Medical Deputising Service must demonstrate that consultations and visits are provided during the unsociable hours from 11pm till 7am.

Definition ***(continued)***

10. In providing complementary care on behalf of local, daytime general practice, a Medical Deputising Service must be independent of any individual or group of general practice(s).

Medical Deputising Service premises must not be co-located with a general practice.

Definition *(continued)*

11. As Medical Deputising Services do not offer comprehensive GP care, direct advertising to encourage patients to use Medical Deputising Services for 'routine' or convenience purposes, thereby compromising their access to the full range of GP services, is prohibited.

Definition *(continued)*

12. A Medical Deputising Service must have a control / communications / operations capacity which must be operational within its premises during the majority of the defined after hours period.

Definition *(continued)*

13. A Medical Deputising Service which contracts out part of its control / communications / operations function may only do so to an MDS accredited control / communications / operations service.

Definition *(continued)*

14. The control / communications / operations room must, during the after hours period, be staffed by personnel appropriately trained in telephone triage, to guarantee maintenance of accreditation standards and ensure the appropriate management of urgent cases.

Definition *(continued)*

Lastly, a Medical Deputising Service must have telephones attended 24 hours per day by trained staff so the Principals can access the service to communicate special patient information and facilitate continuity of care at all times.

For an MDS to join NAMDS it must confirm the organisations' status as an MDS in accordance with this definition, and it must complete a statutory declaration relevant to the state or territory in which it practices.

This statutory declaration together with the accreditation certificate (that the MDS meets the RACGP standards for General Practice, including supplementary materials for after hours care services) forms the evidentiary basis of meeting this definition and allowing the organisation to join NAMDS.

It is the combination of RACGP accreditation together with the NAMDS/Commonwealth Definition of an MDS that explains why only 15 MDS out of 45 alleged providers, are members of NAMDS.

The reasons for this regulatory "fuzziness" is because the RACGP Standards for after-hours care have been significantly watered down from the 2nd Edition Standards in 2001/2002.

Alarmingly, the 4th Editions Standards fail to mention the definition of an MDS, making genuine accreditation of an MDS next to impossible.

For AGPAL and GPA this is a very contentious matter that NAMDS has unsuccessfully lobbied about for over 5 years. "Fuzzy" definitions have allowed Tier 3 AH PIP fraud to occur and this was the subject of a very adverse Auditor Generals report.

For this reason it is crucial that Medicare Locals demand that tendering Medical Deputising services meet the Commonwealth and NAMDS Definition of an MDS and provide a statutory declaration to this effect.

Without meeting the Definition a tenderer will be able to reduce the patient and GP service standards presently in place in Australia.

All Australian MDS's who meet the definition have well-established, complex and detailed software and hardware systems which link in-hours and after-hours patients and doctors.

Crucially, these MDS systems are integrated with more than 9,000 GP practices.

This allows MDS's to provide face-to-face after-hours home visits to approximately 700,000 people each year and to refer these patients back to their regular day-time GP for continuous and coordinated care.

Other than extended-hours practices and EDs, NAMDS MD's are the largest after-hours service providers in Australia, comprising close to 100% of the home visiting capacity of the Australian metropolitan primary health care system.

Importantly, a patient attended by a medical deputising general practitioner after-hours is returned to their regular GP's care.

This ensures comprehensive, continuing, coordinated and cost-effective patient care around the clock.

These are major positives of the Australian 24/7 primary healthcare system.

IMPORTANT STATISTICS

2009/10 BEACH data shows 7.05 million Australians are seen face-to-face by a doctor in the defined after hours period.

Circa 5 million Australians are seen each year in extended hours GP practices. These patient contacts are presently funded by a combination of PIP Tier 1 and Tier 2 of the AH PIP + higher CMBS rebates and, depending on the geographic location of the clinic, bulk-billing incentives.

Circa 1.2 million people are category 4 and 5 patients attended in state-funded emergency departments yearly.

Circa 700,000 Australians are home visited by Medical Deputising Services

Circa 250,000 patients are home visited by general practitioners. Often, these are home visits done by regional, remote or rural GPs who don't have access to contracted Medical Deputising Service support. Additionally many patients are attended in NSW and QLD small country hospitals where GPs are funded by State governments.

Their patient attendances do not show in this data.

FUNDING MODELS (EXISTING)

For a decade, Australian governments have paid general practitioners for their onerous 24/7 patient-care responsibilities via the Practice Incentive Program, for which there is an after-hours component.

FUNDING MODELS (EXISTING)

The highest after-hours PIP Payment is AH PIP Tier 3 of $6,000. This is paid to each full-time equivalent GP within a practice.

A GP practice claiming PIP Tier 3 ($6,000) for each FTE GP receives 98 cents per hour for the GPs 24/7 patient care (and after-hours attendance) responsibilities.

PIP Tier 1 pays GPs 33 cents per hour.

NAMDS contends that most Australians would be shocked at the paucity of these after-hours PIP payments to doctors.

NAMDS' view is that it is highly unlikely that any other members of Australian society would accept 24/7 care responsibility of this magnitude, given the inadequacy of PIP payments offered by successive Commonwealth Governments.

NAMDS contends that there is a significant danger that by abolishing after-hours PIP payments and re-directing this funding to Medicare Locals, the government could unintentionally diminish the present services offered after-hours by GPs

This abandonment of patients occurred in the UK and NAMDS believes this most undesirable outcome could be repeated here in Australia, unless the proposed new system is carefully administered by Medicare Locals.

Historically, after-hours primary medical care services in Australian have been difficult services to establish and operate. They are extremely complex in nature and commercially fragile.

There is a broad rule of thumb that commercially sustainable MDS' require a minimum population of 500,000 people.

Fortunately, many parts of metropolitan Australian have excellent after-hours services in place that have operated well for many decades.

However, in some parts of Australia, MDS have failed to remain sustainable.

This is especially so in rural, remote and regional Australia, where the onerous task of caring for patients 24/7 falls directly on daytime GPs working at night and on weekends.

A NEW MODEL FOR AFTER-HOURS CARE

It would appear that in the future the funder of medical deputising services could be Medicare Locals and not general practitioners.

55

In mid-2011, NAMDS pointed out to DoHA that this change will significantly impact on patient care in Australia.

The problem is not the specifics of how Medicare Locals will address after-hours care, but in the service delivery model for after-hours care itself.

MDS have over 650 after-hours doctors deputising on behalf of the patients of daytime general practitioners.

57

In this existing model, 650 after-hours doctors have access to the patient records of 9,000 day time GP practices. The daytime GP's patient records form part of MDS patient record system.

Under the MDS model information can and does flow freely, without any additional patient consent needed, because MDS doctors care for patients **within a practice that spans the in-hours and after-hours period. This explains why the after-hours doctors are called Medical Deputising General Practitioners.**

When an after-hours doctor from a medical deputising service attends a patient from a subscribing practice in the after-hours period, the after-hours doctor sees that patient with the consent of the daytime doctor, and is often armed with computerised clinical instructions about preferred care.

So too the principal day-time GP has access to all the deputising doctor's patient reports.

61

The system is rational, comprehensive, coordinated and continuous. The systems are also 4G enabled, computerised and span whole cities.

The capital costs invested in these metropolitan-wide medical deputising services in Australia is substantial and unique.

A comprehensive and coordinated after-hours primary medical care home visiting system is crucial for those who are disabled, aged, infirm and house-bound, aged care facility residents, patients with multiple chronic illnesses, and those families with a deceased person at home who require a life extinct certificate.

No other service can replace the services provided by MDS, other than ambulance evacuation to emergency departments.

95% of all patients attended by NAMDS MDS are bulk-billed.

In summary Medical Deputising Services presently operate **within** the primary care system under the direction of general practitioner principals after July 2013.

MDS presently work for GPs and the GPs are our clients.

MDS care for GP's patients, on their behalf.

As in the UK, NAMDS believes there is a danger that some GPs could transfer authority, accountability and responsibility for after-hours patient care to Medicare Locals.

Such an outcome would severely fragment the 24/7 primary medical care services of Australia, and is highly undesirable.

Another matter poorly understood by either the Government and DoHA is that AH PIP payments are **NOT** just to remunerate day-time general practitioners for their after-hours attendances, whether carried out themselves or by MDS contractors.

They also pay GPs (and their practices) for the myriad follow-ups and referrals that flow from patients who are attended after-hours, that need to be resolved during day-time practice.

This complex, continuous and individualised exchange of patient data and information between daytime and after-hours practice is both time consuming and costly – and in future it seems, may not be subject to any recompense by the PIP.

If GPs were to abandon or reduce their support for 24/7 care in Australia after July 1st 2013, the contingent liability of patient care may unintentionally transfer to Medicare Local Directors, unless the contracted provider supplies an indemnity

This has significant implications for ML directors. At the very least ML directors would be advised to:

(A) Obtain ML-funded Directors and Officers insurance.

(B) Acquire professional indemnity insurance to cover off ML director risk.

(C) Demand that after-hours providers are accredited, meet the NAMDS/ Commonwealth definition of an MDS and provide an indemnity to ML directors before entering into legally binding tenders.

So, rather than just criticize the intended reforms, NAMDS sets about working out how things could work in practice.

We got to work and tried to present a model that could keep all the good features of the Australian system whilst helping the Government to implement its' Medicare Local after-hours reform policies.

Our website has copies of the Medicare Local GP link model for funding Australian GP managed after-hours care.

The NAMDS Medicare Local GP link model for funding Australian GP managed after hours care has been distributed to all ML Directors and CEO's, DoHA, AMA, RACGP, RDAA and ALMA. So far it has been well received.

77

The NAMDS model can be applied wherever Medical Deputising Services exist in Australia (roughly 85% of the national population).

Note that where Medical Deputising Services do not exist, NAMDS contends that direct funding of GPs to provide 24/7 patient care must be maintained by Medicare Locals (MLs).

The NAMDS model creates a:

- Seamless patient journey
- Universal patient access
- Ease of accessibility to face-to-face medical care, including home visits where clinically warranted.
- National access to nurse and medical advice via HealthDirect and support of the PCEHR.

The model establishes the funding role of:

Medicare Locals in supporting the 24/7 patient care access to primary medical care in Australia.

The NAMDS model maintains the coordinative role and authority of General Practitioners in managing 24/7 primary healthcare in Australia.

62

The model embeds the governments preference for essential continuity of care principles, including accessibility to genuinely available face-to-face medical care 24/7, nurse and medical triage, home nursing, palliative care and extended hours pharmacy.

The model develops linkages to HealthDirect and PCEHR compliance for patient reporting by after-hours service providers.

The model can be assessed at www.NAMDS.com

NAMDS is concerned about the pace of the Governments' after-hours reform program.

MLs have been given very little time to tackle one of Australia's most complex and fragile primary medical care policy areas.

Many ML's are only just established.

Some had only just appointed staff, others are yet to appoint people to tackle this issue.

The time available to implement the policy changes is very tight.

NAMDS met with Julie Porritt from the Australian Medicare Local Alliance and agreed to help map out what steps are required from each metropolitan Medicare Local to effectively implement the Governments policy.

NAMDS has identified 11 crucial **ADMINISTRATIVE STEPS** that need to be tackled if this program is to be effectively implemented.

Step 1

61 ML complete preferred service delivery model(s) for both gaps and ongoing AHPMC services.

Step 2:

Draft tenders based on the MLs preferred model(s).

NAMDS

Step 3:

Submit tender documents to ML Board for approval.

NAMDS

Step 4:

Submit tender documentation to DoHA for review and approval.

NAMDS

Step 5:

Prepare legal contracts which specifies tender processes, service delivery criteria, related agreements, indemnities insurances, service delivery standards, etc.

Step 6:

Call for tenders and give tenderers time to complete documentation.

Step 7:

Evaluate submitted tenders.

Step 8

Shortlist successful tenderers and submit to ML Board for approval.

Step 9:

Lodge documentation for successful tenderers with DoHA and obtain approval to appoint successful tenderers and to commit funding.

Step 10

Notification of successful tenderers and execution of legally binding contracts.

Step 11

Allow at least 4 weeks for the successful tender(s) to implement service prior to 1/7/2013.

In conclusion

(A) Keep day-time GPs engaged in 24/7 patient care co-ordination and support.
(B) Where well-functioning after-hours services exist, build on strengths
(C) There needs to be effective transitional arrangements for existing providers. Depending on the time available, this may require some grandfathering arrangements to allow MLs time to complete tendering processes.

On behalf of NAMDS,
Thank you for your time today