



National Association of Medical Deputising Services (Australia)

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The daunting new role for Medicare Local Directors and CEOs in facilitating and funding after hours patient care in Australia

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INTRODUCTION

The Australian Commonwealth Government commenced radical reforms of the Australian 24/7 primary health care and after hours patient care systems when it announced that:

- that Divisions of General Practice (GP controlled organisations) would be replaced by Medicare Locals (MLs) whose board will no longer be dominated by GPs.
- Medicare Locals will be governed by a board of directors comprised of health professionals and community representatives constituted under the Corporations Act.
- Medicare Locals will (in addition to other roles) take over authority, responsibility and accountability for the facilitation and funding of after hours primary medical care services in Australia from July 1 2013.

Presently authority, accountability and responsibility for ensuring 24/7 patient care in Australia is assigned to **General Practitioners**.

The Governments announced Medicare Local reforms also included:

- The national expansion on the 1st of July 2011 of a nurse triage telephone hotline to include GP triage.
- From 1 July 2013, the abolishment of the after hours practice incentives program (AH PIP) payments to general practitioners. Note that these PIP payments presently fund:
 - (i) GP practices for their 24/7 patient care responsibilities, which includes after hours care.
 - (ii) Via the GPs practice, funding of Medical Deputising Services that are contracted directly to GP Principals (with funds sourced from the AH PIP) to provide after hours coverage to 17,500,000 Australians.
- From 2013, the tendering of after hours primary medical care providers, (such as Medical Deputising Services) by Medicare Locals with funds directly provided by the Commonwealth Government to Medicare Locals (not via GPs).

BACKGROUND

Initially the Australian government announced that it was cancelling PIP Tier 1 payments to all Australian GPs starting on July 1 2011. This was planned to occur prior to any Medicare Locals being formed and in advance of any new mechanism to care for Australian patients after hours.

The stated purpose of this cost saving was to fund the new \$40 Million per year after hours GP triage service (which was to be added to the nurse call service) that DoHA naively believed would significantly obviate the need for a patient to be seen face-to-face after hours.

NAMDS was concerned about the intended reforms because they exactly copied those previously undertaken in 2004 in the United Kingdom. These reforms were a substantial failure and caused 95% of UK doctors to abandon their after hours patient care responsibilities, a problem still not resolved in the UK seven years later.

In its negotiations with the government, NAMDS contended that there is nothing in the proposed Australian Medicare Local reforms that would avoid the same patient abandonment outcome that blights the UK primary medical care system.

The key issues of concern expressed by NAMDS to the Prime Minister and Health Minister included:

- That General Practitioners should remain the controllers of 24/7 patient care systems in Australia and should continue to be paid for their important (and in many cases, unavoidable) after hours patient care roles (even more so in regional, remote and rural Australia).
- Medical Deputising Services need to remain the servants of daytime GPs, and to continue to care for patients on behalf of the GP Principals. NAMDS argued to the government that this would preserve the 24/7 continuity of care for patients in-hours and after-hours leading to better patient health outcomes.
- That MLs should not unintentionally weaken well-functioning existing Australian after hours patient care services, such as the large metropolitan medical deputising services, as happened in the UK (where they were unintentionally bankrupted).
- That nurse and GP triage does not (nor will it ever) replace face-to-face after hours patient care. Indeed, 2011 data from the NHCCN shows that after nurse and/or GP triage 26.7% of all patient calls lead to a recommendation for face-to-face medical care within four hours. The experience of NAMDS members is that nurse and medical triage increases patient awareness of service availability and thus increases after hours demands.
- Failure to match nurse and medical triage advice with face-to-face and genuinely accessible medical care perversely encourages patients to attend public hospital emergency departments. The result is a cost shift from Commonwealth funded Medicare benefits payments to home visiting and

extended hours doctors to state funded public hospitals. This is the opposite policy outcome sought by the government when announcing the Medicare Local after hours reforms.

THE MEDICAL DEPUTISING SERVICE (MDS) QUALITY ASSURED CARE MODEL

The present role of accredited medical deputising services is to care for day time GP patients during the defined after hours period (which is 70% of any given week) and to report the patients care back to the regular GP as soon as possible when next their rooms reopen.

To fulfil this role, large Medical Deputising Services exist in all Australian capital cities, have circa 650 deputising GPs working after hours, care for a national population of circa 17,500,000 people and have a capital value of circa \$125-180 Million. Additionally, MDS services have to meet a Commonwealth regulated definition and must be accredited to the RACGP standards. Some MDS are also quality assured to ISO 9001. All Australian MDS have very detailed and complex software and hardware systems that link in hours and after hours patients and doctors.

Crucially, these MDS systems are presently integrated with some 9,000 GP practices with many services able to electronically transmit patient reports directly into GP practice software systems.

This allows MDS to visit approximately 600,000 people each year in their homes with a compound annual growth rate of 7.5% PA. Other than extended hours practice and EDs, the medical deputising services are the largest service after hours providers in Australia and make up close to 100% of the home visiting capacity of the Australian metropolitan primary health care system.

A patient attended after hours by a medical deputising general practitioner is returned to the regular GPs care. This ensures 24/7 comprehensive, continuing and coordinated patient care and is a cost effective and substantial beneficial feature of the Australian primary healthcare system.

Two benefits emerge from the subservient role of a medical deputising service to daytime General Practice principals:

- Patients' receive 24/7 care (including home visits, where clinically warranted)
- GPs get valuable time off for CPD, recreation, sleep and family during the Commonwealth defined after hours period.

Under the Australian MDS model, which is defined in commonwealth government regulation (refer to the AMDSP guidelines under the Health Act) the MDS' client is the principal general practitioner.

Under the proposed Medicare Local reforms, it would appear that the MDS client is to shift from the general practice (doctors) to Medical Local bureaucrats. This is a

substantial theoretical variation to the Australian primary medical care system and potentially has very significant adverse implications for 24/7 patient care.

The expected impact from the Medicare local after hours model of care on the doctor patient relationship and on the free flow of clinical data between regular and after hours GPs is highly problematic and is discussed elsewhere in this presentation.

IMPORTANT STATISTICS

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

- 5 million Australians are seen in extended hours general practices. These medical services 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.
- 1.2 million people are category 4 and 5 patients attended in state funded emergency departments.
- 600,000 Australians are home visited by Medical Deputising Services.
- 250,000 patients are home visited by General Practitioners. Generally, these are home visits done by regional, remote or rural GPs who don't have access to contract Medical Deputising Service support.

Of the 850,000 Australians home visited each year around:

- 35% are residents of aged care facilities or are frail aged and house-bound
- 10% are patients with multiple chronic illnesses.
- 25% of the patients' home visited are very young children, often with anxious parents.

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.

- The highest after hours PIP Payment is AH PIP Tier 3, \$6,000. This is paid to each FTE GP within a practice.
- The least remunerative is AH PIP Tier 1, \$2,000 per 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.

Interestingly, no PIP payments (including the after hours component) have ever been CPI adjusted since their introduction over 10 years ago.

NAMDS takes the view that most Australians would be shocked at the paucity of these after hours PIP payments to doctors. Our view is that it is highly unlikely that any other group of Australians would be prepared to accept 24/7 patient care responsibility for the meagre PIP payment offered by successive Commonwealth Governments.

This historical underfunding highlights the very significant goodwill and responsibility that GPs exhibit in caring for their patients 24/7 and the fragility of the GP managed patient care funding systems that are proposed to be transferred to Medicare Locals.

Sadly, there is a significant danger that abolishing GPs after hours PIP payments and re-directing this funding to Medicare Locals may unintentionally damage the present services offered by GPs after hours. This was the patient abandonment outcome in the UK that NAMDS believes will be repeated in Australia.

Surprisingly, DoHA contends that Australian GPs will continue to remain responsible for 24/7 patient care in Australia. In late 2010 I was informed by a senior DoHA officer, "why should the government pay doctors for 24/7 patient care when they have to do this anyway, as mandated by the RACGP standards"?

Another unresolved matter, which has yet not been recognised by the government and incoming Medicare Local directors, is the potential damage the changes to the after hours PIP payments may cause to the broader financial drivers of general practice accreditation in Australia.

Many Medicare Local directors will be surprised to learn that general practice is not obligated in Australia to undertake accreditation. Instead, GP practices are financially incentivised to become accredited via the Practice Incentives Program (which presently includes a substantial after hours component).

Presently, after hours PIP payments to General Practice amount to \$57 Million PA. For individual practices, these payments are important. For example taking a 6 FTE doctor regional practice claiming Tier 3 of the PIP (and presuming that all PIP payments are accessed) the following financial benefits arise:

	Total PIP payments	Total Tier 3 AH PIP	% PIP reduced
RRMA 1	\$177,599.07	\$29,818.32	20%
RRMA 2	\$177,599.07	\$29,818.32	20%
RRMA 3	\$244,488.93	\$29,818.32	15%
RRMA 4	\$255,118.88	\$29,818.32	14%
RRMA 5	\$297,638.69	\$29,818.32	12%
RRMA 6	\$265,748.83	\$29,818.32	14%
RRMA 7	\$318,898.60*	\$29,818.32	11%

* **Includes rural loading of \$106,299.53**

NAMDS contends that removal of the AH PIP will have an impact on the drivers of GP accreditation in Australia. This is already evident in the data showing a significant reduction in both GP accreditation and AH PIP claims.

Medicare Local directors should note that unaccredited GP practices are not subject to the same controls that apply to accredited practices and it maybe more problematic trying to keep these doctors engaged in 24/7 primary patient care in Australia once they relinquish accreditation.

MEDICARE LOCALS TO REPLACE DIVISIONS OF GENERAL PRACTICE

Nicola Roxon wrote to NAMDS in July 2010 when announcing the new role for Medicare Locals.

As stated in her letter, “Medicare Locals are to subsume the role of Divisions of General Practice, to become independent legal entities with strong links to local communities, health professionals, and service providers”.

This, she wrote, “would enable Medicare Locals to respond more effectively to local needs through more coordinated care, **improved access to services** and via more “driven” integration of services across primary health care, hospital and aged care services (our emphasis)”.

The Ministers message is that the reforms are to encourage improved access to services for patients. How then can Medicare Local directors improve universal after hours access for their community?

Presently, the Medicare Local model in Australia is a very close copy of the Primary Care Trusts (PCTs) of the United Kingdom. These are the same PCTs which the incoming Cameron government intends to abolish and replace with GP controlled 24/7 patient care (the existing Australian model!).

Medicare Locals will be very important and influential organisations. This is because they are designed and have governance structures to facilitate fund holding on behalf of both the Commonwealth and State governments. Thus, substantial funds are provided to Medicare Locals to ensure services exist. Presumably, Medicare Local directors will be held directly responsible for service provision and accessibility and accountable when the services fail or are unavailable.

Medicare Locals will, in future, be required to call and fill tenders for third party service providers for the provision of community healthcare services previously undertaken and/or managed by GPs, GP Practices or State and Commonwealth agencies

This is the same service delivery model used in the UK by Primary Care Trusts.

One of the first jobs given to Medicare Local directors is to appoint after hours primary medical care service providers. Historically, after hours primary medical care services in Australia have been one of the most difficult services to run, commercially fragile and politically contentious and fraught. The standards that will govern

Medicare Local staff and Directors have already been approved by the Health Minister and published on the department website.

Thankfully, many parts of metropolitan Australia have excellent after hours services. For many Medicare Local directors the key task will be not to destroy or damage existing well-functioning services. However, some after hours services are poor and others are non-existent (especially in rural, remote and regional Australia) where the onerous task of caring for patients 24/7 falls directly on day time GPs working at night and on weekends.

Despite the expenditure of tens of millions of dollars over a decade, little has been accomplished by DoHA in resolving poor service availability in regional, rural and remote Australia. In these areas, the role falls on the existing GP or the local hospital.

The Medicare Local model adopted by the Government requires PIP funding allocated to GPs to be redirected to after hours provides such as medical deputising services via a tendering process. In return, Medicare Local directors are expected to secure universal access to after hours care for all members of the community.

Under the new Medicare Local model, GPs will no longer be the gate-keeper of in-hours and after-hours patient care in Australia. This role will be shared between Medicare Locals, after hours care contractors (including MDS) and General Practitioners who agree to participate in the new arrangements.

Exactly how this newly conceived and triangulated relationship will work remains unclear and is an unresolved concern of NAMDS, the AMA, RDAA and RACGP.

A NEW MODEL FOR AFTER HOURS CARE

It seems that the future clients of medical deputising services are likely to be Medicare Locals, not General Practitioners.

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

The problem is not the detail in how things will be done by Medicare Locals (most of whom will no doubt be very well-meaning). The problem is the service delivery model for after hours care itself.

Medical Deputising Services are just that. MDS' 650 after hours doctors **DEPUTISE** on behalf of the patients of daytime General Practitioners.

Thus, the MDS patient record forms part of the General Practitioners (GPs) patient records system, and the GPs records form part of our patient record system.

Information flows freely, without patient consent, because MDS doctors care for patients **within a practice that spans the in-hours and after-hours period.**

So, when an after hours doctor from a medical deputising service attends a patient from a subscribing practice the after hours doctor sees that patient with the consent of the day-time doctor and often with computerised clinical instructions about preferred care. So too, the principal GP has access to all of the Medical Deputising service patient reports for their patients. The system is rational, comprehensive, coordinated and continuous.

The system is also largely electronic, computerised and spans whole cities. The sunk capital costs of these metropolitan-wide medical deputising services in Australia amounts to approximately \$150-\$215 Million.

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

In summary Medical Deputising Services presently operate **within** the Primary care system under the direction of general practitioner principals. MDSs presently work for GPs and the GPs are our clients. MDSs care for GPs patients, **on their behalf**.

However, this will not be the case when Medical Deputising Services are contracted to Medical Locals. In this new paradigm, there is no guarantee, nor any requirement, that GPs will coordinate the work of the after hours provider in caring for their patients when patient care is handed back to the GP when next their rooms reopen.

As in the UK, NAMDS believes it is highly likely that many (if not almost all) GPs will say to the Medical Deputising Services and Medicare Locals, you are being paid directly by Government to sort this out, with money that was originally paid to us, so, **OVER TO YOU**. You are now responsible for this care.

Such a result would fragment the 24/7 primary medical care services of Australia and is highly undesirable.

Medicare Local directors need to be alert to these dangers and will need to be assured that the care systems proposed by their staff will be sustainable and will improve patient access.

Another matter not understood by either the Government nor DoHA is that AH PIP payments are not just to recompense day-time general practitioners for their after hours attendances (whether carried out themselves or by MDS contractors). It also pays GPs (and their practices) for the myriad follow-ups and referrals that flow from patients attended after hours, but needing to be resolved during day-time practice.

All these things are very time consuming and costly – and in future, seemingly not subject to any recompense via the PIP. If GPs abandon their support for 24/7 care in Australia after July 1st 2013 the contingent liability of patient care will transfer to Medicare Local directors unless the contracted provider supplies an indemnity. This has significant implications for ML Directors for which they should seek legal advice.

At the very least ML directors should obtain ML funded directors and officers insurance and professional indemnity insurance.

MEDICARE LOCAL DIRECTOR INDEMNITY, CONTINGENT LIABILITY AND INSURANCE RISKS

This matter appears very complicated and not yet adequately explained in the Medicare local guidelines.

What is known is that Medicare Locals will contract to after hours providers for the provision of universal after hours access, including home visits.

Presumably, Medicare Locals will demand from service providers evidence of quality assurance, evidence of professional indemnity and a full indemnification of Medicare Local directors against action by patients attended by the after hours provider, but making claims against service provider and/or the funder (Medicare Local).

Many MDS already have indemnity cover in the order of \$20,000,000 per annum. Quality assurance standards are measured against both the RACGP standards, ISO 9001 and (when contracting to an MDS) against the Commonwealth definition of a medical deputising service. This together with an unconditional indemnity should provide medico/legal protection for ML directors

However, a significant additional problem exists for ML CEOs and Directors, which needs to be understood and addressed. It is well known that in many parts of Australia around 30% of patients do not have a regular GP. In addition to these patients there will be many daytime GPs who elect not to be involved in ML control of after hours care who will abandon their after hours care responsibilities after 1st July 2013.

For those patients attended after hours but in need of significant additional in-hours primary medical care follow-up care the means through which that care will be provided is difficult to ascertain. Who will do this for patients without a regular GP or where their regular GP has elected not to participate in the new ML after hours arrangements?

One solution is for MDS (or other service providers) to routinely refer this cohort of patients to ED (a perverse outcome that is highly undesirable). However, how can the after hours provider know whether any or adequate clinical follow-up care has been undertaken? This is a very significant medico legal issue because it leaves a potential litigation trap, which directly involves service providers. Arguably, it also involves ML Directors who have created the model through which the patients continuity of care paradigm has been fractured and compromised.

THE NATIONAL EXPANSION OF NURSE AND GP TRIAGE SERVICES

Many States in Australia have established nurse call centres that operate 24/7.

For example Queensland has had "13Health" operational since 2007. Other States have had their services operational for similar periods.

The Howard Government increased funding to these services prior to 2006 and successive Commonwealth governments have been trying to consolidate a national service ever since.

In 2010 the then service provider of the National call centre (McKesson) was purchased by Medibank Private. Soon afterwards the government announced the addition of an after hours GP triage component to the nurse call service and awarded the contract to Medibank Private. The new GP triage service commenced operation on July 1st 2011. Around this time COAG announced that all the State call centres would merge into a national service over the coming two or three years.

This reform, promoted by Coalition and Labor Governments, has been a long term key strategic goal of DoHA.

The NAMDS experience is that DoHA seems to have had three (somewhat conflicting) views when implementing call centre reforms:

- That face-to-face contact between sick people and doctors can be significantly reduced by telehealth, GP and nurse advisory services. DoHA and treasury seem to see these reforms as a cost saving initiative (not a mechanism to improve patient access).
- That the overuse of Emergency Departments by category 4 and 5 patients can be resolved via nurse and GP triage.
- That call centres can improve patient access to the appropriate face-to-face care, when clinically warranted.

When NAMDS pointed out to DoHA that nurse triage in Queensland and Victoria has dramatically increased after hours attendance rates at home they were initially dismissive.

NAMDS contends that while nurse and GP triage does increase self-management in lieu of after hours attendance at an ED, it also potentially promotes the availability of MDS and other face-to-face medical services. Thus, while the percentage of people self-managing after triage increases, this is insignificant compared to the number of people newly advised about the availability of after hours services and facilities.

Some published facts from the last published National Health Call Centre Network report card are of interest.

- 1 The most common advice to the callers using the triage service in 2010 is “see a doctor within 4 hours (21.39%)”. The second most common recommendation is to see a doctor within 24 hours (16.62%).
- 2 50.75% of patients aged over 15 years of age are referred to either ambulance (5.12%), ED (11.82%), See Doctor immediately (12.42%), See Doctor within 4 hours (21.39%).
- 3 If seeing a doctor during the weekend within 24 hours is added to the statistics, some 67.37% of patients are likely to be referred to face-to-face medical care.

- 4 Looking at the data set over 2010, the number of patients referred to ED appears to be steadily increasing while the number of patients referred to their regular GP or extended hours GP practice appears to be steadily decreasing.

Looking at the data set for 2010 it seems that the NHCCN is cost shifting patient demand from CMBS funded GPs to State funded Emergency Departments. This cost shift is confirmed by the data provided from the NHCCN in 2011. This result will alarm State Health Ministers and almost certainly become contentious at COAG in 2012.

The 2011 data provided by the National Health Call Centre Network (NHCCN) post the implementation of a \$40 million after hours GP triage service shows the following

- A. The NHCCN has unintentionally adopted a preference for referral to ED in lieu of GP or after hours GP attendance through inadequate systems to inform triage staff about face-to-face service availability in the community.
- B. Anecdotal advice is that Nurse and GPs triage services routinely advise patients to attend ED irrespective of available alternative face-to-face medical services.
- C. The various call centres do not have up to date data available which allows triage professionals to actually know what services exist in the community, thus obliging the triaging health professional to refer to ED.

NAMDS is concerned about these perverse outcomes and intends to raise these matters with the government, DoHA and the NHCCN in 2012.

ABOLISHMENT OF AFTER HOURS PRACTICE AND INCENTIVE PAYMENTS TO GENERAL PRACTITIONERS

The Government has announced that all after hours PIP payments to GP practices will be abolished on the 1st of July 2013.

To implement the reform several things will need to occur:

- A The Labor Government will need to survive past the hand-over date set for 1/7/2013 and be re-elected thereafter. This is because the Coalition has committed to abolishing Medicare Locals if it secures a mandate from the Australian people and retain and increase the after hours PIP payments to GPs.
- C Medicare Local fund-holding for GPs presumes that those GPs denied remuneration will not abandon their responsibility for 24/7 patient care coordination. This did not happen in the UK, and (in NAMDS view) is unlikely to happen in Australia. NAMDS is encouraging the AMA to survey doctors to see what is likely to occur.
- D Rural, remote and regional GPs are particularly disadvantaged by these reforms. Other than Medicare Locals handing GPs the equivalent of the PIP

money directly, it is hard to envisage how else things could work. Additionally, pity the poor Medicare Local CEO or director that has to try and convince an already stressed and overworked rural or remote GP to accept 98 cents per hour for being on 24/7 call. This amounts to “mission impossible”.

- E If Medicare Locals do opt to just pass the AH PIP money onto General Practitioners paying them 33 to 98 cents per hour is going to be a challenging task. This will unintentionally highlight the underfunding of after hours PIP payments in Australia for over a decade, but leave the Medicare Local directors holding the political blame for the under-funding caused by the Commonwealth.

An additional complication, so far not well understood, is the huge volume of patient care that is presently funded by combining PIP Tier 1 and Tier 2 of the AH PIP and used to subsidise “extended hours” GP practices.

Extended hours general practice is a fragile service offering due to:

- continued poor CMBS rebates which do little to encourage Australian GPs to work clinic shifts late at night and long shifts on weekends.
- increased after hours and weekend penalty rates arising from staff moving from AWA’s to new and higher awards that include after hours and weekend penalty rates under the Fair Work Act
- soon to be abolished PIP payments

There is already clear market evidence reported by NAMDS members of GP extended hours practices reducing their opening hours and/or closing altogether. In NAMDS view, this is potentially the commencement of a significant market failure that abolishment of the PIP will almost certainly exacerbate.

Medicare Local CEOs and directors, the government and DoHA need to be alert to the danger of extended hours GP patients losing existing levels of access to extended hours practice and shifting to ED attendance (in effect a further unintentional cost shift from the CMBS to State funded EDs).

Considering the volumes of attendances catered for by extended hours GP practices (5,000,000 patients attended PA) it is doubtful whether State EDs (1,200,000 category 4 and 5 patents attended PA) would be able to cope with an increase of patients of this magnitude.

SO, WHERE TO FROM HERE?

NAMDS members have a wealth of knowledge and experience over many decades in providing after hours primary medical care services in the Australian community. The following policy responses are suggested as a solution to the policy problems described above.

Suggestion 1

Medicare Local CEOs and directors should re-affirm the long-standing policies of having GPs as the core gatekeepers of the Australian healthcare system, including 24/7 patient care coordination responsibility. They need to instruct their ML staff that service delivery models need to accommodate this requirement.

This may involve conflict with the present government which, to date, has not accepted that the proposed after hours care model is critically flawed. Each ML CEO and Director will need to assess whether they would remain in their role if instructed to implement after hours primary medical care models that won't work.

Suggestion 2

The greatest threat to after hours care in Australia is GP abandonment of their 24/7 care responsibilities.

Other than maintaining the after hours PIP it is difficult to see how this risk can be avoided.

ML directors need to liaise with their local members of Parliament and the opposition, GPs, RACGP, RDAA and AMA and others to test what is likely to happen if untested after hours models of funding and patient care are introduced.

It is crucial for ML Directors and CEOs to recognise that it is they who will be held politically accountable if after hours systems collapse under their management and control.

NAMDS believes that many ML directors who are experienced in general practice will choose to resign from the ML over this issue.

Suggestion 3

NAMDS contends that it is highly unlikely that ML control of after hours primary medical care will ever eventuate in Australia. This is because after hours patient care needs to be managed by GPs, not by ML bureaucrats (no matter how well motivated or skilled).

If, as expected, the government changes its mind on this reform, NAMDS believes that it will be necessary for DoHA to improve some of the definitional rules surrounding after hours care and to strengthen the audit processes so that patients can be assured that after hours services paid for by the tax payer to GPs are actually delivered to patients.

DoHA have been aware of these issues for at least 5 years.

CONCLUSION

Medicare Locals (ML) are already established, nationally. They include professional boards with directors appointed under the corporations act, significant five year budgets and increased staffing with many on long term contracts.

One of the first responsibilities for MLs directors will be approving tenders for after hour's providers in their local area. These tenders are required to include the provision of services for 3-5 years with a national budget in the order of \$550,000,000.

As at the 1/7/2013, GPs will have had their after hours PIP abolished saving the Government \$57 million per annum.

The degree to which GPs abandon 24/7 patient care coordination, post removal of the PIP is predictable. The NAMDS view is that a significant percentage of GPs will be incensed by these changes and will abandon 24/7 patient care responsibility.

How patient care will be coordinated between daytime and after hours care remains unresolved and fraught with complexity. At the very least ML CEOs and directors should require DoHA to issue a formal position statement that can guide directors in their deliberations. This also may help to protect ML CEOs and directors from inevitable community criticism and GP complaints if the failures predicted by NAMDS materialise.

ML Directors also need to ensure that they are adequately insured and indemnified against legal action arising from clinical and organisation contingent liabilities explained in this paper.

DoHA is presently drafting many of the rules that will govern the management of after hours services by Medicare Locals. NAMDS hopes that this will include model contract guidelines and standards for the contracting of after hours primary medical care providers in Australia and the protection of ML directors.

The after hours guidelines developed for MLs by DoHA are now approved by the Health Minister. What is now required are some overarching rules that can be applied to the tendering process to guide Medicare Locals directors in the tendering process. Key matters that need to be included are probity standards, tender periods, timelines and appeals, patient access criteria, GP engagement standards, patient reporting, confidentiality and consent, Informed financial consent, PCEHR compliance, doctor security, indemnity, quality assurance and accreditation.

Lastly, MDS service models are potentially very fragile with most relying heavily upon a combination of Commonwealth Medical Benefits Schedule (CMBS) payments, workforce regulation to support medical recruitment and retention and day-time GP subscriptions to facilitate commercial sustainability.

In transitioning to Medicare Locals (ML) funded models of after hours care ML directors will need to be very careful not to:

- Undermine the 24/7 nature of the Australian doctor patient relationship
- Disenfranchise regular GPs from 24/7 care coordination
- Fragment patient care between in-hours and after-hours practitioners
- Reduce patient after hours medical care accessibility
- Increase pressure on State funded emergency departments
- Decrease after hours Doctor safety
- Increase “silos” between care providers
- Endanger the commercial sustainability of MDS in Australia.

In NAMDS view, all of these failures are likely under the present ML after hours care model adopted by the Gillard government post 1st July 2013.

Additional reading

See www.namds.com , go to the media tab and access the paper titled “Medicare Locals – questions from NAMDS”. This document was sent to the Prime Minister and Health Minister to try and better understand the government’s reform intentions. NAMDS continues to await answers to the issues raised.

See www.namds.com , go to the media tab and access the paper titled “Understanding after hours medical care in Australia” – NAMDS paper presented to DoHA 2010 (Updated December 2011).