Open all hours

Medicare items, urgent services, deputised doctors – the state of after-hours care in Australia.

It's almost midnight, the baby is still crying and her fever is not going down. Her increasingly worried, sleep-deprived parents look at each other. They know they have a decision to make.

‘Do we take her to the hospital?’
‘We’ll have to get her in the car and then probably wait for hours in the emergency department.’
‘What else can we do?’
‘We can call an after-hours doctor.’
‘Great. What’s the number?’

This conversation, or a very similar one, has taken place countless times in homes throughout Australia. However, people calling an after-hours doctor out to their home for an urgent medical situation – whether for themselves, their children, or anyone else – is not as simple as patients contacting their own GP, or one from their regular practice, and having them visit in the middle of the night.

Recent years have seen explosive growth in the use of after-hours home-visiting services in Australia, with the majority provided by medical deputising services. These deputising services are often staffed by doctors with no postgraduate qualifications in general practice and who have no existing relationship with a patient, and do not meet the RACGP’s definition of general practice. This distinction lies at the heart of the RACGP’s position on after-hours home-visiting services in primary healthcare.

Taskforce findings

The Medicare Benefits Schedule (MBS) Review Taskforce’s Preliminary report for consultation – Urgent after-hours primary care services funded through the MBS outlined seven recommendations:

• All medical deputising services (or services that predominantly provide after-hours GP services) should have access to the standard (non-urgent) after-hours items.
• Access to the higher-priced urgent after-hours items should be restricted to GPs who work predominantly in the in-hours period and provide after-hours services to their patients in addition to this in-hours workload.
• Businesses that provide or facilitate medical services mostly in the after-hours periods, including medical deputising services, should not be permitted to claim the high-priced urgent after-hours items.
• In the descriptors for the urgent after-hours items, the current requirement that ‘the patient’s condition requires urgent medical treatment’ will be replaced with ‘the patient’s condition requires urgent medical assessment’.
• The option to book an urgent attendance up to two hours prior to the commencement of the after-hours period in which the attendance occurs should be removed.
• There should be a requirement that the attending practitioner determines that the urgent assessment of the patient’s condition is necessary and for this to be recorded.
• There should be a clearer definition of ‘urgent’, which is that the patient’s assessment cannot be delayed until the next in-hours period; and requires the GP to attend the patient at the patient’s location or to reopen their practice.


Paul Hayes
While the RACGP recognises the need for patients to have access to urgent care when their regular general practice is closed, it has significant concerns about any model of service delivery that fragments care, compromises the quality of healthcare service and fails to use limited healthcare funding efficiently.

The RACGP believes the provision of urgent after-hours services, and the premium Medicare Benefit Schedule (MBS) rebates they attract, should be limited to vocationally registered (VR) GPs, non-VR GPs, doctors on a pathway to RACGP Fellowship or general practice registrars under appropriate supervision from a qualified VR GP.

‘The RACGP is supportive of after-hours medical services; however, in the interests of patient safety they absolutely must be offered by suitably qualified doctors,’ RACGP President Dr Bastian Seidel said. ‘The most urgent call-outs should not be attended by junior doctors with minimal hospital experience and no postgraduate qualifications whatsoever.’

Stunning growth

There has been a more than 150% increase in the number of urgent after-hours MBS services (734,000 to 1,869,000 per financial year) from 2010–11 to 2015–16. By contrast, standard GP services rose only 15% over the same period.

The increase in the use of urgent services raised concerns among healthcare bodies, including the RACGP, the Australian Medical Association (AMA), the Australian College of Rural and Remote Medicine (ACRRM), the Australasian College for Emergency Medicine (ACEM), and others.

‘In some areas, for example in the ACT, we have seen an increase in after-hours visit of 1500% over the last year. Not 5% or 10% or 50% or 100%, but a 1500% increase,’ Dr Seidel told Good Practice. ‘Someone will have to explain to me where the epidemic of urgent visits is coming from. It’s just not plausible.

‘Realistically, it’s the taxpayers’ money that’s being shifted to an area where there probably is no clinical need, but it is supply-driven, and that certainly is not sustainable. That’s what we made clear in our submission to the MBS Review Taskforce.’

In response to such concerns, the MBS Review Taskforce (the Taskforce) has undertaken an evaluation of the four items for urgent after-hours services (597, 598, 599 and 600), all of which have much higher rebates than standard after-hours or GP attendance items. The review found the substantial growth in the number of services and benefits paid for urgent items was driven more by increasing numbers of medical deputising businesses rather than clinical need.

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The distinction between what constitutes urgent and non-urgent was another significant aspect of the Taskforce’s findings.

‘Many urgent after-hours services claimed as urgent are not truly urgent, as intended when the items were created, and the distinction between “urgent” and “non-urgent” appears to be not well understood by many medical practitioners,’ the report found.

‘The most urgent call-outs should not be attended by junior doctors with minimal hospital experience and no postgraduate qualifications’

The Taskforce has recommended MBS item descriptors be rewritten to provide an expanded definition of an urgent consultation.

This suggested definition includes situations in which a patient’s assessment ‘cannot be delayed until the next in-hours period’ and ‘requires the GP to attend the patient at the patient’s location or to reopen their practice’.

According to Dr Seidel, the idea of any misunderstanding about the use of urgent and non-urgent MBS items holds little weight.

‘The medical indemnity insurance is actually very clear about what the marker is. The marker is that it has to constitute urgent treatment; it has to be the need for urgent treatment. Full stop,’ he said.

RACGP President Dr Bastian Seidel describes the continuing rise in after-hours care driven by supply, rather than clinical need, as unsustainable.
AFTER-HOURS CARE

‘Just because a doctor thinks that by getting a triaging call that it’s urgent, or the patient thinks it’s urgent, doesn’t mean it attracts an urgent Medicare rebate.’

‘If the doctor leaves without initiating any urgent treatment for the patient, they can’t claim an urgent Medicare item number.’

The RACGP has expressed its unease over adequately qualified doctors and the use of urgent items to the Federal Government.

‘I am concerned about reports that some doctors are claiming to be providing urgent services when they’re not urgent at all,’ Federal Health Minister Greg Hunt said. ‘We have an absolutely rock-solid commitment to after-hours medical access. But we also have a commitment to ensuring that every service provided is genuine and that every doctor is up to scratch.’

According to Dr Umberto Russo, National Home Doctor Service (NHDS) General Manager – Clinical Governance, Dr Umberto Russo, believes NHDS practitioners who provide after-hours services are indeed up to scratch.

‘NHDS invests heavily in the training and development of its doctor workforce and extends well beyond the need to meet regulatory requirements,’ he told Good Practice. ‘Our commitment reflects the values and day-to-day practises of an organisation committed to providing high-quality care to patients on behalf of GPs.’

Dr Russo, himself a GP with a history of working in an after-hours capacity, describes the RACGP’s belief that this type of care be provided by qualified GPs or doctors on a pathway to Fellowship as ‘aspirational’.

‘It would be great in an ideal world, but the reality is that the delivery of after-hours visits is an area of GP scarcity and unmet need,’ he said. ‘An idealistic approach does not solve the issues for the very patients that need these types of services.

‘As a consequence, the Commonwealth Government allows doctors to provide after-hours visits as part of the AMDS [Approved Medical Deputising Service] Program. Doctors need to meet certain minimum requirements to be part of the program and then satisfy ongoing requirements, with reporting to the Department of Health.’

Dr Russo said all doctors in the AMDS Program are involved in a clinical governance framework. This includes work with pharmacists, medical directors and other doctors; online communication modules; a life support course; urgent care training; and mentor meetings.

‘In addition, all AMDS Program participants must satisfy the requirements of the RACGP QI&CPD [Quality Improvement and Continuing Professional Development] Program or the ACRRM professional development program, and progress to Fellowship of the RACGP or ACRRM within six years of commencing the Program,’ he said.

Restricting urgent items

Following its review, the Taskforce’s Preliminary report for consultation – Urgent after-hours primary care services funded through the MBS has made seven recommendations. (Refer to breakout on page 18 for the full list.)

Restricting the use of urgent after-hours items was key among the suggestions. The Taskforce recommends that:

• access to the higher-priced urgent after-hours items should be restricted to GPs who work predominantly in the in-hours period and provide after-hours services to their patients in addition to this in-hours workload

• businesses that provide or facilitate medical services mostly in the after-hours periods, including medical deputising services, should not be permitted to claim the high-priced urgent after-hours items. In simple terms, the lucrative urgent after-hours items should be limited to GPs who work normal hours and not be claimed by medical deputising services.

Dr Spiro Doukakis, President of the National Association for Medical Deputising Services (NAMDS), has been vocal in his opposition to this idea. He believes such a change would limit their role and that of deputised practitioners, ultimately placing enormous strain in the country’s hospitals and putting patients at risk.

‘Emergency departments across Australia will be flooded if these recommendations are pursued by the Federal Government, because our services will have no choice but to close,’ he told the ABC.

RACGP statements

The RACGP has used its position as the voice for Australian general practice to speak about the topic of after-hours care, releasing multiple statements on the issue.

The After-hours home visiting services in primary healthcare: Position statement, released in late 2016, outlined the RACGP’s aim of encouraging an effective model for the delivery of general practice care in the after-hours period, patient access to high-quality after-hours care services, appropriate billing of Medicare item numbers and compliance, and sustainable healthcare expenditure.

In addition, RACGP President Dr Bastian Seidel provided a formal submission to the Medicare Benefits Schedule (MBS) Review Taskforce in response to its Preliminary report for consultation – Urgent after-hours primary care services funded through the MBS. This July 2017 submission detailed the RACGP’s overall support of the report’s recommendations, while raising its concerns with some unintended consequences of those recommendations.

Visit www.racgp.org.au to access all statements and submissions.
Dr Russo feels any moves to limit access to urgent MBS items will radically reduce doctors’ remuneration and deal a potentially crushing blow to the after-hours workforce.

‘With such a drastic and sudden cut, all doctors will consider their options,’ he said. ‘In short, the doctor workforce, which is already difficult to recruit at existing rebate levels, will leave the sector, taking with them a cohort of GP Fellows who provide mentoring, clinical governance and leadership, and underpin the quality framework in the sector.

‘Cutting the available after-hours workforce by some 60–70% would mean GPs would have to be rostered on to do after-hours work on weekdays, weekends and public holidays. The vast majority of GPs do not want to do more after-hours work, and say that they are unable to do so.’

While the RACGP welcomes the aim of limiting after-hours rebates, Dr Seidel has pointed out some unintended consequences.

‘A lot of RACGP members are working for medical deputising services, or even running and owning them,’ he said. ‘The Taskforce’s recommendations as currently constituted do not recognise the scenario where a qualified GP employed by an after-hours service provider undertakes an urgent assessment for a patient, referred by the patient’s regular GP/practice, in the after-hours period.’

As an alternative to help ensure better continuity of care, the RACGP has recommended to the Taskforce that urgent after-hours service providers be required to enter into formal agreements with local general practices, and provide a summary detailing the clinical management of the patient to the patient’s regular GP as soon as possible.

‘The RACGP also recommends patients’ eligibility be linked to their usual GP or practice. This would mean after-hours service providers could only access urgent items when a patient is referred by their usual GP or practice, and the service would need to be provided by a qualified GP or doctor on a pathway to Fellowship.

‘Stronger links between after-hours services and general practices would help stop the fragmentation of patient care and ensure the effective use of the funding available for Medicare rebates,’ Dr Seidel said.

The RACGP is not opposed to medical deputising services or their right to provide after-hours care, but is rather calling for what applies to day-time practice be applied to after-hours care. It is working in the best interests of Australia’s GPs and their patients.

‘It is not the role of the RACGP to influence a particular business model of care,’ Dr Seidel said. ‘It’s our role to ensure the appropriate standard of care is being delivered and patients are being seen by an appropriately qualified doctor.

‘It’s okay for doctors without any postgraduate qualifications to see a patient. The question really is whether that consultation should attract the same premium urgent Medicare rebate that is attracted by a fully qualified specialist GP.

‘I think it goes without saying that the answer is no.’

References