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SUBMISSION

Tuesday, 7 May 2024

Review of primary care after hours programs and policy

Online submission to Allen and Clarke Consulting

Dimension 1: The extent to which the current after hours primary care service and funding system supports the provision of the right services, at the right time, in the right places, by the right providers

How effective are the current financial arrangements, including relevant MBS items and the After Hours Practice Incentive Payment, in supporting the provision of after hours primary care services? What changes to the current financial arrangements would better support practitioners to provide after hours services?

Current financial arrangements supporting after hours primary care services have variable effectiveness. The after hours MBS rebates are not sufficient enough to attract GPs to work unsociable hours without creating patient gap payments. The AMA understands that currently medical deputising services quality and usage varies. Some quality issues include difficulties with continuity of care and handover.

After-hours services should be better supported under the MBS by redefining the after-hours period to 6pm-8am weekdays – at a minimum. The AMA also recommends after-hours definition also includes all of Saturday and Sunday and public holidays. When amending MBS rebates to better provide after-hour services, the rebate must adequately account for the costs of these services.

Practice Incentives

Practice incentives should:

- enable practices to have flexible arrangements to align after-hours services with community need
- incentivise practices to provide a minimum of 10 hours per week (the base level)
- incentivise each additional hour (after the base level) the practice commits to
- incentivise practices to open on weekends by providing a funding tier or additional loading to further support practices operating on Saturday and Sunday
- incentivise (substantially) practice nurse availability in the after-hours period

MyMedicare

Under MyMedicare registered patients should have:

- access to adequate rebates for telehealth and telephone items for clinically necessary consultations in the after-hours period provided from their registered MyMedicare practice, including patients in RACFs
- access to adequate rebates for a home visit, when clinically necessary, in hours and out of hours, from their nominated GP (or a GP from the nominated practice)
- access to integrated digital health technologies that support care delivery.

MBS

After-hours services should be better supported under the MBS by:

- redefining the after-hours period to 6pm-8am weekdays – at a minimum. The AMA after-hours definition also includes all of Saturday and Sunday and public holidays
- providing MBS rebates that adequately account for the costs of providing after-hours services.

After-hours Funding should not:

- be subject to any requirement to bulk bill services
- encourage unsafe working hours or work environments
- enable a government funded or controlled service to compete unfairly with local GPs provision of after-hours services
- impose a perceived or actual compulsion on GPs to participate in the provision of after hour services.

After-hours period should be redefined to start at 6pm on weekdays

Staff hourly rates of pay increase from 6pm, making it more costly for practices to provide services beyond 6pm.

It is very difficult to find GPs who will work between 6-8pm at in hours rates, and not being able to cover this "gap" inhibits practices from staying open and taking advantage of increased rebates after 8pm.

If After Hour rebates applied from 6pm this would encourage practices to stay open and would better support patient continuity of care as they would not need to be referred to the practice's Approved Medical Deputising Service or default to attending an emergency department.

It would also put general practices on an even playing field with Approved Medical Deputising Services who can provide higher rebated services from 6pm weekdays under Medicare.

How effective is the current after hours system in supporting the provision of multidisciplinary team based care to consumers in the after hours period? How could the system better support practitioners other than medical practitioners (e.g., nurses and nurse practitioners, allied health practitioners and Aboriginal and Torres Strait Islander health workers) to provide after hours services?

The AMA believes there is merit in exploring how practice nurses or nurse practitioners working within general practice could be utilised for triaging, supporting patient self-management, treating minor cuts, abrasions, bruises, lesions or burns or illnesses, and how this could best be funded.

The current after hours system through the MBS does not support the provision of multidisciplinary care from nurses and allied health professionals. Effective and efficient patient centred primary care services include the use of multidisciplinary teams to deliver care. There are opportunities to provide greater care after hours in primary care settings through the development of innovative blended funding including through MyMedicare and the MBS.

How does demand for services change across the after hours period, and how can the system support alignment between service availability and need?

Key Data

The State of Emergency 2022 produced by the Australasian College for Emergency Medicine (ACEM) reports that of all emergency department presentations:

- 39 per cent occurred between 6pm and 7:59am
- 29 per cent resulted in a hospital admission.

Research in 2016 of a Melbourne Medical Deputising Service found that:

- Over 80% of bookings for older patients were for patients of residential aged care facilities.

Analysis conducted as part of the Evaluation of Primary Health Networks After Hours Program suggests moderate reductions in unnecessary hospital emergency department attendances where Medicare funded after-hours services are available.

Australia Bureau of Statistics data shows that in 2021-22:

- 5.5% of patients surveyed saw an after-hours GP
- females were more likely to use an after-hours GP (6.1% compared to 4.9%)
- people aged 85 years and over were less likely than those aged 15-24 years to see an after-hours GP (2.5% compared to 5.2%)
- patients with long term conditions were more likely to see an after-hours GP (6.7% compared to 4.2%)
- people living in major cities were more likely than those living in outer, regional, remote, or very remote areas to see an after-hours GP (6.3% compared to 3.4%)
- people living in in outer, regional, remote, or very remote areas were more likely than those living in major cities to visit a hospital emergency department (18% compared to 13.6%)
- people living in areas of most socio-economic disadvantage were more likely than those living in least disadvantage to delay or not use after-hours GPs (45.7% compared to 30.2%)
- people living in in outer, regional, remote, or very remote areas were more likely than those living in major cities to delay or not use after-hours services (55.6% compared to 33.5%)
- an increase in the proportion of people who delayed or did not used an after-hours GP for reasons other than cost (eg “service not available when required”, “too busy”, or “waiting too long”) (34.5% up from 30.4% in 2020-21)
- an increase in the proportion of females who were more likely to report reasons other than cost for delaying or not using an after-hours GP (38.2% up from 30.4% in 2020-21).

Regardless of individual patient needs, the system needs an appropriately compensated and available workforce to address a range of needs. This includes on call staff, rostered in person staff, and professionals available via telehealth.

There is often a misunderstanding amongst consumers regarding the difference between urgent care and after-hours care.

Dimension 2: The extent to which the after hour primary care system – and different models of after hours service delivery – meet the needs of consumers and the community

To what extent, and in what ways, is the need for after hours primary care in the community being met? What gaps exist in service provision?

The AMA is advocating for improved access to general practice afterhours, by aligning the definition of 'after hours' to the Approved Medical Deputising Service (AMDS) definition of after 6pm on weeknights and after 12pm on a Saturday, an investment of $339.7 million over the forward estimates.

Currently, after hours services are funded through various funding streams, including fee-for-service after hours MBS items, the After Hours Practice Incentive Program (AH PIP), funding for a Primary Health Network (PHN) After Hours Program 'to support general practices to fill access gaps' and funding to support healthdirect and the after hours GP helpline.

Whilst the 2023–24 Federal Budget included $149.5m over two years to 'improve access to after hours care', this funding went mainly to PHNs and healthdirect's after hours GP helpline.

At the same time, the Budget also included $358.5m over 5 years for Urgent Care Clinics (UCC) (including eight new clinics) with no out-of-pocket costs to patients.

In addition, Level C and D telephone consultations and Level E video consultations for MyMedicare patients, which also attract the Triple Bulk Billing Incentive, are available for use in the after hours period.

With regard to UCC's, while the AMA has not been supportive of their introduction, the AMA has argued that where they are established UCCs must:

- Use existing general practice infrastructure (as opposed to establishing new community-based or hospital-based services).
- Be led by general practitioners, with support from other healthcare professionals including allied health, nurses, and non-general practitioner specialists.
- Include triage support for patients, so they access the right care. This support needs to be provided locally (as opposed to a national call centre) by an appropriately trained professional, as knowledge of the local services and community is key to referring a patient to the right care.
- Be properly scoped, to ensure they are established in areas where this type of care is required to meet community need.
- Be properly evaluated, to determine effectiveness.

The extent of after hours service provision being met varies across communities and patient cohorts and needs. Gaps in after hours primary care services leads to patients turning to emergency departments to receive care. The AMA has also heard anecdotal evidence of patients being unfamiliar of available after hours services and turning to unscrupulous for profit telehealth corporations without continuity of care.

Key gaps in after hours primary care service also include the poor support for multidisciplinary teams and administrative staff with opportunities for pathology and radiology to be supported to provide urgent results.

What are the main factors driving demand for services in the after hours period?

People get sick outside of business hours, and our 24/7 economy also means that people cannot always visit their GP during the day. When patients need medical care outside of normal hours, they prefer to access this through their usual GP or general practice .

Current Medicare arrangements, however, discourage GPs from offering in-clinic services after 6pm on a weeknight, as well after 12pm on Saturdays. As a result, they may delay necessary care, visit the emergency department unnecessarily, or rely on an Approved Medical Deputising Service – which may result in fractured care.

Additional factors driving demand in after hours periods include urgent care for parents of young children requiring care and medical attention in addition to consumers working shift work or unsociable hours requiring regular primary care services.

What are the specific needs of people living in rural and remote Australia, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, residents of aged care facilities and people receiving palliative care, people with disability and/or chronic illness, older people, children, and people in precarious or less flexible employment? How can these needs best be met?

Broadly the needs of these diverse groups can be best met through accessible and available workforce providing after hours primary care. Innovative, blended, stepped funding that rewards GPs, primary care nurses, and administrative staff to work unsociable hours will improve the availability of care for these patient cohorts. Some challenges include rural and regional doctors providing after hours care immediately after providing regular primary care services during regular hours at the risk of fatigue.

What is the proper role within the system of different models of care, including telehealth and home visits? How can consumers be matched to the most appropriate services?

Ideally consumers will be matched to the most appropriate service through their regular GP who can work with or refer to an after hours team. Consumers deserve access to care that is tailored to their needs, this includes availability of care via a range of mediums. Post-COVID has allowed innovation in digital health and telehealth in general practice that will assist with the accessibility and availability of after hours primary care services.

How can after hours services be made more accessible and easier for consumers to navigate? Would a 'single front door' or access point improve Australia's after hours system?

While a single front door will improve accessibility and navigation, it is not the only option. A 'single front door' will assist in visibility and care navigation especially for older people and people who don't regularly interact with primary care services. The AMA supports a range of initiatives and platforms to deliver after hours primary care. Telehealth does play a role in providing accessible after hours care and triaging.

Dimension 3: The experiences of primary care providers, and barriers and enablers to afterhours service provision

What are the factors which enable or obstruct practices and practitioners from providing after hours services – or from expanding the services they provide?

There are a range of factors which may obstruct or make after hours primary care inaccessible. These are outlined above but can include the following:

- Lack of multidisciplinary care due to poor funding arrangements
- Lack of workforce to adequately provide after hours care
- Lack of awareness of after hours services from consumers. Many consumers opt to attend the Emergency Department without the knowledge of after hours services.
- Accessibility and cost of care for consumers
- Broader issues affecting general practices and their viability including the threat of state and territory payroll taxes etc.

<u>Problems identified by AMA GP members:</u>

- Multiplicity of after-hours offerings outside of general practice of varying efficacy
- Structure of PIP After Hours Incentive provides for only two-time tiers of operation and does not effectively support practices to extend their hours of operation – i.e. 8pm to 11pm or 24/7

- Limited number of GPs wanting to work in the after-hours period – with initiatives like the Urgent Care Clinics (UCCs) cannibalising what workforce there is
- Diminishing volume of services required over the after-hours period vs cost of availability
- After-hours care is very costly – as evidenced by the funding for UCCs
- Changing work patterns (flexible work arrangements, extended working hours, shift-work etc) mean people increasingly need to access care in the after-hours period. Government needs to recognise the value in patient's accessing care when required rather than being focussed on when that care is accessed given economic and health benefits of timely care.
- Perceived patient need for urgent care and for a service facility that has access to diagnostics (imaging and pathology) coupled with a lack of awareness of the health system cost

Possible options to address these include:

- Re-align (i.e. expand) the after-hours period
- Providing an after-hours subsidy for practice nurse support and triage
- Provide after-hours rebate for telehealth items
- More research into after hours care and utilisation of data on after-hours care acuity, actions taken, clinical and patient outcomes, and costs, supported by enhanced integrated coding mechanisms, to inform policy positions
- Fund after-hours services to provide a mix of services – telehealth, other digital health in addition to hands-on clinical care when required
- Stepped funding to support practices for each additional hour of after-hours care provided
- Educate patients about what is urgent care and the costs of care
- Prosecute the value of supporting the existing infrastructure of general practice to expand hours of operation as the most cost-effective care option.

Do those factors vary across service models (e.g., home visits, visits to registered aged care facilities, telehealth) and time of day?

Yes, each of these service models all have a range of unique barriers and enablers.

How do barriers and enablers vary across different practitioner types and different parts of Australia?

What after hours primary care services varies according to place and context. For example, delivering after hours primary care services in rural and regional areas are more difficult due to workforce difficulties. Currently, most after hours primary care services are provided by 'corporate' general practices and medical deputising services.

What changes to after hours primary care policies and programs would be most effective in increasing after hours service provision?

After-hours funding should:

- adequately support general practices to extend their hours of operation
- ensure MBS rebates are sufficient to attract GPs to work after-hours without creating unaffordable patient gap payments
- enable general practices providing after-hours care to share proportionally in savings generated from reductions in emergency department attendances for their community
- support continuity of care and facilitate timely diagnosis and treatment initiation
- enable access to complementary services for pathology/radiology/pharmacy if required (may include allowing GP use of hospital facilities)

- support practices with access to a properly integrated directory of clinical support service providers (pathology, diagnostic imaging, crisis support, etc) available locally in the after-hours period
- support the implementation of interoperable technologies to facilitate real time exchange of clinical information for referred or deputised care (for example immediate referral with clinical handover to emergency department or transfer of clinical notes to a patient's regular GP if providing care on their behalf) to support seamless patient care in the after-hours period
- ensure patients affordable access to clinically necessary care, diagnostic and pharmacy services
- support practices to provide point of care testing where appropriate in the after-hours period
- Monitoring and evaluation framework
- Alleviate pressure and presentations to emergency departments through access to primary care and continuity of care.

After-hours Funding should not:

- be subject to any requirement to bulk bill services
- encourage unsafe working hours or work environments
- enable a government funded or controlled service to compete unfairly with local GPs provision of after-hours services
- impose a perceived or actual compulsion on GPs to participate in the provision of after hour services.

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