SUBMISSION TO THE MEDICARE BENEFITS SCHEDULE (MBS) REVIEW TASKFORCE

PRELIMINARY REPORT FOR CONSULTATION –
URGENT AFTER-HOURS PRIMARY CARE SERVICES FUNDED THROUGH THE MBS

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Overview

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers and those with an interest in health consumer issues. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF welcomes the opportunity to provide this submission in response to the Medicare Benefits Schedule (MBS) Review Taskforce’s preliminary report on urgent after-hours primary care services funded through the MBS. This submission elaborates on CHF’s responses provided via the online survey.

The Taskforce’s report acknowledges that after-hours GP services are essential services and highly valued by consumers. While there has been an increase in the number of urgent after-hours services provided under the MBS, CHF notes that this increase on its own does not mean that these services were unjustified. Other factors, such as better access to and availability of after-hours services, could explain the increase. Moreover, an increase is not of itself surprising given the Government’s policy initiatives in recent decades to increase access to better organised after-hours services. Without these services many people, including parents and young families, the elderly including residents in aged care facilities, carers and people with terminal or chronic conditions, have faced great difficulty in getting the care they need.

CHF notes that other reports from the Taskforce and its clinical committees have a strong scientific focus on the clinical evidence and accepted clinical best practice. This focus is not as apparent in the urgent after-hours report, reflecting the different nature of GP items in the MBS. This also means that the views expressed in the preliminary report are more interpretative and not always compelling. For example:

- “…the Taskforce is not convinced by the argument that the increasing use of urgent after-hours attendances has led to a reduction in visits to hospital emergency departments” (page 26) implying that the onus is not on the Taskforce to make a convincing case for its position, but on others to convince the Taskforce why it should think differently; and
- “It is not anticipated that these changes will have an impact on the provision of appropriate after-hours services for residential aged care facilities” (page 9) without providing a reassuring argument to support this statement.

The contentious recommendations in the preliminary report are recommendations 2 and 3, which propose extensive restrictions to access to the higher-priced urgent after-hours MBS items. CHF is concerned that the case for recommendations 2 and 3 has not been sufficiently well made, and considers that these recommendations are premature given other possible measures.
CHF recommends that:

- Any new measures must not reduce services for people with valid needs for urgent after-hours care.
- More work needs to be done on the potential adverse consequences of recommendations 2 and 3 for consumers prior to the proposed restrictions being accepted and put in place.
- For example, more research is required into the impact of recommendations 2 and 3 on hospital emergency departments. While CHF supports the MBS Review’s efforts to ensure Medicare is cost-effective, we also would want to avoid a situation where a decline in after-hours GP visits results in increased demand at hospital emergency departments. A whole-of-system approach and the evidence of the value offered by strong primary health care to high performing health systems needs to be taken into account in considering any alternative after-hours arrangements to those which presently exist.
- More research is required to determine the impact of recommendations 2 and 3 on the medical workforce, and the implications for consumer access. Working hours of GPs have tended to decline in recent years, and there is no reason to think that the existing or emergent GPs will become more willing to provide after-hours services. At the same time, recommendations 2 and 3 could result in doctors leaving medical deputising services, resulting in reduced availability of after-hours services for many consumers. Consumers want clear and convincing evidence that regular GPs will fill this gap.
- Specific research is needed into why consumers use medical deputising services, and the possible adverse effects from recommendations 2 and 3 as a result, such as reduced access to care and increased cost to patients.
- Recommendations 4 to 7 should be implemented and their impact monitored before more radical measures with a greater chance of adverse effects, such as recommendations 2 and 3, are pursued.
- Other solutions not included in the report should also be pursued and monitored before implementing recommendations 2 and 3. Other solutions include enhanced monitoring of the utilisation of urgent after-hours item numbers, particularly home visits, by the Professional Services Review (PSR), a greater role for Primary Health Networks to work with GPs and other primary care providers (eg, community, nurses, paramedics and pharmacists) to provide access to after-hours care, and the development of a code of conduct for medical deputising services and sector-wide triage protocols.

**Comments on recommendations**

*Recommendation 1 - All medical deputising services (or services that predominantly provide after-hours GP services) should have access to the standard (non-urgent) after-hours items.*
Recommendation 1 is stating what is already the case and reflects the status quo, and to that extent CHF agrees with it. However, it is unclear why the Taskforce thought it necessary to include recommendation 1.

CHF notes that the equivalent recommendation in the preliminary report’s summary for consumers (at Attachment E to the preliminary report) is worded more clearly and comprehensively, by proposing “no changes to standard after-hours items” and that MBS funding “should continue to be available for after-hours services provided by a patient’s GP as well as by a medical deputising service”.

As discussed below in relation to recommendation 3, CHF would not agree with recommendation 1 if it was meant to say that “all medical deputising services (or services that predominantly provide after-hours GP services) should only have access to the standard (non-urgent) after-hours items.

 Recommendation 2 - 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 work-load.

CHF does not agree with recommendation 2.

The reality is that GPs who work predominantly in the in-hours period are generally wishing to work fewer hours, whether for personal reasons or to pursue other professional opportunities, and so are less able and less willing to undertake after-hours work. There is no reason to believe that this situation will change:

- In general, in-hours GPs are not currently doing after-hours work even though they have access now to the higher-priced urgent after-hours items. Why are regular GPs not doing after-hours work now despite the MBS items being available?
- The recommendations in the report do not provide new incentives for these GPs to undertake more after-hours work, whether urgent or non-urgent. Why should consumers accept that their regular GPs will be more available to do after-hours work?

Recommendation 2 ignores the history of after-hours GP care in Australia, as well as characteristics of the contemporary Australian medical workforce. Consumers do not have confidence that recommendation 2 is realistic without other changes.

In-hours GPs are also busy with limited if any capacity to undertake after-hours work. Whether working full-time as a GP, or part-time but with personal responsibilities or other work interests in their lives, there is a concern about the desirability of already busy GPs also undertaking after-hours work. Patients may not live nearby, and neither the GP nor their patients may live close to the practice nor able to get there readily in the after-hours period.
CHF is concerned about the possible adverse impacts of recommendation 2. For example:

- Patients with an urgent need to see a GP in the after-hours period, who are unable to see their usual in-hours GP for whatever reason, may then go to an emergency department instead or, worse, seek no care at all with possible deleterious results.
- Recommendation 2 assumes that all Australians have one regular GP who they see consistently, yet we know that there are many Australians who do not have a regular GP. While CHF agrees that patients should be encouraged to have a regular GP, recommendation 2 is not an appropriate mechanism for facilitating this. We believe it is possible as we move into policy environments designed to encourage better connected and better value care (eg, My Health Record, digitally enabled shared care, and the desire of state/territory governments to more actively look at models of care in the community) to put in place models of care where the outcomes of one-off visits to a deputising after-hours GP can be quickly and easily conveyed to the patient’s usual GP and, moreover, incentives put in place to encourage patients to establish a relationship with a regular GP. There is a role for Primary Health Networks working with Local Hospital Networks to support the advancement of such models of care.
- Many medical deputising services bulk bill. Fewer in-hours GPs bulk bill. Recommendation 2 is therefore of concern to consumers who require a bulk-billed urgent after-hours service. Out of pocket expenses may cause people who need after-hours care to not seek it.

While CHF supports the MBS Review’s efforts to ensure Medicare is cost-effective, we also would want to avoid a situation where a decline in after-hours GP visits results in increased demand at hospital emergency departments:

- A survey in January 2016 by Dr Chris Ifediora of Griffith University of patients who had used medical deputising services found that after-hours GP services do have a significant impact on reducing the use of emergency departments across Australia and across all patient demographics. Dr Ifediora goes on to recommend a larger and perhaps longer version of this study. CHF supports the need for more research along these lines.

Given these risks and possible adverse effects, CHF considers that it is premature to proceed with recommendation 2. A more appropriate approach would be to implement other less risky measures first, such as recommendations 4 to 7, and to undertake the above research.

**Recommendation 3 – 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.**

This means that doctors employed by a medical deputising service should not be permitted to claim the high-priced urgent after-hours items.

CHF does not agree with recommendation 3, which is the corollary of recommendation 2.
While the precise impact of recommendation 3 on medical deputising services is not clear, it is likely that recommendation 3 would result in a reduction in the availability of after-hours services. As noted above in relation to recommendation 2, CHF is not confident that the current situation in relation to after-hours care provided by in-hours GPs will change. CHF is therefore concerned that the combination of recommendations 2 and 3 would see grave reductions in services for people with valid needs for urgent after-hours care. These people include parents and young families, the elderly including residents in aged care facilities, carers, and people with terminal or chronic conditions.

CHF’s key concern in response to recommendations 2 and 3 is that they would result in fewer after-hours services being provided, with medical deputising services’ activity reduced and regular GPs not increasing their current after-hours availability. Inevitably, people with valid needs for urgent after-hours care would be adversely affected and the country would face higher health costs overall.

The preliminary report seems to be assuming that most after-hours calls currently are not urgent and should either attract a non-urgent after-hours rebate, or wait for an in-hours consultation. On this basis, the preliminary report does not consider possible adverse consequences from recommendations 2 and 3. However, in the absence of research into why consumers use medical deputising services, and given that there are valid reasons for urgent after-hours care, it is reasonable to be concerned about recommendations 2 and 3.

The PSR is responsible for reviewing and examining possible inappropriate practice by practitioners when they provide MBS services. Strong PSR evidence of significant levels of inappropriate claiming of urgent after-hours items would be a persuasive part of a case for recommendation 3. However, the material from the PSR in section 7.7 (page 24) of the report, drawn from the PSR Annual Report 2015-16, is not compelling. PSR data for 2015-16 only is mentioned, so it is unclear whether a trend is apparent. The language is also vague, referring to “a number of practitioners have been referred to the PSR” and “some practitioners have billed these items for (non-urgent) medical conditions”. This suggests that while PSR has received some referrals concerning claiming of urgent after-hours items, it is not yet known whether this is a significant issue, nor how different it is to any incorrect claiming in the in-hours period. The PSR goes on its Annual Report 2015-16 to say that it has established committees to assess practitioner provision of urgent after-hours services. Enhanced monitoring by PSR would allow a better understanding of the extent of inappropriate claiming of the urgent after-hours items and the justification for measures such as recommendation 3.

CHF considers it unfortunate that the National Association for Medical Deputising (NAMDS) was not represented on the Taskforce’s After-Hours Working Group. Other medical groups with their own interests in after-hours issues were represented on the Working Group, and similarly medical deputising services should have been represented. Their input into the deliberations could well have resulted in a more balanced report and the exploration of alternative approaches to those recommended.
CHF understands that NAMDS is developing a code of conduct for medical deputising services focussing on issues such as continuity of care, and quality reporting back to patients’ usual GPs, and seeks sector-wide triage protocols. It is disappointing that such initiatives have not been considered in the preliminary report, and that NAMDS has not had the opportunity to address any concerns in these ways in the first instance.

The preliminary report (page 25) is critical of medical deputising services’ use of non-VR GPs. CHF notes that non-VR GPs work in other types of medical services, and in the case of medical deputising services this situation is encouraged by Commonwealth through specific workforce programs. Where is the quality of care evidence to support the report’s concerns about the use of non-VR GPs by medical deputising services, and if there is such evidence, presumably it would apply to non-VR GPs working in other settings?

**Recommendation 4 – 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”. This recognises that the need for an assessment is the actual trigger for the service and that treatment may or may not be necessary on the basis of that assessment.**

CHF agrees with recommendation 4.

Changing the current requirement from “the patient’s condition requires urgent medical treatment” to “the patient’s condition requires urgent medical assessment” is a sensible and logical amendment to the descriptors for the urgent after-hours items.

CHF suggests that it would be appropriate to apply recommendation 4 to the non-urgent after-hours items as well for the same reasons and for consistency.

**Recommendation 5 – 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.**

CHF agrees with recommendation 5, but with a caveat.

In general, restricting bookings until the commencement of the after-hours period in which the urgent attendance occurs is not unreasonable, noting too that some regular general practice clinics offer appointments in the early after-hours period on weeknights, and on some of the weekend. However, the risk is that this recommendation will disadvantage some vulnerable groups of patients in particular.

For example, we know that medical deputising services provide significant care to residents of aged care facilities, often reflecting the limited availability of regular GPs to these residents. CHF recommends that there needs to be a specific and separate investigation into the primary health care needs of residents of aged care facilities, to ensure that this vulnerable group is not adversely affected by the preliminary report’s recommendations.
If implemented, the impact of this recommendation will need to be monitored carefully, with scope for modifications or exceptions to be made.

**Recommendation 6 – 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.**

CHF agrees with recommendation 6.

Requiring and recording that the attending doctor determines that urgent assessment is necessary is not unreasonable.

What might constitute an urgent attendance is a matter for wide difference of opinion. Parents worried by the illness of an infant and elderly people in need will seek urgent attention for a condition that ultimately may not meet the clinical definition of urgent. But their plight is genuine and arguably a timely visit by a doctor can mean a better longer-term outcome for many patients.

**Recommendation 7 – There should be clearer definition of ‘urgent’, which is that the patient’s assessment:**

1. cannot be delayed until the next in-hours period; and
2. requires the GP to attend the patient at the patient’s location or to reopen their practice rooms.

CHF agrees in-principle with recommendation 7.

Clarification of the definitions around urgent and non-urgent visits would remove possible confusion and encourage appropriate claiming. The differentiation between urgent and non-urgent needs to be clear and unambiguous.

That said, there will be occasions when an urgent assessment is considered by the doctor to be necessary based on the information available, but is found to not be urgent when the doctor has seen and assessed the patient. This risk can be reduced through clear definitions and appropriate protocols and triage processes, but it can never be completely mitigated.

If the definition of ‘urgent’ is to require that the patient’s assessment cannot be delayed until the next in-hours period, this begs the question of whether the patient will be able to get an appointment in that next in-hours period, especially with their regular GP. In many cases, patients will be unable to see their regular GP in the next in-hours period anyway.
Other comments

CHF notes that while in general the preliminary report is clearly written, it has multiple sets of recommendations which is confusing, especially when each recommendation is not addressed and justified individually:

- There are four recommendations listed on page 11 of the report. However, there are six recommendations listed in the report’s summary for consumers at Attachment F, and seven recommendations in the online survey for the report. CHF has addressed the seven online survey recommendations in this submission to align with our responses made via the online survey.
- The report does not follow the widespread practice of making a case for each specific individual recommendation in turn. Rather the recommendations are presented as a group in response to the report’s findings. It would be easier for readers, including but not only consumers, to understand and respond to each of the online seven recommendations if there was a corresponding case made in the main text of the report for each individual recommendation. Justifying each recommendation individually would also make the Taskforce’s arguments for its recommendations more transparent.

Section 4 of the preliminary report addresses “concerns raised by stakeholder about urgent after-hours items”:

- Section 4 says “Concerns about the use of these items have been raised with members of the Taskforce by individuals GPs and consumers. Concerns have also been raised by the RACGP, AMA, ACRRM, RDAA and Consumers Health Forum and the RACGP and AMA have released public statements on this topic”.
- Section 4 then lists ten areas of concern identified by stakeholders, without indicating which concerns have been raised by which stakeholder/s, and implies that we all have the same concerns.

CHF requests that the reference to CHF on page 13 of the preliminary report be removed:

- CHF has not expressed concerns about the urgent after-hours items to the Taskforce. We have, however, issued a media release about our concerns about access to after-hours care at the time the Taskforce’s latest tranche of draft reports was released (click here for CHF’s media release).
- CHF has made very few comments about the urgent after-hours items in any forum, and would not share the same concerns as RACGP, AMA, ACRRM and the RDAA.
- RACGP, AMA ACRRM and the RDAA were all represented on the Taskforce’s After-Hours Working Group, whereas CHF was not (as correctly stated in the report’s Attachment B, the consumer representative on the Working Group was not a CHF representative).
- The wording of section 4 incorrectly implies that CHF is somehow aligned with the RACGP, AMA, ACRRM and RDAA.
Conclusions

CHF believes that:

- Recommendations 4 to 7 should be implemented and their impact monitored before more radical measures with a greater chance of adverse effects, such as recommendations 2 and 3, are pursued.
- Other solutions not included in the report should also be pursued and monitored before considering recommendations 2 and 3. Other solutions include enhanced monitoring by the PSR, a greater role for Primary Health Networks to work with GPs and others to provide access to after-hours care, and the development of a code of conduct for medical deputising services and sector-wide triage protocols. Consideration would need to be given to how such a code could be effectively monitored.
- More independent and authoritative work needs to be done on the potential adverse consequences of recommendations 2 and 3 for consumers and the rest of the system (e.g., emergency departments) prior to the proposed restrictions being considered further for possible implementation.
- Any new measures must not reduce services for people with valid needs for urgent after-hours care. CHF is concerned that recommendations 2 and 3 could indeed reduce services for these consumers.