
**Medicare Benefits Schedule Review
Taskforce**

**Urgent after-hours primary care
services funded through the MBS**

Final report

2017

Important note

The recommendations from the Medicare Benefits Schedule (MBS) Review Taskforce detailed in the body of this report, including the executive summary, were released for public consultation on 7 June 2017.

The MBS Taskforce considered feedback from the public consultation and did not make any amendments to the recommendations.

The Taskforce endorsed all recommendations from the reports and submitted the final recommendations to the Minister for consideration.

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1. Executive summary

In response to significant concerns raised by professional medical bodies and Medicare data showing an increase far in excess of population growth in the use of and expenditure on the Medicare items for urgent after-hours home visits, the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) has reviewed the four items for urgent after-hours services (items 597, 598, 599 and 600).

The Taskforce's role, in this and other areas under review, is to ensure that the structure of MBS items provides consumers with access to appropriate quality care.

The urgent after-hours items have much higher rebates than standard after-hours items or standard general practitioner (GP) attendance items—in some cases almost \$100 more compared with the same GP service provided at the GP's clinic. For example, item 597, the most commonly used urgent after-hours attendance, has a rebate of \$129.80. This is compared to a standard after-hours Level B GP attendance with a rebate of \$49.00 if provided at the doctor's rooms (item 5020), or \$74.95 if provided at the patient's home (item 5023). The rebate for a standard 'in-hours' Level B consultation is \$37.05 when the GP sees the patient in their consulting rooms (item 23) or \$63.00 when visiting the patient's home (item 24).

The items under review (items 597, 598, 599 and 600) specify that the patient's condition requires *urgent treatment*.

1.1 Findings

The Taskforce is satisfied that the current structure of the urgent after-hours items supports the provision of comparatively low-value medical care and does not represent value for money for the taxpayer.

In reaching this conclusion the Taskforce considered the expert opinion of representatives from professional medical organisations (including the Australian Medical Association, Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine and Rural Doctors Association of Australia) and Medicare data on usage patterns.

The Taskforce noted that:

- △ In the five years between 2010–11 and 2015–16, the number of urgent after-hours MBS services has increased by 150 per cent (from 734,000 to 1,869,000). In contrast, growth in standard GP services over the same period was 15 per cent¹.
- △ Benefits paid have increased by 170 per cent for urgent after-hours services over the same period (from \$90.8m in 2010–11 to \$245.9m in 2015–16), whilst benefits paid for standard GP services increased by 27 per cent¹.
- △ The growth in use of these urgent after-hours items is concentrated in some areas of urban Australia.
- △ Most urgent after-hours services are being provided by medical deputising services (MDSs).
- △ The growth in the provision of urgent after-hours services appears not to be driven by increasing clinical need for these services, but has coincided with the entry of new businesses into the market with models that promote these services to consumers, emphasising convenience and no out-of-pocket costs.
- △ 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. Investigations by the Professional Services

¹ Based on Medicare data. Date of processing for group A1 items.

Review (PSR), the body that carries out peer reviews of inappropriate use of MBS services, found after reviewing clinical records that some practitioners are claiming these services for patients whose conditions are not urgent and could more appropriately be managed through ordinary GP attendances (either in-hours or through extended-hours GP clinics).

- △ It is not convinced by arguments that the growth in use of urgent after-hours home visits has had a significant impact on hospital emergency department services.
- △ The increasing use of the items by MDSs interferes with continuity of care by the patient's regular GP and MDS services are often provided by less qualified clinicians.
- △ Further information on the evidence and findings is available in [Section 7 – Analysis of Medicare and other data](#).
- △ The key conclusions of the Taskforce are:
 1. MBS funding should continue to be available for home visits, including in the after-hours period. Funding should continue to be available for after-hours services provided by a patient's GP, as well as by a MDS.
 2. The rebates for urgent after-hours services should only be payable in circumstances where a GP who normally works during the day is recalled to work for management of a patient who needs, in the opinion of the GP, urgent assessment. The higher rebate recognises the additional clinical value provided by, and lifestyle and financial imposts on, GPs who deliver these services to their own patients, the practice's patients or patients of other local practices where on-call work is shared.

In this setting it is more likely that there will be better patient triage, based on the GP's (or a closely supervised GP trainee's) knowledge of the patient's circumstances, better access to patient records facilitating management, and better follow-up to ensure continuity of care.

3. Where a business has been established specifically to routinely or exclusively provide care in the after-hours period (including a MDS) then all of the other (non-urgent) items for after-hour services should remain available to these entities.
4. The MBS items for urgent after-hours attendances should not be available where the patient has made an appointment prior to the commencement of the after-hours period (that is, 6pm on weeknights).

1.2 Recommendations

The Taskforce is recommending changes to the four urgent after-hours items (items 597-600) only. These changes would be implemented through revised MBS item descriptors and explanatory notes for these items. The proposed new descriptors and notes are given below. There are no changes recommended for the 24 other after-hours items.

1.3 Proposed item descriptors and explanatory notes for the urgent after-hours items 597–600

	GROUP A11 – URGENT ATTENDANCE AFTER HOURS
	SUBGROUP 1 – URGENT ATTENDANCE – AFTER HOURS
597	<p>Professional attendance by a GP on not more than 1 patient on the 1 occasion –each attendance (<i>other than an attendance between 11pm and 7am</i>) in an after-hours period if:</p> <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in the same unbroken urgent after-hours period during which the attendance occurs; b) the attending practitioner determines that the patient’s condition requires urgent medical assessment; c) the attendance is not provided by the GP as an employee, contractor, member or otherwise of a: <ul style="list-style-type: none"> i. medical deputising service; or ii. organisation that provides or facilitates medical services predominantly in after-hours periods; and d) if the attendance is performed at consulting rooms, it must be necessary for the practitioner to return to, and specifically open, the consulting rooms for the attendance. <p>See para A5 and A10 of explanatory notes to this Category Fee: \$129.80 Benefit: 75% = \$97.35 100% = \$129.80 Extended Medicare Safety Net Cap: \$389.40</p>
598	<p>Professional attendance by a medical practitioner (other than a GP) on not more than 1 patient on the 1 occasion –each attendance (<i>other than an attendance between 11pm and 7am</i>) in an after-hours period if:</p> <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in the same unbroken urgent after-hours period during which the attendance occurs; b) the attending practitioner determines that the patient’s condition requires urgent medical assessment; c) the attendance is not provided by the practitioner as an employee, contractor, member or otherwise of a: <ul style="list-style-type: none"> i. medical deputising service; or ii. organisation that provides or facilitates medical services predominantly in after-hours periods; and d) if the attendance is performed at consulting rooms, it must be necessary for the practitioner to return to, and specifically open, the consulting rooms for the attendance. <p>Fee: \$104.75 Benefit: 75% = \$78.60 100% = \$104.75 Extended Medicare Safety Net Cap: \$314.25</p>
	SUBGROUP 2 – URGENT ATTENDANCE UNSOCIABLE AFTER HOURS
599	<p>Professional attendance by a GP on not more than 1 patient on the 1 occasion –<i>each attendance between 11pm and 7am</i>, if:</p> <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in the same unbroken urgent after-hours period during which the attendance occurs; b) the attending practitioner determines that the patient’s condition requires urgent medical assessment; c) the attendance is not provided by the GP as an employee, contractor, member or otherwise of a: <ul style="list-style-type: none"> i. medical deputising service; or ii. organisation that provides or facilitates medical services predominantly in after-hours periods; and d) if the attendance is performed at consulting <i>rooms</i>, it must be necessary for the practitioner to return to, and specifically open, the consulting rooms for the attendance. <p>See para A5 and A10 of explanatory notes to this Category Fee: \$153.00 Benefit: 75% = \$114.75 100% = \$153.00 Extended Medicare Safety Net Cap: \$459.00</p>
600	<p>Professional attendance by a medical practitioner (other than a GP) on not more than 1 patient on the 1 occasion –each attendance <i>between 11pm and 7am</i>, if:</p> <ul style="list-style-type: none"> a) the attendance is requested by the patient or a responsible person in the same unbroken urgent

	GROUP A11 – URGENT ATTENDANCE AFTER HOURS
	<p>after-hours period during which the attendance occurs;</p> <p>b) the attending practitioner determines that the patient’s condition requires urgent medical assessment;</p> <p>c) the attendance is not provided by the practitioner as an employee, contractor, member or otherwise of a:</p> <ul style="list-style-type: none"> i. medical deputising service; or ii. organisation that provides or facilitates medical services predominantly in after-hours periods; and <p>d) if the attendance is performed at consulting rooms, it must be necessary for the practitioner to return to, and specifically open, the consulting rooms for the attendance.</p> <p>Fee: \$124.25 Benefit: 75% = \$93.20 100% = \$124.25</p> <p>Extended Medicare Safety Net Cap: \$372.75</p>

Explanatory notes:

A10 - Urgent After-hours Attendances (Items 597- 600)

Items 597, 598, 599 and 600 are available when, on the information available to the attending practitioner, the patient’s condition requires **urgent** medical assessment during the after-hours period to prevent deterioration or potential deterioration in their health. Specifically the patient’s assessment:

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

In considering the need for urgent assessment, the practitioner may rely on information conveyed by the patient or patient’s carer; other health professionals or emergency services personnel and that information should be recorded in the patient’s medical record.

Items 597,598, 599 and 600 are only available for services provided by GPs and other medical practitioners who provide after-hours care in addition to their predominantly in-hours practice. They recognise the additional clinical value and time impost of services provided by medical practitioners who provide after-hours care to their patients, their practice's patients or patients that attend another general practice that shares an after-hours roster, compared to after-hours services provided by medical practitioners within structures that routinely offer care in the after-hours period.

For the sake of clarity items 597,598, 599 and 600 are not available for services provided through medical deputising services or other medical businesses that directly offer home attendances (including to residential aged care facilities) predominantly in the after-hours period. Such services can be billed using item 5003, 5010, 5023, 5028, 5043, 5049, 5063 or 5067 (for GPs) or 5220, 5223, 5227, 5228,5260, 5263, 5265 or 5267 (for other medical practitioners).

If more than one patient is seen on the one occasion, the standard after-hours items should be used in respect of the second and subsequent patients attended on the same occasion.

The changes flowing from the revised item descriptors and notes can be summarised as follows:

1. All primary care medical services that operate in the after-hours period, including MDSs and any other organisation that provide or facilitate medical services predominantly in the after-hours period, will continue to have access to the standard after-hours items.
2. Organisations that provide or facilitate medical services predominantly in after-hours periods, including MDSs, will not be permitted to claim the urgent after-hours items. Doctors employed by a MDS or obtaining work from a MDS will not be permitted to claim urgent after-hours items.
3. 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.
4. 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 will be removed.
5. There will 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.
6. There will be a fuller definition of ‘urgent’, being that the patient’s assessment:
 - a. cannot be delayed until the next in-hours period; and
 - b. requires the GP to attend the patient at the patient’s location or to reopen their practice rooms.
7. Furthermore, the Taskforce recommends that the PSR continue to monitor after-hours use by clinicians.

1.4 Implications of changes

Rebates for after-hours attendances will continue to be available to all Medicare-eligible patients. The rebates for home visits and attendances in doctors’ consulting rooms in the after-hours periods will remain higher than for GP services provided during standard business hours. Providers’ options to provide home visits and to bulk-bill patients (with bulk billing incentives available for children under 16 years and Commonwealth concession card holders) for these services will continue.

To support the more appropriate use of the urgent after-hours items and ensure that items support high-value care, the urgent after-hours items will remain available where a GP who normally works during the day is recalled to work to manage a patient whose condition requires an urgent assessment that cannot wait until the next working day.

It is not anticipated that these changes will have an impact on the provision of appropriate after-hours services for residential aged care facilities.

1.5 Consumer engagement

The Taskforce and its After-Hours Working Group both include a consumer representative. The consumer representatives have reviewed the report and a consumer overview is provided in [Section 2 – Overview for consumers](#). Each Taskforce recommendation has also been summarised for consumers in [Attachment F](#). The summary describes the recommendations and what the impact of the proposed changes would be.

The Taskforce believes it is important to find out from consumers if, how and why they will be helped or disadvantaged by the recommendations.

2. Overview for consumers

This overview for consumers offers a brief outline of the report's findings and recommendations in the context of consumers. Specific consumer impacts for each of the recommendations are provided in [Attachment F – Summary for consumers](#).

2.1 Scope of the review and impact of recommendations

There are 28 after-hours MBS items. The current review of after-hours MBS items is considering four of these— items 597, 598, 599 and 600 which are for 'urgent' after-hours attendances in clinics, residential aged care facilities (RACFs) or the consumer's home.

The recommendations in this report propose to change the urgent after-hours items so that only doctors who work mainly in normal business hours and provide after-hours care in addition to this workload are able to claim these items. The relatively high fees for the urgent after-hours items are intended to compensate these doctors for the additional expense and lifestyle disruption they experience when they provide after-hours care.

For doctors who work predominantly in the after-hours period, such as those employed by medical deputising services, the after-hours period is in effect their normal business hours—they don't provide after-hours services in addition to other work and don't have the same lifestyle and expense imposts that 'in-hours' doctors experience when they provide after-hours care.

No changes are being proposed to the remaining 'non-urgent' or 'standard' items, some of which are also available for home or RACF visits, and there is no proposal to remove the urgent after-hours items from the MBS.

2.2 Key principles and facts

- △ Consumers need and want access to after-hours health care.
- △ Consumers get a payment from Medicare for after-hours GP care when they:
 - visit an after-hours clinic/service; or
 - ask a GP to see them at home.
- △ Sometimes it is clinically urgent for consumers to see a GP after working hours. Sometimes it is convenient but not genuinely urgent for consumers to see a GP after working hours.
- △ Medicare pays for two kinds of after-hours care:
 - standard care; and
 - clinically urgent care, which is a higher payment.
- △ Doctors and consumers have reported that some companies providing after-hours services:
 - charge consumers (and therefore Medicare) the higher 'urgent' fee when the matter is not clinically urgent, and the lower 'non-urgent' fee should be charged;
 - do not check with/report back to the consumer's usual GP (where they have one), as medical deputising services are supposed to do; and/or
 - encourage people to use their after-hours service for convenience, and then charge the higher 'clinically urgent' fee.
- △ The reports of Medicare payments for after-hours GP visits show that:
 - The number of urgent after-hours services has more than doubled in five years, from around 730,000 in 2010–11 to 1.87 million in 2015–16.
 - The cost of after-hours services is similarly increasing, from \$90.8m in 2010–11 to \$245.9m in 2015–16. At the same time there has been no significant impact on the use of hospital emergency department services.
- △ Reports from the medical profession indicate that many urgent after-hours services are not urgent and should not be claimed at the higher rate.

- △ The growth in use of urgent after-hours services does not seem to reflect consumers' clinical needs, but has coincided with the entry of new businesses into the market with models which promote these services to consumers, emphasising convenience and no out-of-pocket costs.

2.3 Taskforce findings

The Taskforce is of the view that:

- △ After-hours GP services are essential services, highly valued by consumers.
- △ Nothing should be done that prevents consumers from accessing after-hours GP services delivered by appropriately qualified clinicians.
- △ GPs who provide after-hours care should have a relationship with the consumer's usual general practice so information is shared and quality, safe care is maintained.
- △ Companies which just provide after-hours GP services provide an important service when local GPs cannot visit patients in the after-hours period.
- △ Urgent after-hours GP services should only be provided in genuinely clinically urgent situations.
- △ The MBS fees for urgent after-hours services should reflect the complexity of the service and the impact on GPs who work in-hours and then are called out in the after-hours period.
- △ Consumers and Medicare should pay the standard fee—not the higher 'urgent' fee—when the care provided is not urgent.

2.4 Recommendations

1. MBS funding should continue to be available for home visits, including in the after-hours period, for services provided by:
 - a. a consumer's GP
 - b. a medical deputising service i.e. a service that works closely with local GPs to provide services when the practice is not open.
2. MBS funding for *urgent* after-hours services should only be payable if a GP who normally works during the in-hours period is recalled to work for management of a patient who needs, in the opinion of the GP, urgent assessment.
 - a. The higher rebate recognises the additional clinical value provided by, and impost on, GPs who deliver these services to their own patients, the practice's patients or patients of other local practices where on-call work is shared.
 - b. In this setting it is more likely that there will be better patient triage, based on knowledge of the patient's circumstances by the GP (or a closely supervised GP trainee), better access to patient records facilitating management, and better follow-up to ensure continuity of care.
3. Where a business has been established specifically to routinely provide care in the after-hours period (including a medical deputising service) then all of the other items for after-hour services should remain available.
4. The MBS items for *urgent* after-hours attendances should not be available where the consumer has made an appointment prior to the commencement of the after-hours period (that is, 6pm on weeknights).

3. About the MBS Review and the process for reviewing the after-hours items

The Taskforce (membership and Terms of Reference at [Attachment A](#)) is undertaking a program of work—the MBS Review—that considers how the more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for consumers. The Taskforce will also seek to identify any services that may be unnecessary, out-dated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health that will allow the MBS to deliver on each of these four key goals:

- △ Affordable and universal access
- △ Best-practice health services
- △ Value for the individual patient
- △ Value for the health system

The Taskforce has established a standard review methodology whereby the clinical review of MBS items is undertaken by clinical committees and working groups with memberships comprising clinicians, consumer representatives and other experts who are appointed as individuals rather than as representatives of particular organisations.

Draft reports and recommendations from these groups are released, under the authority of the group, for broad public consultation. The relevant group considers feedback from stakeholders and then provides recommendations to the Taskforce in a review report. The Taskforce considers the review report and stakeholder feedback before making recommendations to the Minister for Health, for consideration by the Government.

The process for the review of urgent after-hours items differs in some respects from the standard approach outlined above, in that the After-Hours Working Group (the Working Group) which conducted the review was a subcommittee of the Taskforce rather than a semi-autonomous clinical committee. Also, and importantly, the Working Group's membership included, among others, members representing the four major general practice bodies: the Australian Medical Association (AMA), Royal Australian College of General Practitioners (RACGP), Australian College of Rural and Remote Medicine (ACCRM) and Rural Doctors Association of Australia (RDAA). The members of the Working group are listed at [Attachment B](#).

Because of this structure, this report and recommendations are from the Taskforce and are based upon its review of the evidence and the advice of the Working Group.

4. Concerns raised by stakeholders about urgent after-hours items

Concerns about the use of these items have been raised with members of the Taskforce by individual 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.

The RACGP position statement on after-hours care states:

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 efficiently².

Urgent after-hours visits attract a premium Medicare rebate. Currently those premium rebates are often being billed by doctors who do not have any postgraduate or specialist qualifications in general practice, at a cost to the taxpayer and Medicare of over \$250 million in the last year alone.

The RACGP is supportive of after-hours medical services, however in the interests of patient safety they absolutely must be offered by suitably qualified doctors³.

The *Review of After-Hours Primary Health Care* undertaken for the Australian Government in 2014 (Prof Claire Jackson, 2014) noted significant concerns about the use of the urgent after-hours items, including by MDSs.

Areas of concern identified by stakeholders include:

- △ The routine claiming by some doctors of 'urgent' items for services which are not urgent, when there are lower rebated MBS items that support non-urgent after-hours home visits or after-hours attendances at GP clinics. This additional Medicare expenditure could be better utilised for other forms of patient care.
- △ The relatively high rebates for the urgent after-hours items compared with other GP services.
- △ The provision of care by doctors who are not linked to a patient's usual general practice.
- △ The clustering of services in areas of relatively high population density where short travel times and high numbers of clients maximise efficiencies and throughput.
- △ Urgent after-hours arrangements are subsidising services to consumers who could have been seen more cost effectively in consulting rooms in a general practice during normal business hours.
- △ The quality of care that the consumers receive from some doctors providing urgent after-hours services.
- △ The regular use of MDSs by some patients may compromise the continuity of care they receive from their usual GP.
- △ Growth in the use of urgent after-hours items is underpinned by new business models that have been able to leverage the opportunity provided by relatively high-priced MBS items, rather than any true increase in the clinical need for these services.

² Royal Australian College of General Practitioners. 2016. After-hours home visiting services in primary healthcare: Position Statement. Available at <http://www.racgp.org.au/download/Documents/Policies/Health%20systems/After-hours-position-statement.pdf>

³ RACGP media release. 13 March 2017. RACGP calls for focus on patient safety in after-hours debate. Available at <http://www.racgp.org.au/yourracgp/news/media-releases/racgp-calls-for-focus-on-patient-safety-in-after-hours-debate/>

- △ Direct-to-consumer advertising that emphasises patient convenience over clinical need. The RACGP has also expressed concern over the direct consumer advertising stating: “The RACGP’s view is this type of advertising encourages the excessive and unnecessary use of after-hours health services, which is inappropriate.”
- △ Appointment services that can be accessed during business hours, allowing a patient to ‘book’ an ostensibly urgent service in advance of the after-hours period and wait for several hours before seeing a doctor.

5. Principles for after-hours services provision

The Taskforce recommends that the following principles should underpin MBS funding of after-hours services generally and urgent after-hours services in particular:

1. After-hours GP services are essential services, highly valued by consumers, and no measures should be introduced which would impact adversely on their responsible provision by appropriately qualified health professionals.
2. Urgent after-hours GP services should only be provided in genuinely urgent situations.
3. The MBS fees for urgent after-hours services should reflect the complexity of the service and the lifestyle disruption and other imposts incurred by GPs who provide urgent after-hours services in addition to their normal in-hours workload.
4. Ideally, after-hours services should be provided by GPs who have a relationship with the patient's usual general practice, facilitating quality and continuity of care.
5. After-hours services provided by medical deputising services have an important role in ensuring patients have access to necessary after-hours services, recognising that it is not feasible for all general practices to offer comprehensive after-hours care.
6. Providers of MBS-funded urgent after-hours services should not market these services by prioritising convenience and low (or no) cost over clinical need.
7. The rebate structure for after-hours services should not provide perverse incentives to divert services from in-hours to out-of-hours or to drive utilisation that is not commensurate with clinical need.

6. Background - MBS items for after-hours services

The Australian Government provides a range of programs and funding streams to support access to after-hours services in addition to MBS services (see [Attachment C](#) for further information on alternative pathways to seeking care in the after-hours period and other programs funded by the Commonwealth). Of the more than \$1.0 billion provided annually in direct funding by the Commonwealth for after-hours primary care services, urgent after-hours items accounted for more than \$0.25 billion in 2015–16.

The MBS lists 28 items for after-hours attendances in a range of settings: a doctor’s consultation rooms; the consumer’s home or a hospital or other facility; and services provided in RACFs. Further information on the range of items available is provided at [Attachment D](#). Items also exist for in-hours attendances in these settings.

6.1 Urgent after-hours items

The urgent after-hours items are the focus of this review. There are currently four items for urgent after-hours attendances (current item descriptors and explanatory notes at [Attachment E](#)). Items 597 and 599 (for vocationally registered (VR) GPs and non-VR GPs who are part of eligible workforce programs), and 598 and 600 (for non-VR GPs or ‘other medical practitioners’) can be used for urgent services provided in consulting rooms, or at a place other than consulting rooms (including the patient’s home), in the after-hours period. The MBS fees for these items are significantly higher than those for standard attendance items.

Within the urgent after-hours category, a distinction is made between ‘after-hours’ and ‘unsociable after-hours’ to reflect the latter’s greater separation from normal business hours (being between 11pm and 7am) and the greater impost attached to providing services in that period. This is summarised in Table 1.

Table 1: Summary of urgent after-hours items by provider eligibility

Time of day	Provider type			
	VR GP item	VR GP fee	Non-VR GP item	Non-VR GP fee
After-hours (all other after-hours periods)	597	\$129.80	598	\$104.75
Unsociable after-hours (between 11pm and 7am)	599	\$153.00	600	\$124.25

Notes: Items 597 and 599 can also be claimed by non-VR GPs who are part of the AHOMPS workforce program.

MBS items for urgent after-hours attendances have existed since the 1990s. In 2010 there was a restructure of primary care items which reduced the number of after-hours items. The intention of these changes was to simplify the administration of the items. The recent growth in expenditure for urgent after-hours attendances is not a direct result of the 2010 item restructure.

Currently, the attendance for all the urgent items must be requested by the patient or a responsible person in, or not more than 2 hours before, the start of the same unbroken urgent after-hours period. The patient’s condition must require urgent medical treatment and if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to and open the consulting rooms for the attendance.

The MBS explanatory notes (A.10) provide the following guidance on claiming urgent after-hours items:

Medical practitioners who routinely provide services to patients in the after-hours periods at consulting rooms, or who provide the services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms will not be able to bill urgent after-hours items 597, 598, 599 and 600.

Therefore, practitioners who work in after-hours clinics cannot bill the urgent items. However, a practitioner who works in the after-hours period providing home visits is able to bill the urgent items.

6.2 Non-urgent after-hours items

In addition to the 'urgent' after-hours items there are (by default) 'non-urgent' after-hours items. These mirror the standard time-tiered Level A to D GP attendance items and cover services provided in consulting rooms, home visits and RACFs.

For most of these services the rebate payable depends on the time and complexity of the service, and where the service is provided. For home visits and visits to RACFs, the total rebate also depends on how many patients are seen.

The most commonly claimed non-urgent after-hours items are:

- Item 5020 – a Level B standard GP attendance after-hours with an MBS fee of \$49.00.
- Item 5023 – a Level B home visit with an MBS fee of \$74.95

The non-urgent after-hours items for RACF visits also attract higher fees than standard items.

The definition of 'after-hours' varies, depending on the day of the week and the setting. Figure 1 sets out the periods in which each different 'urgent' MBS item can be claimed. The MBS allows for a premium to be paid for the 'unsociable' after-hours period for which an urgent after-hours attendance is made. This 'unsociable' period is for after 11pm and before 7am daily, including on weekends and public holidays.

The 'urgent' after-hours period commences at 6pm, while the 'non-urgent' after-hours period for services provided in consulting rooms, as shown in Figure 2, commences from 8pm on weekdays. Figure 2 highlights the different times that 'non-urgent' after-hours items can be used. Note that a 'place other than consulting rooms' includes home and RACF visits.

Figure 1: Operational time periods for urgent after-hours items 597-600

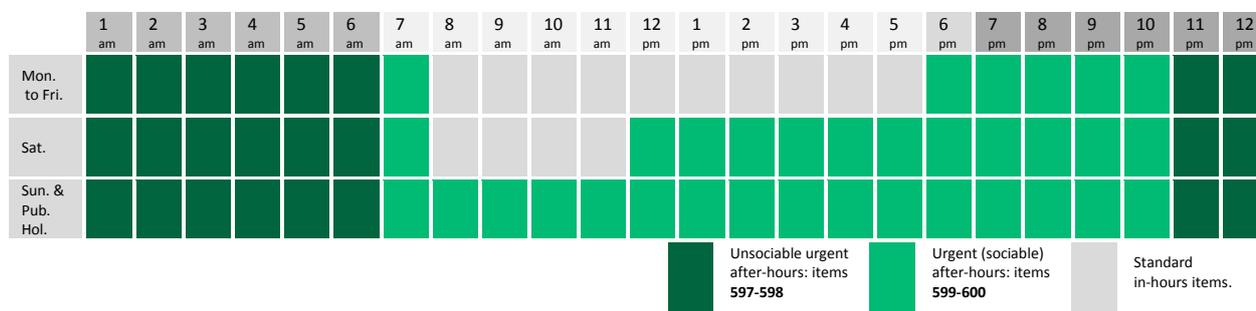
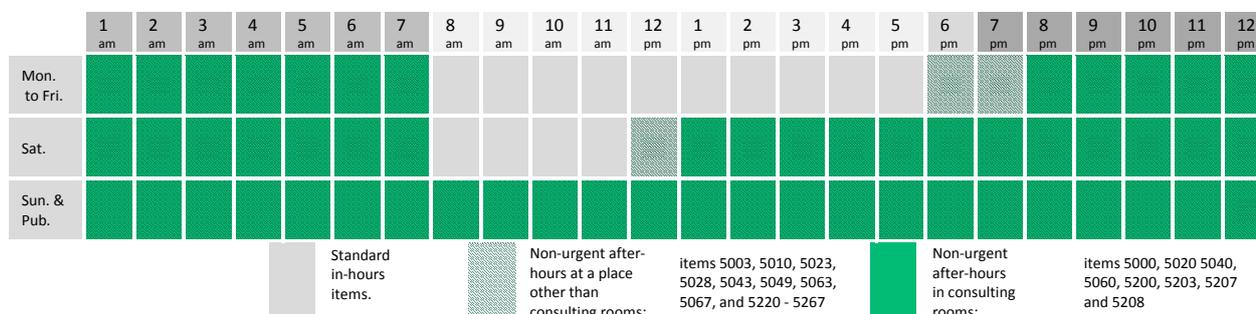


Figure 2: Operational time periods for non-urgent after-hours items 5000-5267



6.3 Claiming of urgent vs. non-urgent items

Non-urgent items (e.g. item 5020 for a standard Level B home attendance with a fee of \$74.95) relate to the situation where the attendance is scheduled by the GP as part of their known workload or the consumer's condition does not require urgent attention.

The urgent items are intended to apply to a situation where a GP is unexpectedly recalled to work to deal with a consumer's urgent unforeseen condition (e.g. item 597 with a fee of \$129.80), whether provided at the doctor's consulting rooms or at the consumer's home. The higher rebate for the urgent item reflects the greater lifestyle disruption and other imposts incurred by the GP in providing this type of service.

One fundamental problem with the current structure is that the MBS stipulates no clear definition of 'urgent'. Although desirable, developing a better definition of 'urgent' is challenging. After-hours attendances arise from a wide range of clinical presentations which do not lend themselves to defining specific clinical criteria.

The current structure of the urgent items allow a patient to 'book' an ostensibly urgent service up to two hours in advance and wait for several hours before seeing a doctor. This principle is inconsistent with the generally understood concept of 'urgent'.

6.4 Vocationally registered GPs (specialist GPs) and non-vocationally registered GPs

The introduction of the Vocational Register for general practice over 20 years ago recognised general practice as a distinct medical specialty for the purposes of Medicare. GPs who are vocationally registered (VR GPs—those who have completed specialist GP training and hold a fellowship from the RACGP or ACCRM) have access to higher Group A1 MBS items (as well as items 597 and 599 in Group A11). Practitioners without specialist GP qualifications (non-VR GPs) have access only to lower-value Group A2 MBS items (and items 598 and 600 in Group A11).

Non-VR GP fees are set much lower than VR GP fees and have not been indexed since the introduction of this structure. The introduction of vocational registration for general practice and the differential fees was intended to improve professional standards, encourage professional development and to reward high-quality practice.

6.5 Medical deputising services

A medical deputising service (MDS) is an organisation responsible for directly arranging for medical practitioners to provide after-hours services to patients on behalf of practice principals. An Approved Medical Deputising Service (AMDS) belongs to a subset of MDSs whose accreditation under a Commonwealth workforce program enables 'other medical practitioners' (OMPs) normally prevented from claiming MBS rebates, to provide MBS-rebatable services.

The AMDS program was established in September 1999 to increase the number of doctors providing after-hours services. The program also provides OMPs, including overseas trained doctors and junior doctors, with vocational experience while working in supervised deputised positions.

6.6 After-Hours Other Medical Practitioners Program

The AMDS program does not confer a right on any doctor who works for a MDS to claim the higher VR GP MBS rebates for urgent after-hours items. However, virtually all AMDS program participants currently claim the higher-rebated items through the After-Hours Other Medical Practitioners (AHOMP) Program, established in 2005. The AHOMP Program provides access to the higher-rebated items to encourage doctors to provide after-hours services and this incentive has been extended to deputising doctors who may not be part of a comprehensive general practice. In practice the AMDSs rely on a workforce which has a large number of non-VR doctors who are able to access the higher-rebated VR GP items and in particular item 597.

7. Analysis of Medicare and other data

In response to the identified concerns about the provision of urgent after-hours services, a comprehensive review of Medicare data was undertaken. The data and findings are summarised below.

7.1 Significant growth in urgent after-hours services

Key points:

- △ Growth in the number of services and benefits for urgent after-hours services is significant. Between 2010–11 and 2015–16, the number of services increased by more than 150 per cent (or more than 1.1 million) and benefits paid increased by 170 per cent (or more than \$155 million).
- △ Growth in urgent after-hours services was significantly higher compared to in-hours GP services and standard after-hours attendances.

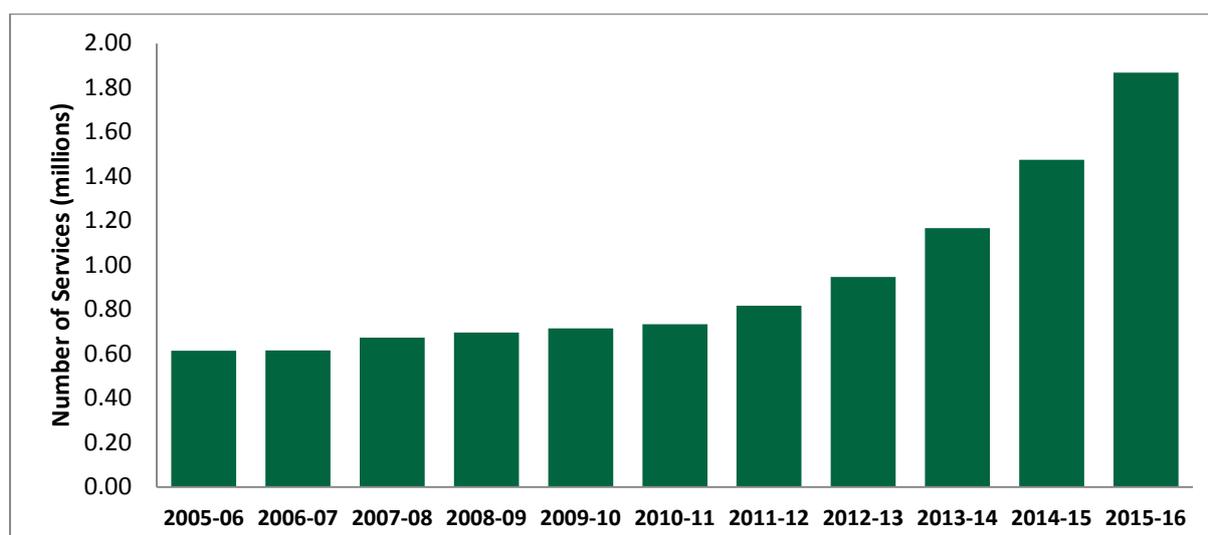
The use of urgent after-hours services had been increasing steadily but moderately until 2010–11. Since then, these services have been growing substantially. The volume has doubled since 2005–06 and has increased by approximately 150 per cent compared to the level in 2010–11 (see Table 2 and Figure 3). This rate of growth has not been seen in standard GP items more generally.

Table 2: Volume of urgent after-hours services (items 597, 598, 599 & 600) over 10 years

Year	Number of services	Growth from previous year
2005-06	614,736	
2006-07	615,378	0.1%
2007-08	672,953	9.4%
2008-09	696,368	3.5%
2009-10	715,291	2.7%
2010-11	733,685	2.6%
2011-12	817,043	11.4%
2012-13	946,926	15.9%
2013-14	1,167,191	23.3%
2014-15	1,475,547	26.4%
2015-16	1,868,727	26.6%
Growth over 5 years (2010-11 to 2015-16):		154.7%
Growth over 10 years (2005-06 to 2015-16):		204.0%

Note: Medicare data, date of processing, includes MBS items 597-600.

Figure 3: Number of services for urgent after-hours items between 2005–06 and 2015–16



Note: Medicare data, date of processing, includes MBS items 597-600.

Table 3 shows growth in the individual urgent after-hours items, indicating the predominance of item 597.

Table 3: Number of services - urgent after-hours items

Item	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
597	562,497	629,654	724,129	907,993	1,179,106	1,516,916
598	38,017	41,934	49,132	42,954	47,447	68,391
599	125,025	136,447	161,815	204,827	235,453	257,774
600	8,146	9,008	11,850	11,417	13,541	25,646
TOTAL	733,685	817,043	946,926	1,167,191	1,475,547	1,868,727

Note: Medicare data, date of processing.

Table 4 shows that in 2015–16, a total of \$245.9 million in MBS benefits were paid for urgent after-hour services. Of these, 80 per cent was paid under item 597, 16 per cent was paid under item 599, and 4 per cent was claimed under item 598 and 600.

Table 4: Benefits paid (\$ million) – urgent after-hours items

Item	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
597	\$68.3	\$78.0	\$91.4	\$115.4	\$152.9	\$196.8
598	\$3.7	\$4.1	\$4.8	\$4.2	\$4.6	\$6.7
599	\$17.9	\$19.9	\$24.1	\$30.7	\$36.0	\$39.4
600	\$0.9	\$1.0	\$1.3	\$1.3	\$1.5	\$3.0
Total	\$90.8	\$103.0	\$121.7	\$151.6	\$195.0	\$245.9

Note: Medicare data, date of processing.

7.2 Claiming of ‘unsociable’ urgent after-hours items

The number of ‘unsociable’ (between 11pm and 7am) urgent after-hours services (item 599) as a percentage of all urgent after-hours service has fallen from less than 20 per cent of all urgent after-hours services in 2013–14. This is despite the overall growth in urgent after-hours items since 2011–12. It might be expected that a higher number of urgent after-hours items would be claimed in the ‘unsociable’ period than is currently the case, as there are less mainstream after-hours GP clinics open during this time, compared to the standard urgent after-hours times—however data show that this is not the case.

7.3 Growth in after-hours GP services, compared to in-hours GP services

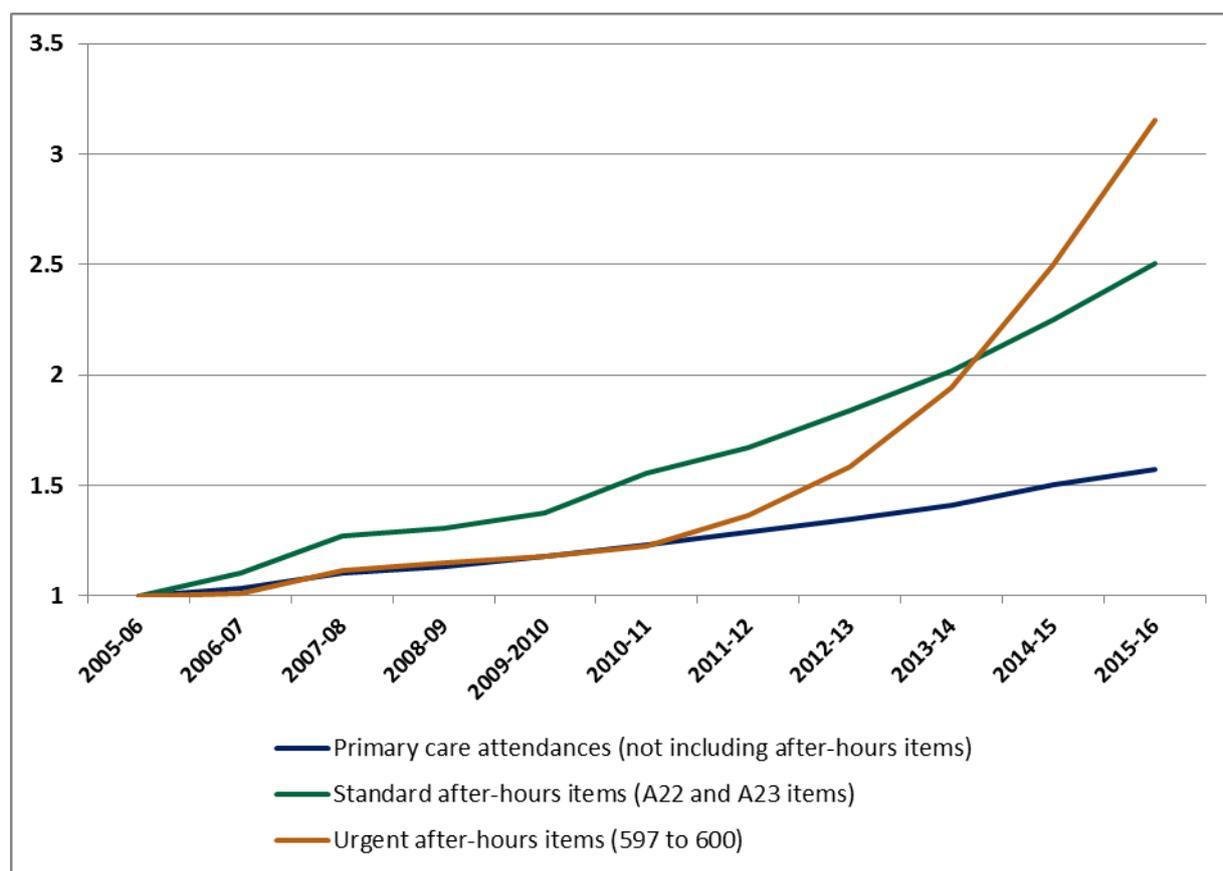
Key points:

- △ There has been a much higher growth rate in use of after-hours items compared to standard in-hours items.
- △ There has been a much higher growth rate in the use of ‘urgent’ after-hours items compared to standard (non-urgent) after-hours items.

Since 2005–06, benefits paid per capita for all after-hours items have grown over 160 per cent. Figure 4 shows that the growth in benefits paid per capita for urgent after-hours items has contributed to a significant proportion of this growth.

MBS funding for all after-hours attendances (standard and urgent) has been growing at a much faster rate than in-hours GP services, which is also shown in Figure 4. In the 10 years from 2005–06, MBS funding per capita for in-hours GP services increased by a factor of 1.6 (or almost 60 per cent), whereas MBS funding per capita paid for standard after-hours items increased by a factor of 2.5 (or 150 per cent). Since 2005–06 MBS funding per capita for the four ‘urgent’ after-hours items increased by a factor of more than 3 (or 215 per cent).

Figure 4: Growth in MBS benefits per capita for in-hours primary care attendances vs standard after-hours attendances and urgent after-hours attendances (standardised to 2005–06)



Notes: Date of processing. Primary care attendances includes MBS Groups A1, A2, A5, A6, A7, A14, A15, A18, A19, A20. After-hours attendances include MBS Groups A22, A23. Urgent after-hours attendances include MBS Group A11.

7.4 Growth does not appear to be driven by clinical need

Key points:

- △ There has been much higher growth in use of urgent after-hours items compared to standard after-hours items.
- △ There is a high geographical concentration of services, with the claiming of the urgent items apparently being more related to local models of service provision rather than patient factors.
- △ There are an increasing number of urgent after-hours services provided in areas where MDSs have been established and direct-to-consumer advertising has commenced.

The growth rate of urgent after-hours consultations—specifically item 597, which can be claimed for consultations in a doctor’s consulting rooms and home visits (although evidence seems to indicate that a high proportion of claims are for home visits, rather than in doctor’s consulting rooms)—is higher than that of non-urgent standard after-hours home visits (Level B—item 5023, see Table 5). Since 2011–12, the volume of the former has increased by 141 per cent, compared to a 113 per cent increase for the latter over the same period.

Table 5: Volume of most commonly claimed home visit services over time

	2011-12	2012-13	2013-14	2014-15	2015-16	% increase from 2011–12
Urgent after-hours home visits* (item 597)	629,654	724,129	907,993	1,179,106	1,516,916	141%
Standard after-hours home visits (item 5023)	154,314	178,754	214,877	260,172	328,726	113%

Notes: Medicare data, date of processing. *Note that this item can be claimed for both consultations in doctors’ consulting rooms and home visits. Evidence seems to indicate that a high proportion of claims are for home visits.

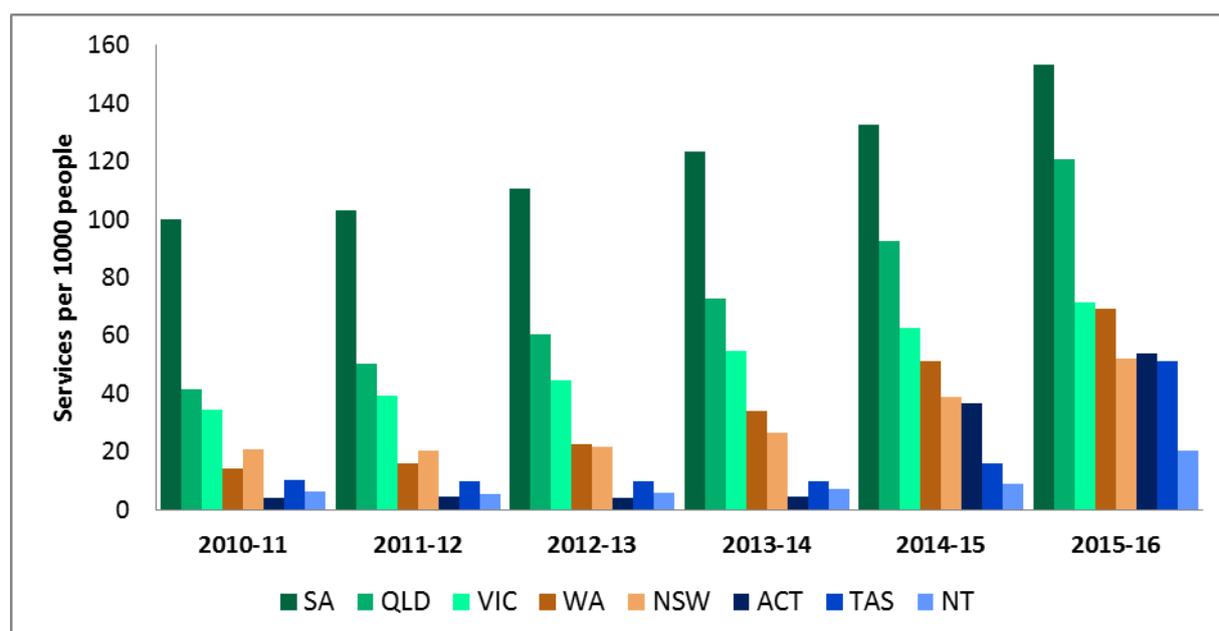
7.5 Service variation by geographical area

There is significant geographical variation in service usage for the urgent after-hours items, including by state and territory and by small statistical areas. Geographical variation is not necessarily indicative of inappropriate service provision or use, but can indicate that the service warrants examination⁴.

Figure 5 demonstrates the state variation in the use of urgent after-hours items, with South Australia and Queensland having the highest rate of use per 1,000 people. However, high rates of growth can be observed for most states and territories over this period.

⁴ Appleby et al. 2011. Variations in health care: The good, the bad and the inexplicable. The King’s Fund. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Variations-in-health-care-good-bad-inexplicable-report-The-Kings-Fund-April-2011.pdf

Figure 5: Urgent after-hours service per 1,000 people, 2010-11 to 2015-16



Note: Medicare data, date of processing.

In some areas of Australia, more than 10 per cent of benefits paid for GP and primary care services are paid for urgent after-hours attendances (items 597, 598, 599 and 600 as a percentage of all other GP and other non-referred attendances).

Analysis of benefits paid per person by smaller geographical areas shows significant variation in urgent after-hours services usage.

Analysis based on SA3 data (a unit of geographical area defined by the Australian Bureau of Statistics to report on regional data), shows that urgent after-hours services are concentrated in urban areas. For example, the average benefit paid per person for urgent after-hours items in Playford, Adelaide, comprises 11.3 per cent of benefits paid for all GP services per person. In comparison, in the Adelaide Hills, this same figure is 1.4 per cent (see Table 11 in [Section 11 – Additional data](#)). Similarly, in Queensland the average benefit paid per person for urgent after-hours items in Ormeau-Oxenford on the Gold Coast comprises 11.4 per cent of the benefits paid for all GP services per person. In comparison, in Beaudesert this same figure is less than 1 per cent (see Table 10 in [Section 11 – Additional data](#)).

In general, it has been observed that the use of the urgent after-hours items is commonly higher in those areas where MDSs have been established. There is no compelling reason why clinical need for these urgent after-hours services should be higher in these areas relative to similar parts of Australia. Further data about benefits paid for urgent after-hours items by SA3 for New South Wales, Victoria, Queensland and South Australia is available in [Section 11 – Additional data](#).

7.6 MDS providers commencing services and the relation to the use of urgent after-hours items

Between 2011–12 and 2015–16, MDS providers have expanded services to a number of regions around Australia. Medicare data suggest a high correlation between the emergence of new MDSs in certain regions, and an increase in the use of the urgent after-hours items in these areas.

MDSs are known to actively market the launch of their new services through advertising on TV, print, radio and other media. One large MDS provider, which launched into a number of the locations listed in table 6, publicly stated that “research shows only 31 per cent of the general public is aware of bulk billed, after hours doctor services. To address this, we recently launched a new advertising

campaign that features GPs recommending the service for patients who need to see a doctor when their regular GP is closed.”⁵

Table 6 focuses on six SA4 locations across Australia where there have been a number of high-profile MDS services established. The commencement of these services has been accompanied by awareness/advertising campaigns across different platforms. In these six locations from five different states, there is a correlation between the growth in the use of all four urgent after-hours items and MDS providers commencing services.

Over a period of three years, where the first year was prior to the launch of a new MDS service, and the third year was well after the launch of a new MDS service, high levels of growth are evident. The growth in each of these markets ranges from 162 per cent in South-West Perth, where other MDS in-home providers were already active, and 1,090 per cent in the Australian Capital Territory, where other MDS providers were not providing in-home urgent after-hours services. Some of these locations witnessed more than one large MDS provider commence operations in their area within the three year period.

Table 6: Urgent after-hours MBS services by specific SA4 - where new MDS providers have commenced operations

State	Geographical Area (SA4)	MDS Launch Year	2011-12	2012-13	2013-14	2014-15	2015-16	3 year change	3 year % change
QLD	319: Wide Bay	2015	4,923	4,629	4,353	11,984	30,318	25,964	596%
QLD	318: Townsville	2012	1,624	9,596	16,456	17,336	24,084	14,831	913%
NSW	111: Newcastle and Lake Macquarie	2014	9,332	10,314	11,985	27,732	33,441	21,455	179%
ACT	801: Australian Capital Territory	2014	1,618	1,549	1,750	14,082	20,826	19,075	1090%
TAS	602: Launceston and North East	2016	2,217	2,151	2,133	2,295	7,459	5,325	250%
WA	507: Perth - South West	2015	4,812	6,456	13,313	22,948	34,849	21,535	162%

Note: Unpublished Medicare data, date of processing.

7.7 Many after-hours services claimed as urgent are not truly urgent services

Key points:

- △ Investigations by the Medicare compliance body, the Professional Services Review, have found that some practitioners have claimed an urgent after-hours item when the service should have been claimed under a standard after-hours item.
- △ The number of urgent after-hours services claimed relative to non-urgent after-hour services is disproportionate. It would be expected that there should be a more even distribution, or more non-urgent services.
- △ The number of urgent services claimed in the ‘unsociable’ after-hours period, between 11pm and 7am (item 599), is low in comparison to urgent services provided in other after-hours periods (item 597). It would be expected that the number of urgent services would be higher due to the lower number of after-hours clinics available at this time.

The Professional Services Review (PSR) was established in 1994 to protect the integrity of Medicare and the Pharmaceutical Benefits Scheme through a system of reviews conducted by

⁵ The West Australian, advertising liftout, 15 April 2016.

doctors on their peers. The PSR protects patients and the community from the risks associated with inappropriate practice, and protects the Commonwealth from having to meet the cost of medical / health services provided as a result of inappropriate practice. The PSR's *Annual Report 2015–16* makes the following observations in relation to after-hours services:

- During 2015–16, a number of practitioners have been referred to PSR with concerns about their provision of urgent after-hours services.
- Examination of clinical records has shown that some practitioners have billed these items for medical conditions such as an uncomplicated rash, reissuing prescriptions for patients' regular medication and for routine completion of medication charts in residential aged care facilities.
- As there is a fee differential between urgent and non-urgent after-hours MBS items, potentially inappropriate use of these services has a significant financial impact on Medicare.

Members of the Taskforce and the Working Group have been advised of numerous examples of patients obtaining urgent after-hours home visits for conditions which *prima facie* did not need urgent attention. These include routine prescriptions and the need for medical certificates for carers leave.

7.8 Increasing use of urgent after-hours items by MDSs

Key points:

- △ A growing proportion of urgent after-hours services are provided by MDSs using a medical workforce of largely non-VR GPs. Many of these non-VR GPs are less experienced doctors who are not participating in a GP or other training program.
- △ Non-VR GPs provided double the number of urgent after-hour services provided by VR GPs in 2015–16.
- △ It appears that the generous rebates for the urgent after-hours items have led to the proliferation of businesses which promote patient convenience in addition to access based on clinical need, with billing models structured to benefit from the higher rebates available for the urgent after-hours items.

The Taskforce's role is to make certain that the structure of Medicare items ensures that people are receiving appropriate care and that the items support the provision of high-value care. The current structure of the urgent after-hours items and high rebates available appears to be driving use of the items and the proliferation of business models structured to benefit from the items.

Medicare data do not link an individual service to an individual business entity. It is therefore not possible to gauge precisely how many urgent after-hours services are being provided by a mainstream GP providing care to the patients of their own practice, and how many have been provided through a MDS.

However, the qualifications of each doctor and their eligibility to claim Medicare benefits are available and are linked to each service. The majority of urgent after-hours attendances are now provided by doctors who are not recognised as specialist GPs (that is, doctors who are not fellows of the RACGP or ACCRM), and nor are they formal GP trainees.

In 2015–16, non-VR GPs with access to VR GP items through their participation in a Commonwealth workforce program provided 63 per cent of all VR GP urgent after-hours attendances (Table 7). They also provided 52 per cent of non-urgent after-hours home visits (Level B). It is likely that a proportion of these services are the standard after-hours attendances that occur in the same household as the 'original' urgent attendance (as subsequent after-hours attendances provided in the same household must be claimed as standard after-hours items). Around 70 per cent of urgent after-hours services are provided by non-VR GPs and GP trainees employed by MDSs, who work exclusively in the after-hours period. This form of practice can be so lucrative as to disincentivise non-VR GPs from pursuing full qualification.

Table 7: Proportion of after-hours attendances provided by derived speciality, 2015–16.

Item Description	Derived speciality				% of total provided by non-VR GPs
	VR GP	Non-VR GP*	GP Trainee	Total	
VR GP urgent after-hours home visits (item 597)	439,584	945,704	106,272	1,491,560	63%
VR GP standard after-hours home visits (item 5023)	140,117	168,901	16,072	325,090	52%

Notes: A small proportion of services were provided by other specialists. *Non-VR GPs affiliated with home deputising services can access the VR GP MBS items. Unpublished Medicare data, date of processing.

The RACGP position paper on after-hours visiting services in primary care states that:

The ‘gold standard’ for any GP working in Australia, either within usual practice hours or after hours, is registration as a Specialist GP. The quality and safety of patient care is at risk in the absence of appropriately trained and experienced GPs providing primary care services in the after-hours period⁶.

7.9 Impact on hospital emergency departments

Key point:

- △ Based on MBS and other available hospital data, 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.

An argument used to support the recent growth in the use of urgent after-hours items is that it has relieved pressure on hospital emergency departments (EDs). The Taskforce does not accept this view as it has not been substantiated by compelling evidence.

The Taskforce believes that people present to an ED for a variety of reasons. A recent study has suggested that the main reason people visit an ED is their perception of urgency, or the need for ED care, rather than convenience or cost factors⁷. In contrast, it appears that major drivers of the growth in urgent after-hours services are convenience and because they are free at the point of care (99 per cent services bulk-billed). Recent marketing and campaigns by after-hours MDS providers across Australia targeted at consumers often emphasise these two factors—convenience and no cost to the consumer.

7.10 Urgent after-hours home visits compared to care received in an ED

Key point:

- △ It is not appropriate to compare the level of care or the cost of a hospital ED presentation with a MBS-funded urgent after-hours home visit.

ED presentations and urgent after-hours home visits represent very different levels of care. Presenting to an ED provides a consumer with a level of resources and treatment far in advance of

⁶ Royal Australian College of General Practitioners. 2016. After-hours home visiting services in primary healthcare: Position Statement. Available at <http://www.racgp.org.au/download/Documents/Policies/Health%20systems/After-hours-position-statement.pdf>

⁷ Douglas K, Aleksandric V, Shaw H, Batt K. (2015). Low acuity presentations to the Emergency Department in the ACT - Why aren't they seen in the elsewhere in the primary health care system? In: 2015 Primary Health Care Research Conference: Program & Abstracts. Primary Health Care Research and Information Service, Australia. phcris.org.au/conference/abstract/8241

an in-home visit by a practitioner. Public EDs across Australia are often equipped with state-of-the-art resources such as diagnostic imaging, pathology and medicines. In a home visit setting, diagnostic and pathology services are limited to simple tests and the patient does not have the care from a specialist emergency physicians or support from nurse practitioner when required. The Taskforce does not accept that an ED presentation should be compared to that of an in-home after-hours visit.

For some patients a hospital ED is the most appropriate setting for treatment. The current rules for urgent after-hours MBS items allow consumers to book an attendance up to two hours before the actual after-hours period commences. This can result in the after-hours visit occurring more than two hours after the initial call to the service was made. The Australian College of Emergency Medicine policy on the Australian Triage Scale states a maximum waiting time for medical assessment and treatment for a category 4 and 5 to be 60 minutes and 120 minutes respectively⁸.

Due to the differing levels of care it is also not appropriate or valid to compare the cost of a MBS-funded urgent after-hours service to the average cost of an ED presentation. Depending on the time of day or night it is more appropriate to compare the cost of an urgent after-hours service to the much lower cost of an in-hours consultation in rooms or home visit, or a non-urgent after-hours consultation or home visit.

7.11 The high MBS rebate for urgent after-hours items is driving use

Key points:

- △ The urgent after-hours items are generously rebated in comparison to standard after-hours items and GP consultations provided in business hours.
- △ The recent growth in use of these services is evidence of pricing failure.
- △ As some services claimed under the urgent after-hours items are not genuinely urgent and could be provided more efficiently by the patient's usual GP or during business hours at consulting rooms, the payment of higher rebates for these services is diverting MBS expenditure away from higher-value services.

The urgent after-hours items have much higher rebates than standard after-hours items or standard GP attendance items. For example, item 597, an urgent after-hours attendance (during the periods 7am-8am and 6pm-11pm) has a rebate of \$129.80. This is compared to a standard after-hours Level B GP attendance with a rebate of \$49.00 if provided at the doctor's consulting rooms (item 5020) or \$74.95 if provided at the consumer's home (item 5023). The rebate for a standard 'in-hours' Level B consultation is \$37.05 when the GP sees the consumer in their consulting rooms (item 23) or \$63.00 when visiting the consumer's home (item 24).

The MBS rebates for item 597 and other urgent after-hours items were originally introduced to compensate GPs who have made themselves available to treat their patients outside normal operating hours in the patient's home, where the service is unplanned or unscheduled, and requires treatment which cannot wait until the following day. However the same rebate is also available to GPs providing home visits exclusively in the after-hours periods. These providers will have different costs structures and through technological advancements such as route optimising mobile applications, are able to schedule patients to maximise business efficiencies and throughputs. The current MBS rebates do not reflect this. A GP who predominantly operates in-hours has a very different business structure and overhead costs to that of an after-hours-only provider of GP services. This has therefore seen the market adapt to these prices, by increasing the provision of these services and distorting the appropriateness of the care provided.

⁸ Australian College of Emergency Medicine. 2016. Guidelines on the implementation of the Australasian Triage Scale in Emergency Departments. Available at <https://acem.org.au/getattachment/4320524e-ad60-4e7c-a96d-bdf90cd7966c/G24-Implementation-of-the-Australasian-Triage-Scale.aspx>

The distortion in the provision and fee of GP services comes at a cost to the taxpayer. The opportunity cost of the use of urgent after-hours items is large; with some urgent after-hours rebates almost \$100 more than GP service provided at the GP's clinic during business hours. The growth in MBS expenditure on urgent after-hours items ultimately means that there are fewer resources available for other higher-value care.

7.12 Potential impacts on continuity and quality of care

Key points:

- △ Some patients are receiving all their primary care through these urgent after-hours home visit services and are no longer receiving mainstream GP care. The shift in patients is disrupting continuity of care.
- △ Some GPs have raised concerns about the quality of care provided by after-hours doctors as they do not have access to patient histories or records.

MBS data show that of the over 180,000 patients who received three or more urgent after-hours services in a 12 month period between 2014 and 2016, over 10,000 received no standard, in-hours GP care at all. This suggests that some patients are substituting after-hours home visits for routine general practice care.

The RACGP position statement on after-hours home visits states that:

GPs provide continuous, coordinated and comprehensive healthcare. GPs know their patients' medical history, can undertake preventive care, manage chronic health conditions and coordinate their patients' multidisciplinary care needs. This enables highly efficient primary care. Care provided outside of this model causes fragmentation which results in wasted health resources, largely through duplication of services and the provision of unnecessary services.

Therefore, it is strongly recommended that patients are encouraged and supported to see their regular GP or practice and only utilise dedicated after-hours home visiting services when this is not possible. Patients should only have access to after-hours home visiting services that have formal links with general practices and emergency departments⁹.

⁹ Royal Australian College of General Practitioners. 2016. After-hours home visiting services in primary healthcare: Position Statement. Available at <http://www.racgp.org.au/download/Documents/Policies/Health%20systems/After-hours-position-statement.pdf>

8. Options considered

The Working Group of the Taskforce considered six options to address concerns about the appropriate use of urgent after-hours items, as follow:

1. Better define 'urgent' versus 'non-urgent'.
2. Enforce the current item requirements noting that the item requires that the treatment is urgent, not simply the assessment.
3. Lower the rebates for urgent after-hours services for all providers.
4. Reduce rebates for urgent after-hours attendances when those services are provided by home deputising services.
5. Reduce rebates for urgent after-hours attendances when those services are provided by home deputising services in metropolitan areas only.
6. Restrict access to urgent after-hours items to providers who work predominantly 'in-hours'.

There was consensus that no single option would be completely effective, and that elements of several should be combined to form the optimal approach. It was agreed that quality should be the overarching priority and that the approach adopted focus on promoting high-quality models of care, with the suppression of low-value care being a natural consequence of the new arrangements.

In relation to Option 1, there was general agreement that definitions of 'urgent' in relation to medical services are too subjective to be helpful as a compliance tool, although further efforts in this area should be made.

In relation to Option 2, it was noted that the current item descriptors for the urgent after-hours items stipulate that "the patient's condition requires urgent medical treatment". It was agreed that the trigger for a service should be the urgent assessment of the patient's condition, and that treatment might in fact not be necessary based on that assessment. This means that the current wording might inadvertently make a valid urgent attendance ineligible for a MBS benefit. It was therefore agreed that the wording of the descriptors be amended to stipulate "assessment" as the trigger for an urgent after-hours attendance.

Option 3 was seen as disrespectful to GPs providing high-quality after-hours care in addition to their in-hours workload, and as a fatal impediment to after-hours care in rural areas. Similarly, Option 5 was seen as disrespectful to GPs in metropolitan areas, who would have access to lower rebates than their rural colleagues for equivalent services. Members also noted the longstanding MBS fee-setting principle, supported by the AMA and RACGP, under which fees and rebates are uniform across the country no matter the location of services.

Option 4 and 6 effectively address the same issue (rewarding high-value care through a provider gateway). Option 6, with its emphasis on recognising and rewarding high-quality providers, was seen as most consistent with the Working Group's preferred approach.

An alternative to these options was considered, being the abolition of urgent after-hours items 597 and 599, with their higher fees. It was noted that other after-hours items are available and are routinely used. A variation on this proposal involved retaining the urgent after-hours items but capping access to them at 1 or 2 claims per provider per day.

While the Working Group was attracted to the simplicity of this approach, it was felt that the deletion of these items would unfairly penalise GPs providing high-quality after-hours services in addition to a normal in-hours workload, by removing additional compensation for the lifestyle disruption and costs incurred by them.

It was agreed that an approach be developed drawing on the intent of Options 1, 4 and 6. Ultimately, this took the form of revised MBS item descriptors and explanatory notes for urgent after-hours items which exclude the use of these items for services provided by medical deputising services but preserve the use of these higher rebated items for GPs and other medical practitioners who are providing urgent after-hours services to their patients through after-hours on call arrangements.

9. Taskforce findings

The Taskforce is satisfied that the current structure of the urgent after-hours items supports the provision of comparatively low-value medical care and does not represent value for money for the taxpayer.

In reaching this conclusion the Taskforce considered the expert opinion of representatives from professional medical organisations (including the AMA, RACGP, ACRRM and RDAA) and Medicare data on usage patterns.

The Taskforce noted that:

- △ In the five years between 2010–11 and 2015–16, there has been substantial growth in the number of services and benefits paid for the urgent after-hours items.
- △ The growth in use of these urgent after-hours items is concentrated in some areas of urban Australia.
- △ Most urgent after-hours services are being provided by MDSs and the growth in urgent after-hours services is well in excess of the growth in standard after-hours items.
- △ The growth in use of urgent after-hours services appears not to be driven by increasing clinical need for these services, but has coincided with entry of new businesses into the market with models which promote these services to consumers emphasising convenience and no out-of-pocket cost.
- △ Many urgent after-hours services are claimed for matters which are not urgent and could be better and more cost-effectively dealt with by the patient's usual GP during normal business hours.
- △ It is not convinced by arguments that the growth in use of urgent after-hours home visits has had a significant impact on the use of emergency department services.
- △ The increasing use of the items by MDSs has implications for continuity of care with the patient's regular GP.

These findings led the Taskforce to recommend changes to the item descriptors and explanatory notes for items 597, 598, 599 and 600.

10. Conclusions and implications of changes to the urgent after-hours items

The key conclusions of the Taskforce are:

1. MBS funding should continue to be available for home visits, including in the after-hours period. Funding should continue to be available for after-hours services provided by a patient's GP, as well as by a MDS.
2. The rebates for 'urgent' after-hours services should only be payable in circumstances where a GP who normally works during the day is recalled to work for management of a patient who needs, in the opinion of the GP, urgent assessment. The higher rebate recognises the additional clinical value provided by, and lifestyle and financial imposts on, GPs who deliver these services to their own patients, the practice's patients or patients of other local practices where on-call work is shared. In this setting it is more likely that there will be better patient triage, based on the GP's (or a closely supervised GP trainee's) knowledge of the patient's circumstances, better access to patient records facilitating management, and better follow-up to ensure continuity of care.
3. Where a business has been established specifically to routinely provide care in the after-hours period (including a MDS) then all of the other (non-urgent) items for after-hours services should remain available to these entities.
4. The MBS items for urgent after-hours attendances should not be available where the patient has made an appointment prior to the commencement of the after-hours period (that is, 6pm on weeknights).

Rebates for after-hours Medicare services will continue to be available to all patients, with a higher rebate than GP services provided during business hours. The option of providing home visits and for practitioners to bulk-bill patients for these services will continue.

The urgent after-hours items will remain available where the GP who normally works during the day is recalled to work to manage a patient whose condition requires an urgent assessment that cannot wait until the next working day.

11. Additional data

11.1 Analysis of average benefits paid per person by SA3 geographical area

Table 8: Average benefits paid per person by place of residence (SA3), NSW, 2015-16

New South Wales	Urgent after-hours (\$)	After-hours (\$)	All other non-referred services (\$)
Top 10			
Bankstown	11.91	38.84	325.99
Lake Macquarie - East	11.85	17.35	296.12
Canterbury	11.78	49.27	319.45
Newcastle	11.75	14.86	275.50
Coffs Harbour	11.72	7.09	339.67
Kogarah - Rockdale	11.49	26.46	287.73
Merrylands - Guildford	11.37	46.25	341.74
Liverpool	11.02	33.39	326.25
Penrith	10.77	32.32	321.80
Maitland	10.55	14.55	280.41
Bottom 10			
Southern Highlands	1.51	10.24	317.80
Lower Murray	1.51	9.06	300.70
Goulburn - Yass	1.40	13.82	281.13
Orange	1.33	3.76	254.68
South Coast	1.20	3.78	293.57
Blue Mountains - South	0.99	3.27	299.80
Lithgow - Mudgee	0.97	6.52	265.02
Snowy Mountains	0.91	3.97	211.81
Dubbo	0.81	24.00	275.50
Bathurst	0.70	4.04	251.53

Table 9: Average benefits paid per person by place of residence (SA3), Vic, 2015-16

Victoria	Urgent after-hours (\$)	After-hours (\$)	All other non-referred services (\$)
Top 10			
Moreland - North	18.26	40.19	309.37
Melbourne City	16.89	22.00	203.87
Glen Eira	14.73	28.30	244.52
Maribyrnong	14.63	33.73	239.25
Brunswick - Coburg	14.33	27.11	261.49
Keilor	14.33	32.42	293.07
Hobsons Bay	14.30	35.88	261.12
Port Phillip	13.41	23.74	224.39
Darebin - North	13.29	40.34	288.01
Darebin - South	12.89	19.99	242.68
Bottom 10			
Ballarat	3.56	22.57	248.10
Wodonga - Alpine	3.51	8.53	300.53
Campaspe	3.45	14.24	333.63
Glenelg - Southern			
Grampians	3.44	9.95	273.52
Barwon - West	3.25	13.60	273.46
Gippsland - East	2.47	5.82	233.57
Mildura	2.34	15.48	286.53
Latrobe Valley	2.30	9.99	306.07
Macedon Ranges	2.30	17.43	316.08
Baw Baw	1.88	15.32	335.98

Table 10: Average benefits paid per person by place of residence (SA3), QLD, 2015-16

Queensland	Urgent after-hours (\$)	After-hours (\$)	All other non-referred services (\$)
Top 10			
Ormeau - Oxenford	39.25	23.45	282.62
Nerang	34.18	31.36	274.03
Gold Coast - North	33.38	30.74	338.04
Southport	31.72	36.79	303.36
Broadbeach - Burleigh	27.66	24.24	312.01
Robina	26.23	23.20	282.15
Coolangatta	25.64	21.50	310.35
Toowoomba	24.88	12.95	267.53
Wynnum - Manly	24.74	16.11	241.56
Mudgeeraba - Tallebudgera	24.18	21.26	271.24
Bottom 10			
Far North	4.32	7.96	173.88
Bowen Basin - North	4.20	5.01	176.18
Charters Towers - Ayr - Ingham	3.58	9.10	290.10
Ipswich Hinterland	3.50	16.64	326.00
Outback - South	3.43	6.33	235.91
Granite Belt	3.38	4.99	271.37
Caboolture Hinterland	3.33	11.40	279.84
Tablelands (East) - Kuranda	3.10	11.39	252.30
Port Douglas - Daintree	2.71	6.55	266.94
Beaudesert	2.48	14.44	356.70

Table 11: Average benefits paid per person by place of residence (SA3), SA, 2015-16

South Australia	Urgent after-hours (\$)	After-hours (\$)	All other non-referred services (\$)
Top 10			
Playford	46.26	41.28	320.56
Charles Sturt	33.26	29.30	263.83
Port Adelaide - West	31.83	32.10	269.93
Adelaide City	30.49	26.15	215.61
Salisbury	29.86	27.23	302.19
West Torrens	28.59	23.23	244.64
Port Adelaide - East	27.97	29.60	271.77
Marion	25.44	24.72	257.04
Campbelltown (SA)	24.13	20.28	268.30
Tea Tree Gully	24.13	19.34	262.11
Bottom 10			
Gawler - Two Wells	11.39	25.44	293.99
Lower North	10.09	7.94	271.27
Murray and Mallee	8.30	11.66	263.95
Mid North	7.86	6.26	295.35
Eyre Peninsula and South West	7.09	8.94	276.24
Barossa	6.79	9.87	256.49
Outback - North and East	4.87	11.11	258.79
Fleurieu - Kangaroo Island	4.72	8.67	322.04
Adelaide Hills	3.72	10.31	246.81
Limestone Coast	3.68	5.23	241.29

Note: All non-referred services exclude urgent after-hours and after-hours services. Some locations have been excluded where there are fewer than 3 providers. Unpublished Medicare data, date of processing.

12. Glossary

Term	Description
ACCRM	Australian College of Rural and Remote Medicine.
AHOMP Program	After-Hours Other Medical Practitioner Program. The AHOMP program provides access to higher urgent after-hours Medicare rebates to non-vocationally recognised medical practitioners providing after-hours general practice services through an accredited general practice or an accredited Medical Deputising Service. Normally non-vocationally recognised medical practitioners would access lower Medicare rebates.
AMA	Australian Medical Association.
AMDS	Approved Medical Deputising Service. The Approved Medical Deputising Service Program is a workforce program intended to expand the pool of available doctors who provide after-hours ONLY services including home visits on behalf of general practice principals. A AMDS service provider is an organisation which directly arranges for medical practitioners to provide after-hours medical services to patients of practice principals during the absence of, and at the request of, the practice principal. A AMDS service provider is required to operate and provide uninterrupted access to care, for the whole of the after-hours period. The defined after-hours periods that must be covered by the AMDS service provider are: 6pm – 8am Weekdays, from noon Saturday, all day Sunday and public holidays. A AMDS service provider must demonstrate that consultations and home visits are provided during the unsociable hours.
GP	General practitioner.
GP Trainee	A doctor who is undertaking a training program for the award of Fellowship.
High-value care	Services of proven efficacy reflecting current best medical practice, or services for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use/misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	The use of an intervention that evidence suggests confers no benefit or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.
MBS	Medicare Benefits Schedule.
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, comprising an item number, service descriptor and supporting information, Schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
MDS	Medical deputising service. A MDS is an organisation responsible for directly arranging for medical practitioners to provide after-hours services to patients on behalf of practice principals.
NAMDS	National Association for Medical Deputising Services.
Non-VR GP	Non-vocationally registered general practitioner. Non-VRGPs are doctors who have not undertaken the appropriate training and continuing development to be considered a fellow of the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine. These doctors are not eligible to access the higher MBS rebates for consultations unless they are part of a workforce program such as the AHOMP or ROMP programs.
OMP	Other medical practitioner.

Term	Description
	These are doctors who have not qualified to be recognised as a specialist (including consultant physicians and general practitioners). Some OMPs are on training pathways to become recognised as a specialist. Unless they are in a specific program, OMPs can only access MBS items with lower Medicare rebates than GPs and specialists.
PSR	Professional Services Review.
RACF	Residential aged care facility. A special-purpose facility which provides accommodation and other types of support, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living, to frail and aged residents.
RACGP	Royal Australian College of General Practitioners.
RDAA	Rural Doctors Association of Australia.
ROMP Program	Rural Other Medical Practitioners Program. The ROMPS programme provides access to GP items with higher Medicare rebates to non-vocationally recognised medical practitioners providing general practice services in eligible rural and remote areas. Normally non-vocationally recognised medical practitioners would access MBS items with lower Medicare rebates.
Taskforce, The	The Medicare Benefits Schedule Review Taskforce.
Urgent after-hours items	Refers to MBS items 597, 598, 599 and 600. These items provide for 'urgent' consultations in the after-hours period commencing from 6pm to 8am, provided at consulting room or other location such as patient's home or RACF. Urgent after-hours consultation Item 597 and 598 provide for 'urgent' after-hours consultations in the after-hours periods of 7am-8am & 6pm-11pm, seven days a week. Urgent consultation in 'unsociable' after-hours Items 599 and 600 provide for 'urgent' after-hours consultations in the 'unsociable' after-hours period of 11pm to 7am, seven days a week.
VR GP	Vocationally registered general practitioner. VR GPs are fully qualified general practitioners who have the appropriate experience and undertaken the appropriate training and continuing development to be considered a fellow of the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM).
Working Group	After-Hours Working Group. A working group of the MBS Review Taskforce.

Attachment A – MBS Review Taskforce membership and Terms of Reference

The Taskforce:

Name	Position/Organisation
<i>Prof Bruce Robinson, Chair</i>	Former Dean, Sydney Medical School; Chair, National Health and Medical Research Council
<i>Dr Steve Hambleton, Deputy Chair</i>	Clinical member (General practice); Past President, Australian Medical Association
<i>Dr Matthew Andrews</i>	Clinical member (Diagnostic imaging); Past President, Royal Australian and New Zealand College of Radiologists
<i>Prof Michael Besser</i>	Clinical member (Neurosurgery); Retired Head, Department of Neurosurgery, Royal Prince Alfred Hospital
<i>Dr Michael Coglin</i>	Clinical member (Private provider); Chief Medical Officer, Healthscope Ltd
<i>Prof Adam Elshaug</i>	Health technology assessment; <i>Co-Director, Menzies Centre for Health Policy</i>
<i>Prof Paul Glasziou</i>	Clinical member (General practice); Professor of Evidence-Based Medicine, and Director, Centre for Research in Evidence-Based Practice, Bond University
<i>Prof Michael Grigg</i>	Clinical member (Surgery); Past President, Royal Australasian College of Surgeons
<i>Dr Lee Gruner</i>	Clinical member (Medical administration); Past President, Royal Australasian College of Medical Administrators
<i>Ms Rebecca James</i>	Consumer representative; Consultant, Medicines for Malaria Venture
<i>Dr Matt McConnell</i>	Clinical member (Public health); Public Health Physician, Country Health SA Local Health Network
<i>Dr Bev Rowbotham</i>	Clinical member (Pathology); Past President, Royal College of Pathologists of Australasia
<i>Prof Nick Talley</i>	Clinical member (Medicine); Chair, Council of Presidents of Medical Colleges

Taskforce Terms of Reference

1. An early, high-level review of the MBS as a whole to identify priority areas taking account of factors including concerns about safety, clinically unnecessary service provision and accepted clinical guidelines.
2. From this high-level review, identify Review topics and assign priority to nominated topics, providing this initial advice to the Minister for Health by late 2015.
3. Commission evidence-based reviews that rely on assessment of literature and data by Working Groups.
4. Analyse the advice from the Working Groups and, in turn provide advice to the Minister, including advice on the evidence for services, appropriateness, best practice options, levels and frequency of support through Medicare.
5. Monitor the outcome of MBS reviews and trends in MBS growth to inform an ongoing cycle of reviews, including advising on a system of ongoing analysis of MBS data, integration of other relevant available data, policy development and implementation.
6. Advise on a departmental programme of work that aims to update the *Health Insurance Act 1973* and regulations (MBS 'rules') that underpin MBS funding.
7. Provide advice to the Minister about the MBS and related health financing issues, as appropriate.
8. Engage with health consumers, medical professionals, peak bodies and other stakeholders to seek their views about appropriate Review approaches and processes.

Attachment B – Membership of the After-hours Working Group

Name	Position/Organisation
<i>Dr Steve Hambleton (Chair)</i>	GP; Past President, Australian Medical Association; Co-Sponsor Clinical Programs, Australian Digital Health Agency
<i>Dr Tony Bartone</i>	GP; Vice President, Australian Medical Association
<i>Dr Penny Browne</i>	GP; Senior Medical Officer, Avant
<i>Dr Eleanor Chew</i>	GP; Past Chair, Royal Australian College of General Practitioners; Member, Australian Digital Health Agency Board
<i>Dr John Davis</i>	GP; Proprietor, After Hours Doctor (Hobart); Proprietor, GP Assist
<i>Dr Aniello Iannuzzi</i>	GP; Member, Australian College of Rural and Remote Medicine Quality and Safety in Practice Council
<i>Dr Gerard Ingham</i>	GP; Member, Professional Services Review Panel
<i>Ms Debra Kay</i>	Consumer representative; Chair, MBS Review Consumer Panel
<i>Dr Mark Morgan</i>	GP; Member, Royal Australian College of General Practitioners Expert Committee – Quality Care
<i>Dr Peter Rischbieth</i>	GP; Past President, Rural Doctors Association of Australia
<i>Prof Tim Usherwood</i>	GP; Head of the Department of General Practice, Sydney Medical School Westmead; Visiting Professorial Fellow at the George Institute for Global Health

Attachment C – Pathways for seeking care in the after-hours period

There are a range of information sources and primary care services available for people in the after-hours period. The Australian Government provides in excess of \$1.0 billion annually to support the provision of after-hours primary care services through various programs and incentive payments. Urgent after-hours expenditure currently comprises around a quarter of this expenditure.

There are a range of alternative pathways funded by a combination of Commonwealth, state and territory governments, which a patient can access when they need medical assistance during the after-hours period.

- **After-hours telephone helpline** through Healthdirect, which provides free access to a GP at night, on weekends and public holidays, when a patient's regular GP is not available and medical advice is needed. Healthdirect also provide a free helpline for health advice from a registered nurse that is available 24 hours a day, 7 days a week. Authoritative health information and a symptom checker are also available on the website.
- **Extended after-hours clinics** are usually regular general practice clinics that offer appointments in the after-hours periods. These clinics typically remain open until 10pm - 12pm on weekdays, and are open on the weekend.
- **After-hours home visits** are provided by doctors for patients who need medical care in their homes.
- **Pharmacies** offer extended trading hours, with pharmacists available for medical advice.
- **Emergency departments** provide care 24 hours a day, 7 days a week for patients who require emergency medical assistance.
- **Ambulance** services provide emergency and non-emergency transport to patients in the community and at hospital.
- **Self-care** at home, if professional medical assistance is not needed.

Examples of local initiatives funded through by the Commonwealth and state and territory governments include:

- **Urgent Care Centres** such as the St John Urgent Care Centres in Western Australia, which allow for patients with non-life threatening injuries or illnesses to be seen by a doctor without the need to attend an emergency department. These centres are open 7 days a week, up to 10pm at night.
- **Nurse walk-in centres** such as the Walk-in Centres funded by the ACT Territory Government which provides free one-off advice and treatment for people with minor illness and injury, with no appointment necessary. These centres are usually open seven days a week, from 7:30am to 10pm.
- **Primary Health Networks** fund services to provide care to patients in the after-hours period if there is a need. The Hunter GP Access scheme for example, is based in the Hunter Valley of New South Wales and triages and refers patients onto necessary care. They also conduct home visits, and fund transportation of patients when they cannot access a clinic.

Other Commonwealth funding relating to after-hours service provision

The Practice Incentives Program (PIP) After-Hours incentive payments encourage general practices to provide after-hours care for their patients. The incentive payment consists of five payment levels for practices to choose the model of care that best suits their business needs. Large practices providing complete after hours coverage at level five, can receive up to \$220,000 per year, however only a very small number of practices would receive this amount. The average after-hours payment to a practice is approximately \$15,000 per year.

Funding of up to \$5,000 per practitioner is also provided through the Practice Incentives Program Aged Care Access Incentive to encourage GPs to provide care into RACFs. Nationally, 84.9 per cent of general practice activity is undertaken by practices enrolled in the PIP¹⁰.

In addition to incentive payments, the Government provides funding to Primary Health Networks (PHNs) to work with key local after-hours stakeholders to plan, coordinate and support locally-tailored after-hours health services. PHNs focus on addressing gaps in after-hours service provision, targeting solutions for 'at risk' populations, and improving service integration, particularly where gaps exist due to a lack of access to general practices registered for the PIP After-Hours payment. In 2015–16 approximately \$70 million was provided to PHNs to support after-hours care.

The Commonwealth and states and territories jointly fund Healthdirect. Healthdirect provides people with advice and information from nurses. In 2015–16, there were 761,044 calls handled by the helpline.¹¹

For people who require health advice during the after-hours period but do not have access to face to face GP services, the Government provides funding for the after-hours GP helpline, which is an extension of the Healthdirect helpline.

In 2016–17, the Government will provide \$17.9 billion in National Health Reform funding to support state health services, including hospital services and public health. This is an increase of approximately \$1.0 billion, or 6.2 per cent, from 2015–16. The funding focuses on improving patient safety and the quality of services, and reducing unnecessary hospitalisations.

¹⁰ Source: Report on Government Services 2016, Productivity Commission, Table 10.A.56

¹¹ Figures provided by Healthdirect Australia as at 30 November 2016

Attachment D – MBS after-hours items—Complete list

Attendance period item descriptors and fees for in-hours and urgent and standard after-hours services

Attendance	Attendance period	Location	Provider type	Items	Descriptor	Schedule Fee	Fee for 1 patient
Urgent after-hours	After-hours ¹²	Consultation room, home visit or RACF visit	GP or non-VRGP on eligible program	597	VRGP Urgent attendance after-hours (7am-8am & 6pm-11pm)	\$129.80	
			Other Medical Practitioners	598	Non-VRGP Urgent attendance after-hours (7am-8am & 6pm-11pm)	\$104.75	
	Unsociable hours ¹³		GP or non-VRGP on eligible program	599	VRGP Urgent attendance unsociable after-hours (11pm-7am)	\$153.00	
			Other Medical Practitioners	600	Non-VRGP Urgent attendance unsociable after-hours (11pm-7am)	\$124.25	
Non-urgent after-hours	After-hours ¹⁴	Consultation rooms	GP	5000	Level A	\$29.00	
				5020	Level B	\$49.00	
				5040	Level C	\$83.95	
				5060	Level D	\$117.75	
			Non-VRGP	5200	<5mins	\$21.00	
				5203	5<x<25mins	\$31.00	
				5207	25<x<45mins	\$48.00	
				5208	>45mins	\$71.00	
	After-hours ¹⁵	Home Visits	GP	5003	Level A	Derived fee – see table A, B and C below.	\$54.95
				5023	Level B		\$74.95
				5043	Level C		\$109.90
				5063	Level D		\$143.70
			Non-VRGP	5220	<5mins		\$34.00
				5223	5<x<25mins		\$43.50
				5227	25<x<45mins		\$61.00
				5228	>45mins		\$83.00
		RACF visits	GP	5010	Level A		\$75.70
				5028	Level B		\$95.70
				5049	Level C		\$130.65
				5067	Level D		\$164.45
Non-VRGP	5260	<5mins	\$46.45				
	5263	5<x<25mins	\$57.55				
	5265	25<x<45mins	\$73.45				
	5267	>45mins	\$95.45				
Standard in-hours	In-hours	Home Visits	GP	4	Level A	\$42.90	
				24	Level B	\$63.00	
				37	Level C	\$97.65	
				47	Level D	\$131.50	
		RACF		20	Level A	\$63.65	
				35	Level B	\$83.75	
				43	Level C	\$118.40	
				51	Level D	\$152.25	
		Consultation room		3	Level A	\$16.95	
				23	Level B	\$37.05	
				36	Level C	\$71.70	
				44	Level D	\$105.55	

¹² Mon –Fri: 7am - 8am & 6pm - 11pm; Sat: 7am - 8am & 12 noon - 11pm; Sun and/or public holidays: 7am - 11pm

¹³ 11pm - 7am

¹⁴ Mon –Fri: before 8am or after 8pm; Sat: before 8am or after 1pm; Sun and/or public holidays: 24 hours

¹⁵ Mon –Fri: before 8am or after 6pm; Sat: before 8am or after 12 noon; Sun and/or public holidays: 24 hours

Fees for non-urgent after-hours home visits (\$)

Number of patients	VRGP standard after-hours home visits (Level A-D)				Non-VRGP standard after-hours home visits (short to prolonged)			
	5003	5023	5043	5063	5220	5223	5227	5228
1	54.95	74.95	109.90	143.70	34.00	43.50	61.00	83.00
2	41.95	61.95	96.90	130.70	26.25	34.75	53.25	75.25
3	37.65	57.65	92.60	126.40	23.65	31.85	50.65	72.65
4	35.50	55.50	90.45	124.25	22.35	30.35	49.35	71.35
5	34.20	54.20	89.15	122.95	21.60	29.50	48.60	70.60
6	33.30	53.30	88.25	122.05	21.10	28.90	48.10	70.10
7	31.00	51.00	85.95	119.75	19.20	26.70	46.20	68.20

Fees for non-urgent after-hours RACF visits (\$)

Number of patients	VRGP attendances in RACFs after-hours				OMP RACF items in after-hours			
	5010	5028	5049	5067	5260	5263	5265	5267
1	75.70	95.70	130.65	164.45	46.45	57.55	73.45	95.45
2	52.35	72.35	107.30	141.10	32.45	41.75	59.45	81.45
3	44.55	64.55	99.50	133.30	27.80	36.50	54.80	76.80
4	40.65	60.65	95.60	129.40	25.50	33.90	52.50	74.50
5	38.35	58.35	93.30	127.10	24.10	32.30	51.10	73.10
6	36.80	56.80	91.75	125.55	23.15	31.25	50.15	72.15
7	32.30	52.30	87.25	121.05	19.75	27.25	46.75	68.75

Fees for in-hour visits (\$)

Number of patients	In-hour home visit				In-hour RACF visit			
	4	24	37	47	20	35	43	51
1	42.90	63.00	97.65	131.50	63.65	83.75	118.40	152.25
2	29.90	50.00	84.65	118.50	40.30	60.40	95.05	128.90
3	25.60	45.70	80.35	114.20	32.50	52.60	87.25	121.10
4	23.45	43.55	78.20	112.05	28.60	48.70	83.35	117.20
5	22.15	42.25	76.90	110.75	26.30	46.40	81.05	114.90
6	21.25	41.35	76.00	109.85	24.75	44.85	79.50	113.35
7	18.95	39.05	73.70	107.55	20.25	40.35	75.00	108.85

Explanatory notes:

A10 - Urgent After-hours Attendances (Items 597- 600)

Items 597, 598, 599 and 600 can be used for urgent services provided in consulting rooms, or at a place other than consulting rooms, in an after-hours period.

Urgent After-hours Attendances (Items 597 and 598) allow for urgent attendances (other than an attendance between 11pm and 7am) in an after-hours period.

Urgent After-hours Attendances during Unsociable Hours (Items 599 and 600) allow for urgent attendances between 11pm and 7am in an after-hours period.

The attendance for all these items must be requested by the patient or a responsible person in, or not more than 2 hours before the start of the same unbroken urgent after-hours period. The patient's condition must require urgent medical treatment and if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance.

If more than one patient is seen on the one occasion, the standard after-hours attendance items should be used in respect of the second and subsequent patients attended on the same occasion.

Medical practitioners who routinely provide services to patients in the after-hours periods at consulting rooms, or who provide the services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms will not be able to bill urgent after-hours items 597, 598, 599 and 600.

A routine service means a regular or habitual provision of services to patients. This does not include ad hoc services provided after-hours in consulting rooms by a medical practitioner (excluding consultant physicians and specialists) working in a general practice or a clinic while participating in an on-call roster

After-hours attendance items may be claimed as follows:

Items 597, 598, 599, 600 apply only to a professional attendance that is provided:

on a public holiday;

on a Sunday;

before 8am, or after 12 noon on a Saturday;

before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday

Attachment F – Summary for consumers

Attendance	Type of Attendance	Applicable time		
		Monday to Friday*	Saturday*	Sunday/and or public holiday
Standard attendance items	Standard attendance in consulting rooms	Between 8am and 8pm	Between 8am and 12 noon	N/A
Urgent after-hours items	Urgent attendance – after-hours	Between 7am – 8am and 6pm – 11pm	Between 7am – 8am and 12 noon – 11pm	Between 7am – 11pm
	Urgent attendance – unsociable hours	Between 11pm – 7am	Between 11pm – 7am	Between 11pm – 7am
Non-urgent after-hours items	Non-urgent after hours at consulting rooms	Before 8am or after 8pm	Before 8am or after 1pm	All day
	Non-urgent after hours at a place other than consulting rooms	Before 8am or after 6pm	Before 8am or after 12 noon	All day

The tables below describe the medical service, the recommendation(s) of the Taskforce, what the recommendation does, what would be different and why the recommendation(s) has been made.

Recommendation: no changes to standard after-hours items

Taskforce recommendation	Item	What it does	What would be different	Why
No changes to non-urgent after-hours items.	5000-5067, 5200-5267.	These items cover a non-urgent attendance by a doctor in the after-hours period.	No change.	<p>The Taskforce recognises that after-hours GP services are essential services and highly valued by consumers.</p> <p>The Taskforce’s view is that MBS funding should continue to be available for home visits, including in the after-hours period.</p> <p>Funding should continue to be available for after-hours services provided by a patient’s GP, as well as by a medical deputising service (MDS).</p>

Recommendation: changes to the item descriptor and explanatory notes for all urgent after-hours items

Taskforce recommendation	Item	What it does	What would be different	Why
Revise item descriptor for the urgent after-hours items. Restrict the use of these items to GPs and other medical practitioners working within a general practice setting.	597, 598, 599, 600	These items cover an urgent attendance by a doctor in the after-hours period.	Consumers will continue to have access to urgent after-hours services that are provided by GPs who provide after-hours care in addition to their in-hours practice. Any organisation that primarily provides care in the after-hours period will no longer be able to claim these items and will instead claim the non-urgent after-hours items.	<p>The growth in claiming of urgent after-hours GP attendances by MDSs which operate only in the after-hours period is supporting low-value care.</p> <p>These services are provided at a high cost to the MBS relative to other GP services and many urgent after-hour services are not urgent but are being claimed at this higher cost.</p> <p>In support of high-value care, GPs who provide after-hours care to their patients, their practice's patients or patients that attend another general practice that shares an after-hours roster will not be impacted by this proposal.</p> <p>In this setting it is more likely that there will be better assessment of patients, better access to patient records and better follow-up to ensure continuity of care.</p> <p>The higher rebate available to these GPs recognises the complexity of the service being delivered and the impact on GPs who work normal business hours and are then called out at night.</p>

Recommendation: changes to the item descriptor and explanatory notes for all urgent after-hours items

Taskforce recommendation	Item	What it does	What would be different	Why
Revise item descriptor for the urgent after-hours items, replacing the current wording of "the patient's condition requires urgent medical treatment" with "the patient's condition requires urgent medical assessment".	597, 598, 599, 600	These items cover an urgent attendance by a doctor in the after-hours period.	An assessment of a consumer will be the actual trigger for a service, recognising that treatment may not be necessary on the basis of that assessment.	<p>This change better reflects the service that is being delivered.</p> <p>If an assessment is not deemed to be urgent, then a rebate should be paid for a non-urgent after-hours item.</p>

Recommendation: changes to the item descriptor and explanatory notes for all urgent after-hours items

Taskforce recommendation	Item	What it does	What would be different	Why
Revise item descriptor to require that urgent after-hour services must be requested in the same unbroken after-hours period during which the attendance occurs.	597, 598, 599, 600	These items cover an urgent attendance by a doctor in the after-hours period.	In recognition of the time-sensitivity for urgent care, the option of booking the urgent attendance up to two hours prior to the commencement of the after-hours period in which the attendance occurs will be removed.	Urgent after-hours GP services should only be provided in genuinely urgent situations. Sometimes it is clinically urgent for consumers to see a GP in the after-hours period. Sometimes it is convenient but not urgent for consumers to see a GP after working hours. If a service is not deemed to be urgent then a rebate should be paid for a non-urgent after-hours item instead.

Recommendation: changes to the item descriptor and explanatory notes for all urgent after-hours items

Taskforce recommendation	Item	What it does	What would be different	Why
Revise item descriptor to add requirement that the attending practitioner determines that the urgent assessment of the patient's condition is required.	597, 598, 599, 600	These items cover an urgent attendance by a doctor in the after-hours period.	This requires the attending practitioner to themselves determine that a patient needs urgent assessment, based on the information they have available to them.	Many urgent after-hours services claimed as urgent are not truly urgent, and the distinction between 'urgent' and 'non-urgent' appears to be not well understood by many medical practitioners. This change recognises that the attending practitioner is the best placed to determine if a patient requires urgent assessment.

Recommendation: changes to the item descriptor and explanatory notes for all urgent after-hours items

Taskforce recommendation	Item	What it does	What would be different	Why
Revise the item descriptor to provide a fuller definition of 'urgent'.	597, 598, 599, 600	These items cover an urgent attendance by a doctor in the after-hours period.	The definition of 'urgent' in the urgent after-hours items will be expanded to ensure that it reflects that a patient's assessment cannot be delayed until the next in-hours period; and requires the attending practitioner to attend the patient at the patient's location or to reopen their practice rooms.	<p>Urgent after-hours GP services should only be provided in genuinely urgent situations.</p> <p>Sometimes it is clinically urgent for consumers to see a GP after working hours. Sometimes it is convenient but not urgent for consumers to see a GP after working hours.</p> <p>If a service is not deemed to be urgent than a rebate should be paid for a non-urgent after-hours item instead.</p>

Addendum to the Urgent after-hours primary care services funded through the MBS report

MBS Taskforce review of public consultation submissions

The Preliminary report for consultation for Urgent after-hours primary care services funded through the MBS was released for public consultation from 7 June 2017 to 21 July 2017.

The Taskforce considered the feedback from public consultation and did not make any amendments to the recommendations.

The Taskforce endorsed all recommendations from the report and submitted the final recommendations to the Minister for consideration.