GPDV Response to 'Victorian Proposal for Joint Funding Approach to Primary Medical Care Clinics co-located with Emergency Departments'
March 2004

Introduction:

GPDV Board has been circulated with a copy of this proposal and appreciates the opportunity to comment even if the timeframe is constrained.

Any proposal for GP clinics co-located with Emergency Departments is of great interest to the GP community as we showed in our Policy Issues Paper Number 16 entitled 'GP Clinics and Hospital Emergency Departments' April 2002 and the Board's formal position adopted in July 2002. GPDV reiterates that GP concerns about such proposals relate to

- Encouraging consumer behaviour which may ultimately increase hospital demand;
- The evidence of effectiveness of hospital based GP Clinics.

However in the face of increased demands on emergency departments and the constraints on the general practice workforce we are aware of the need to trial different models for after hours care provision. Thus we agree that any such service developments should ensure that patients receive the most appropriate care in the most appropriate setting and that evaluation is vital. Any evaluation should include the impact of a co-located GP clinic on the availability of general practice services in the affected catchment.

We acknowledge the recognition by DHS of the GPDV Board's position that such co-located clinics should only provide service after-hours.

Principles for establishment of co-located clinics

We agree with 6 of the 7 aims outlined.

However we would *question* the aim 'Impose no cost to the patient'. This is contradicted later in the document (See 2vii) where the approach suggested is that the majority are bulk billed and consideration is given to local market conditions.

We would *add* two additional aims:

a) 'Provide quality care'.

Patient confidence and ED physician confidence is needed for such a clinic to be a viable alternative to ED. The experience elsewhere shows that unless quality care is provided a co-located clinic is under-utilised (eg Balmain, NSW)

b) 'Must <u>add to</u> the availability of general practice services in the area'

If general practice staff are attracted to work in such a clinic to the detriment of existing services or if the fees are substantially lower than local clinics then local clinics' viability might be reduced. It would not be desirable for the total supply of GP services to be reduced as this would further increase hospital demand.

i. Service Model

We would suggest that it would be useful to define what 'primary care practitioners' mean. It should be noted that GPs have reservations about the introduction of nurse practitioners but see practice nurses as invaluable, particularly in relation to wound care and the care of children. The New Zealand experience shows that very experienced, well-qualified nurses can greatly contribute to an after hours clinic team.

It would also be useful to specify minimum standards required for quality care. Thus the medical staff should be vocationally registered with RACGP as GPs and, although such practices would not be eligible for accreditation because a full range of services is not provided, practice procedures should be in accordance with the current accreditation standards for general practice.

Other considerations about quality of care should include training time for all staff and time for protocol development. Again the Balmain experience points to these as vital ingredients in a successful co-located GP clinic.

The New Zealand experience also points to the value of observation beds, particularly if the intention is to divert people from ED.

ii. Location

We agree that close co-location is very helpful. We would suggest that there is also a need for face to face contact between general practice staff and the ED staff to improve credibility and trust.

iii. Demand

The GPDV position statement on 'GP Clinics and Hospital Emergency Departments' (July 2002) states that 'Identifying those patients who present to emergency departments but may be more appropriately managed in a primary care setting is complex.' The definition of 'Primary Care Type patients' does not necessarily translate into the number suited to general practice care.

iv. Existing GP resources

We agree very strongly that these clinics' primary focus should be on relieving pressure on EDs, not to compete with general practice. Thus our view is that the after hours focus needs to be unequivocal not 'most probably'.

It is our expectation that recruitment of GPs to work after hours in areas of workforce shortage will be very difficult. The Dandenong experience to date provides evidence to support this concern

v. Effect on ED attendances

Other factors affect ED attendances apart from access to GPs (eg perceptions of acuity, cultural factors, anxiety) There is a need for community education and GP support, not just new services. For instance, some GPLOs have suggested there is a need for a Statewide 'Get

yourself a GP' campaign. In addition, the New Zealand experience has shown that GPLOs can play a vital role in reducing hospital demand by facilitating arrangements for GPs to be supported in treating commonly presenting conditions.

Criteria must be times of peak demand and the need to avoid reducing the viability of existing practices.

vi. Cost Sharing

It seems inequitable that these 'approved clinics' receive top-up funding to the MBS when other clinics do not.

It needs to be clear which level of government will pay for medical supplies.

vii. Billing

As noted above, the statement 'Any co-payment must reflect local market conditions and community expectations' contradicts the 'no cost to patient' aim outlined in the Introduction. The experience in Frankston when the after-hours clinic bulkbilled showed that 'no-cost' can lead to overloading if all the local practices charge a co-payment. There is a need to prevent the use of an after hours service for 'normal care.'

viii. Organisational Model

We agree that the development of clinics should be based on formal agreements between key stakeholders. It is essential that the relevant divisions are specified as key stakeholders and that protocols are developed with the division, not with individual GPs. This will greatly assist in garnering the understanding and support of the local GP community and help ensure issues of continuity of care are addressed.

ix. Integration

We strongly agree that clinics must demonstrate integration with other services. To this end such clinics should not do reviews and should minimise specialist referrals in order to keep control within the hands of the usual practitioner. This is similar to the role of deputising services.

In regard to the telephone advice services GPDV would like to affirm that such services should have a full list of available services and not be a channel just for approved co-located services.

3. Sites for Establishment of Clinics

GPDV cannot help but wonder how such services will recruit GPs if the services are in areas of workforce shortage, and whom they will recruit. As noted above, previous experience has shown that if the workforce is not experienced and well qualified then credibility with the public and ED staff will suffer.

4. Conditions for Establishment of co-located clinics

There is a need to clarify the statement ‘redirection from EDs to GP clinics should only be permitted at these approved clinics’. Some EDs currently encourage people to go to GP practices that are open. We, and we presume DHS, would not like to see this practice placed in doubt.

Summary

GPDV sees that trialing after hours primary medical care clinics co-located with emergency departments in areas of high ED demand from PCT attendances is worthwhile under the following conditions:

- the Division must be included in local negotiations
- adherence to quality standards in the workforce and practice set-up
- co-located clinics should operate only after hours
- billing arrangements include co-payments that reflect local market conditions and community expectations.
- the aims should include ‘ must add to the availability of general practice services in the area.’