FINANCING OF AFTER HOURS PRIMARY MEDICAL CARE SERVICES – INCENTIVE OR BARRIER TO QUALITY CARE?

Discussion Paper by Queensland Divisions of General Practice

At the QDGP Board meeting on 23 February 2001, it was recommended that a discussion paper be developed on the current financing arrangements for after hours primary medical care service provision in Queensland. This followed concerns by Divisions, GPs, Deputising Services and GP cooperatives, about the current financing arrangements, creating a barrier to service provision and the development of quality cooperative service arrangements.

This paper outlines the current financing arrangements for after hours primary medical care services in Queensland, discusses the implications of these, and proposes possible solutions for ensuring quality after hours services provision.

Introduction

The financing of after hours primary medical care services in Queensland is sourced from two distinct areas, namely public financing through the Medicare Benefits Schedule (MBS) and the Practice Incentives Program (PIP), and private financing, such as through medical corporates and private hospitals. The current financing arrangements work on a market-driven approach to service delivery, with financing based mainly on fee-for-service and patient through-put.

The continuing viability of the provision of after hours services is an important issue for after hours service providers. With the current government incentives through the MBS and PIP supporting individual practices and deputising services to provide on-call type services, larger GP cooperatives and local extended rota rely on patient through-put and private funding to remain viable. Another implication of the current financing arrangements is that while the coverage of after hours within a practice works well in many instances and provides a quality service, anecdotal evidence suggests in some areas this has resulted in up to half of the GP workforce on call on any one given night.

The current national focus on developing solutions to the provision and financing of quality after hours primary medical services, provides the opportunity for the Divisions network to participate in the debate. This paper outlines the current issues and possible future scenarios for discussion by Queensland Divisions, GPs, after hours service providers and State Government. As the issues and possible solutions are refined, recommendations can be developed for inclusion in the national debate and national policy development.

Current Financing Arrangements for After Hours Services in Queensland

Commonwealth financing – Medicare

Rebates for after hours services by general practitioners are paid in accordance with the Medicare Benefits Schedule (MBS). Currently the only item numbers in the MBS which relate specifically to after hours services are for emergency services (Refer

Attachment A). There has been a steady decrease in the number of services provided under these item numbers. This however, does not equate to a drop in after hours service provision, as demonstrated when HIC data is compared with Bettering Evaluation and Care of Health (BEACH) Data[1], the use of after hours item numbers accounts for approximately only 1 in 6 after hours services, or about 16%. Reasons for the low usage of after hours item numbers may include:

- the item numbers relate to emergency call-in services, the growth of extended hours clinics and GP cooperatives based in private hospitals has meant that services provided after hours have shifted to other item numbers;
- many after hours services in rural areas are provided in the hospital and so are not billed to Medicare; and
- the level C house call rebate was until 1 May 2001, higher than an after hours item number rebate. As both item numbers are applicable as most house calls after hours take at least 20 minutes, particularly if the patient is not well known to the doctor, so the GP opts for the item number that best remunerates them (if bulk billing) or their patients the most.

The low usage of after hours item numbers for after hours services can be seen as an access issue for the patient. The cost to the practice to open after hours (facility costs, nursing/receptionist costs, consumerables), provide home or nursing home visit services and cover administration costs is evident in the fee to the patient. Where an after hours item number can be accessed, the patient benefits through a significant drop in co-payment between the cost of the service and the Medicare rebate.

The recent increase in rebates for the after hours item numbers therefore only provides benefits for patients seen by their own on-call GP, but not GP cooperative arrangements. As such this increase is not well targeted at excellence in after hours care.

Commonwealth financing – the PIP

The after hours Practice Incentives Program (PIP) payment was introduced to compensate for the limitations of the current fee-for-service arrangements for after hours care and support high quality and continuity of care (refer Attachment B). The PIP has been a major incentive to solo providers of after hours medical care, particularly in rural areas.

The PIP has proven to be supportive in rural settings, with GPs in rural towns accessing financial support via the PIP. The November 2000 statistics (Attachment B) demonstrate the effectiveness of the PIP for rural GPs, given that 92% of RRMA 4-7 practices in the PIP were receiving Tier Two payments and over 50% receiving Tier Three. This uptake rate increases as rurality increases, with 76% of RRMA7 practices in the PIP accessing Tier Three payments.

During visits in Queensland by QDGP over the last few months with Divisions, Deputising Services and GP cooperatives, concerns have been raised that the PIP and current RACGP accreditation requirements (refer Attachment C) have adversely

[1] Pegram, R; 2000; *After Hours Primary Medical Care Services in Australia – An Analysis of Research, Current Data and Activity;* Canberra.

impacted on innovative cooperative arrangements, particularly in provisional and urban areas, which provide quality services after hours. Examples of this include:

- GPs are able to qualify for the PIP and accreditation simply by referring their patients to an after hours service, with no incentive to participate in that service. In fact, on many occasions there is a disincentive for GPs to participate in cooperative arrangements, as they consequently become ineligible or have reduced eligibility for tier 3 PIP payments by no longer providing all of their own cover. As a result, cooperatives are having difficulty retaining a critical mass of GPs to provide the service. This experience has been cited by a number of cooperatives, including the Cairns Doctors After Hours Service (CDAHS) and the Bayside Division After Hours Medical Cooperative.

- Private hospitals in Queensland have been picking up on the after hours market, advertising to GPs that they will provide a letter to meet accreditation standards (Attachment C) and PIP requirements (Attachment B), if the GPs refers their patients to the hospital after hours. This has impacted on existing GP cooperatives and Medical Deputising Services, with GPs withdrawing their support to GP services as the hospital provides a cheaper alternative. In many instances, the private hospital's emergency department, not staffed by GPs, provides the service. This situation has been experienced at the Gold Coast, where three private hospitals have been actively recruiting GPs and as a result the Medical Deputising Service has stated that they are facing difficulty due to the increasing number of practices that are withdrawing support and referring to the private hospitals.

- Urban areas have a multitude of options in services available after hours. A GP Focus Group held in Brisbane in November 2000 (facilitated by Blue Moon Research and Planning Pty Ltd), indicated a trend towards the GP deciding to cover their patients by telephone after hours, and where a visit is needed, the patient is generally referred to the local private/public hospital. This way the GP is not inconvenienced, receives the PIP and doesn't have to pay any subscription fees or participate in any cooperative after hours service.

Commonwealth financing – Implications

Financing of after hours primary medical care services through the MBS and PIP encourages GP or practice to provide 24 hour on-call services for their patients. There are circumstances and regions where this is appropriate and for large practices works well. For example, in rural areas, the GP provides emergency medicine coverage for their region, usually in a cooperative arrangement, either between practices or with various district hospitals. Urgent after hours consultations are usually seen at District hospitals with all the appropriate nursing support. The increase in the MBS after hours item number is also beneficial in rural areas as the GP is able to access the number, decreasing out of pocket expenses for the patient.

In urban areas, some larger practices are cashing out their yearly PIP payment, dividing by the after hours shifts required to cover the practice during the year, and providing as an on-call recompense to the GP who covers the practice each shift, in addition to any call-out billings. This appears to work well for these practices. Another example of GPs utilising the facilities available and current financing arrangements of after hours primary medical care service delivery is in Rockhampton,

where the private hospitals have arrangements with the GPs in the region to provide a triage system after hours. Where a patient needs to see the GP, the hospital will then notify the GP to attend the patient in the hospital. This way, the GP receives the full benefit of the PIP and the patients receive the full benefit of the MBS, plus triage and safe facilities to work in, with the option of admitting the patient where required. While larger practices can work under these financing arrangements, the issue remains whether it is appropriate, efficient or effective, particularly in urban areas, to have multiple GPs and practices on-call every night.

GP cooperatives do not receive the same benefits from the PIP and are unable to claim the after hours MBS item numbers for their patients, even though they generally provide a quality service and have effectively organised a service that benefits both the doctor and the community. Where GP cooperatives have been established, particularly in provincial regions around Queensland, several similar characteristics can be identified:

- The cooperatives have quality guidelines and peer review processes in place;
- The GPs in the cooperative agree on the positive effect on their lifestyle of a collaborative approach to after hours services, including less on-call requirements, meaning they are no longer required to live close to their practice population, and no pressure to be part of a large practice to share after hours;
- The cooperative is based in a safe environment with good facilities;
- The cooperation of GPs has a positive effect on the GP community, encouraging communication between providers, and promoting working as a team for the collective good (sustaining each others patients during after hours period until their usual GP can take over treatment); and
- A general level of satisfaction amongst consumers, knowing a quality service is available after hours and knowing where to go.

In Queensland, GP cooperatives can be found in most provincial regions, and have recently been established in more urban areas. Areas include Cairns, Mackay, Bundaberg, Bayside and Ipswich. Currently however, GP cooperatives reduce the GPs' eligibility for PIP payments and Medicare after hours rebates:

- Cooperative rosters based at a hospital or clinic, become ineligible for the after hours rebate as they have not had to 'unlock' the practice door to see the patient. This has proven to be a double edged sword. The GPs don't qualify for PIP as they are not covering all their own after hours so income is reduced, cooperative arrangements are more expensive than individual on-call arrangements (with nursing and receptionist costs, facility costs etc), and they can only charge for a standard consultation, thus there is increased cost to patients with larger gap between the standard Medicare rebate and fee charged.
- In cooperative on-call rosters, while the GP can claim the after hours Medicare rebate for services provided, they are often ineligible for Tiers two and three of the PIP as the roster is shared. This means that unlike the practices who cash out their PIP payments to support the GP who provides the on-call service, GPs

involved in cooperatives miss out on this on-call recompense. The best example of this is the Bayside cooperative, where the GP on-call firstly talks to the patient, assesses whether the patient will need to go to the hospital, or meet the GP at a clinic, require a home visit, or can self manage with adequate telephone advice. The GPs in the cooperative indicate that over half their calls do not require them to see the patient, so there is no charge. However, there remains the inconvenience of being woken at 3am, affecting an average of 1 ½ hours sleep, without receiving remuneration for their efforts.

State Government Financing

While Queensland Health does not generally have a role in funding after hours primary medical care services, they do provide funding for after hours services in public hospitals. In rural and remote regions, the public hospital is usually looked after by a GP, who is provided with an on-call allowance to cover the hospital after hours. In any consideration of possible future scenarios for financing after hours service provision, the possibility of an on-call allowance and salary for after hours work instead of fee-for-service would be important.

Private Financing – Private Hospitals, GPs

Another form of financing of after hours services in Queensland is the private sector. GPs, like all private providers in an open market, make choices about what services they are prepared to provide at the price that the customer is prepared to pay[2]. Cooperative arrangements and deputising services, which do not receive subsidisation through the PIP have to look at other sources for increasing their income to cover costs or make a profit. In general, income can only be increased through increasing turnover of patients, increasing fees, charging a subscription fee for referring GPs or gaining income or in-kind support from private companies.

Examples of companies who provide support for after hours services are private hospitals, and corporate entities. Where GP cooperatives are based in a private hospital, the hospital usually provides some form of subsidisation for the service. This can occur in the form of free facilities, nurse triaging or support, access to services such as x-ray, and in some cases sessional payments to the GPs.

Corporate services often provide a salary to GPs to provide both in-hours and after-hours services. Alternatively, extended hours clinics and 24 hour centres are based on fee-for-service, so encourage through-put by advertising to certain markets such as one 24 hour clinic in Cairns that caters to the tourist population. In most cases, GPs work on a roster system, so are required to cover a certain number of nights depending on the number of GPs in the centre. The two 24-hour clinics in Brisbane run through Foundation Health Care, have a separate GP workforce for covering after hours, with a reduced administration fee so that the GP receives more remuneration per patient than during the day. Even so, in recent years, 24-hour clinics are closing down or changing to extended hours, due to the lack of profit in providing after hours services.

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[2]DHAC; 2000; *General Practice in Australia; Commonwealth Department of Health and Aged Care:2000;* Canberra.

Another example of market-led after hours services are deputising services. The financing of deputising services is based on subscription fees by referring GPs and fee-for-service. The subscription fees allow the deputising service to recruit and train staff to provide telephone triage. The GP who is employed by the deputising service is remunerated solely on a fee-for-service basis, which also covers the cost of renting a car, equipping a doctors' bag and a security guard to accompany the GP on home visits.

Discussion

The recent AMA discussion paper on after hours primary medical care[3] points out that policy makers "promote a market model of health care and at the same time blame the market, or expect it to take responsibility for limited access to services at times when market conditions are unfavourable". There are indeed mixed messages from the Commonwealth as to whether after hours primary medical care is a public good or a private service. On the one hand, if it is seen as a private service, then there can be no expectations on general practice to provide after hours services, given that a logical business decision of a practice would be to close when patient volume decreases[4]. The RACGP standards and indications from the Commonwealth on the other hand, suggest that general practice has a moral obligation to ensure 24-hour coverage for their patients.

If the provision of after hours services is considered a public good, appropriate supports need be put in place to ensure quality service coverage. The current remuneration system favours private market-driven services, where practices providing on-call services and their patients receive the most benefit from Medicare and the PIP. The incentive then is for each practice to cover their own patients after hours. Where these incentives are taken up, particularly in urban areas, the result is a multitude of GPs on-call each night but not necessarily an increase in access for the patient to a quality service (with anecdotal evidence suggesting that many GPs simply refer patients who call).

Further thought is needed on the effect of financial incentives on practice. Boyden and Carter[5] suggest that while incentives can influence physician behaviour, there are often detrimental effects not taken into account when incentive schemes are developed. As general practice is market driven, have the financial incentives designed to influence behaviour, also resulted in distorting the GPs' judgement, affecting the type and quality of services provided? For example, the current incentives encourage increased throughput of patients[6] to maintain viability of after hours services, not necessarily quality services, emergency services or collaborative arrangements.

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[3] AMA; 2001; *AMA Position Paper on After Hours Primary Medical Care;* Canberra.
[4]Pegram, R; 2000; *After Hours Primary Medical Care Services in Australia – An Analysis of Research, Current Data and Activity;* Canberra.

[5] Boyden, A; Carter, R; 2000; *The Appropriate Use of Financial Incentives to Encourage Preventive Care in General Practice;* Research Report 18; Centre for Health Program Evaluation).
[6] DHAC; 1998; *General Practice Strategy Review;* Department of Health and Aged Care.

The recent UK review of after hours services[7] found that GPs who took part in a cooperative after hours service or local extended rota secured the benefits of economies of scale, including the ability to maintain higher quality standards and peer review mechanisms. The development of possible future funding mechanisms for after hours service provision needs to recognise and support collaborative arrangements.

Possible Future Scenarios

The current tiers of the PIP provide no incentive for improving after hours medical care arrangements and are of limited benefit to the patient, particularly when referred to emergency medicine facilities and providers. The Queensland After Hours Forum[8] recommended that general practice accreditation; the PIP and RACGP entry standards should reflect appropriate 24 hours medical care. The incentives should be for arranging rosters and collaborative arrangements so patients are covered with a minimum on-call commitment from each GP, with a resultant minimum impairment of normal duties. The Forum also suggested that the current RACGP Standards for accreditation of general practices should be modified to reflect a more collaborative approach to the provision of after hours care.

The PIP, if it remains for after hours services, needs to be amended to encourage improved after hours services including the development and maintenance of quality cooperative arrangements and deputising services, which reflect more optimal GP working behaviours. The dollars may be better spent on infrastructure of after hours services and remuneration for GPs who are actually providing services after hours.

There are many GPs who do not wish to provide services after hours. This is understandable. This reinforces the need for incentives provided by the Government to be directed at the GPs who are providing after hours care, reducing the cost and increasing the access for patients and ensuring that the services that are in place are of a high quality standard. **The establishment of a payment system for accredited GP cooperatives to provide after hours services would be one possible solution.** The benefits of such a system include:

- The incentives would be for GPs in a specific region to work together rather than a multitude of GPs to be on call on any one night,
- The payment system would benefit those GPs who participate in a cooperative, not the GPs who simply refer as in the current payment system;
- The payment system would acknowledge the extra costs (both actual and opportunity costs) involved in the establishment and maintenance of a quality cooperative service; and
- There would be accreditation standards ensuring the cooperatives being funded meet set quality requirements.

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[7] Department of Health; 2000; *Raising Standards for Patients – New Partnerships in Out-of-Hours Care;* Department of Health; UK.
[8] Siggins Miller Consultants; 1999; *Queensland After Hours Forum – Hosted by the Department of Health and Aged Care on behalf of the General Practice Adivsory Council;* DHAC; Queensland.

The incentive system could be through the existing government financing initiatives such as the PIP or Medicare. For example,

- if the third Tier of the PIP included accredited GP cooperatives and deputising services providing 24 hour cover, these services would then be required to meet set quality requirements, and would provide incentives for other GPs to participate. The PIP payment could be distributed by the cooperative to the GPs in proportion to the work they perform; or

- if there was a Medicare after hours item number that only accredited GP cooperatives could access, providing equivalent remuneration to that of the existing after hours emergency item numbers, the incentive would be to integrate services and form or participate in cooperatives; or

- if Medicare was "cashed out" for a region to a Division (as with the Hunter After Hours Service), which is then responsible for assessing local need, negotiating with players and establishing and supporting (including salary for GPs) a quality after hours service; or

- if the Government had a Tendering process, where one service per specified region would gain the contract and appropriate funding to provide after hours services for that region. There could be inbuilt incentives to encourage collaborative model development. Funding could be through access to Medicare item numbers, PIP, or on a salary basis.

Ane of the options for GP cooperatives is working with hospitals in their region. The National After Hours Workshop in March 2001[9] identified the need to explore and define the role of hospitals, both public and private in the delivery of after hours primary medical care. In Queensland, there are a number of GP cooperatives based in a private hospital, with differing levels of support. There have also been trials with public hospitals around Australia and there are a number of public hospitals in Queensland that has a salaried GP on staff to attend to primary care patients. Better funding options that provide sustainable infrastructure support would enable these options to be explored further and reduce the cost barrier to services for the patient.

Another option would be the funding of programs to assess and develop local solutions in each region, through Divisions of General Practice. Divisions have given GPs organisational structures that could address the problems of after hours care at a structural level, by assessing local needs, negotiating with other stakeholders and coordinating services. Many Divisions around Australia have already undertaken projects to assess local patterns of service provision, and possible cooperative models[10].

In Queensland, most of the collaborative after hours arrangements to date have not originated from a Division. The key-identifying component of current collaborations is the existence of a GP champion, who went out into the region, had a plan,

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[9] Pegram; 2001; *The After Hours Workshop* In: National Networks: Issue 27:April 2001; Commonwealth Department of Health and Aged Care; Canberra.
[10] Access SERU; 1999; *After Hours General Practice Services: A Guide for Divisions of General Practice;* Access Support and Evaluation Resource Unit; University of Melbourne.

organised/solicited support and got the service started. Where Divisions have been involved, they have mainly provided administrative support. The GP Strategy Review[11] indicated that Divisions could play a main role in new financing systems with Divisions being vehicles for sessional or other non fee-for-service payments for amalgamation, cooperatives and sharing arrangements.

For Divisions to take a more active role in the facilitation of service delivery, such as indicated above, additional financial support would be needed to take on the assessment, facilitation, negotiation and coordination role. An example of a recent funding initiative that supported Divisions to take an active role in the coordination of services is the MAHS project. This type of program would encourage Divisions to assess the need in their local area and coordinate and facilitate the development of support for quality after hours service delivery.

Conclusion

The current position of the Commonwealth is that in order to achieve system change in after hours primary medical care, policies and initiatives need to be developed that are efficient in their delivery and operation, effective in terms of health outcomes, integrated with the rest of the health system, financially and humanly sustainable in the medium to longer term and which address actual problems rather than simply a desire to change[12]. The Commonwealth supports the establishment of GP cooperatives and the recent Budget has provided funding for infrastructure development grants and establishment of 32 new sites around Australia. **It is expected however, that the cooperative service will be self-sustaining once established, even though cooperatives are not supported through the current financing arrangements.**

The recent focus of national debate on after hours services has centred on the level and type of service that should be available after hours. A key component of this is how that service should be funded. As demonstrated above, the current financial remuneration for after hours service provision has both positive and negative implications that impact on the type of delivery, accessibility and quality of care available in the community.

As national policy is developed in this area, it is important to carefully consider the full implications of the financial incentives and how the current infrastructure could be best utilised to ensure a quality service with optimum access for consumers. The upcoming Tender process for up to 32 new after hours service sites around Australia, could also provide the opportunity for Queensland to develop and test a range of financial models for the delivery of after hours primary medical services.

[11] DHAC; 1998; *General Practice Strategy Review;* Department of Health and Aged Care.
[12] Briggs, L; 2001; *Extract from Speech "After Hours in the Broader Policy Context" at the National After Hours Primary Medical Care Workshop, 22, 23 March 2001.*

ATTACHMENT A

MEDICARE REBATES FOR AFTER HOURS SERVICES

The Medicare Benefits Schedule lists the following item numbers as specific to after hours emergency services: 1,2,97,98,601,602,697,698 (refer below for individual item description).

Item numbers 1,2,601 and 602 relate to services provided by recognised GPs, while item numbers 97,98,697 and 698 relate to other medical practitioners. HIC statistics for Medicare items processed from July 1999 to June 2000, shows that in Queensland the utilisation of after hours item numbers compared to national figures was:

After Hours Item Numbers for recognised GPs:	Queensland Services:	National – Total Services
1	22,606 (42.1%)	234,719 (61%)
2	19,060 (35.5%)	85,219 (22%)
601	3,794 (7.1%	45,535 (11.8%)
602	8,268 (15.4%)	19,411 (5%)
Total	**53,728**	**384,884**

After Hours Item Numbers for OMPs:	Queensland Services:	National – Total Services
97	33,302 (61.1%)	132,122 (60.5%)
98	4,994 (9.2%)	29,126 (13.3%)
697	13,146 (24%)	49,908 (22.9%)
698	3,079 (5.6%)	7,129 (3.3%)
Total	**54,521**	**218,285**

Other points to note in relation to the After Hours Item Numbers:

- The item numbers only relate to the first patient attended (i.e. where more than one patient is seen, the second service can only be billed at the standard item rebate.
- Items 2,602,98, 698 relate to services provided in consulting room (where practitioner specifically re-opens the consulting room to attend patient), where Items 1,601,97,697 relate to services provided at a place other than consulting rooms;
- Items 1,2,97,98 relate to after hours (7-8am M-F, 8pm – 11pm M-F, 1pm – 11pm Sat and 7am – 11pm Sunday), while Items 601,602,697,698 relate to unsociable hours (11pm – 7am any day of the week).

Extract from Medicare Schedule:

Item 1 - $59.45 – Professional attendance being an attendance at other than consulting rooms, by a general practitioner on not more than 1 patient on the 1 occasion – each attendance, other than an attendance between 11pm and 7am, on a public holiday, or a Sunday, before 8am or after 1pm on a Saturday or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday, where the

attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment.

Item 2 - $59.45 – Professional attendance being an attendance at consulting rooms, by a general practitioner on not more than 1 patient on the 1 occasion – each attendance, other than an attendance between 11pm and 7am, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance.

Item 97 - $50.95 – Professional attendance being an attendance at other than consulting rooms, by a medical practitioner (not being a general practitioner) on not more than 1 patient on the 1 occasion – each attendance, other than an attendance between 11pm and 7am, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment.

Item 98 - $50.95 – Professional attendance being an attendance at consulting rooms, by a medical practitioner (not being a general practitioner) on not more than 1 patient on the 1 occasion – each attendance, other than an attendance between 11pm and 7am, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance.

Item 601 - $71.10 – Professional attendance, being an attendance at other than consulting rooms, by a general practitioner on not more than 1 patient on the 1 occasion – each attendance on any day of the week between 11pm and 7am, where the attendance is initiated by or on behalf of the patient in the same unbroken after-hours period and where the patient's medical condition requires immediate treatment.

Item 602 - $71.10 – Professional attendance, being an attendance at consulting rooms, by a general practitioner on not more than 1 patient on the 1 occasion – each attendance on any day of the week between 11pm and 7am, where the attendance is initiated by or on behalf of the patient in the same unbroken after-hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance.

Item 697 - $61,55 – Professional attendance, being an attendance at other than consulting rooms, by a medical practitioner, (not being a general practitioner) on not more than 1 patient on the 1 occasion – each attendance on any day of the week between 11pm and 7am, where the attendance is initiated by or on behalf of the

patient in the same unbroken after-hours period and where the patient's medical condition requires immediate treatment.

Item 698 - $61.55 – Professional attendance, being an attendance at consulting rooms, by a medical practitioner (not being a general practitioner) on not more than 1 patient on the 1 occasion – each attendance on any day of the week between 11pm and 7am, where the attendance is initiated by or on behalf of the patient in the same unbroken after-hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specifically open, consulting rooms for the attendance.

ATTACHMENT B

THE PRACTICE INCENTIVES PROGRAM

The introduction of the Practice Incentives Program (PIP) followed recommendations from the General Practice Strategy Review (1998). The PIP is intended to compensate for the limitations of the current fee-for-service arrangements by rewarding aspects of practice which are considered to be high quality and which support continuity of care[13]. The after hours PIP payment is based on ensuring patients have access to 24-hour care and is intended to help resource a quality after hours service arrangement. After hours is required by the PIP in part because it is perceived to be important to consumers, a view consumers themselves support[14,15].

The General Practice Financing Group (GPFG) developed the payment formula that comprises after hours payments in three tiers. The three tiers are:

- Tier One - Ensuring patients have access to 24-hour care (all practices qualify for this payment);
- Tier Two - On average, the practice covers at least 15 hours per week of its after hours arrangements from within the practice; and
- Tier Three - The practice provides 24-hour coverage from within the practice.

A recent edition of the Australian Doctor indicated that changes to the PIP for after hours are on the way. The article stated that the rules would be tightened so that "GPs who refer patients to hospitals will have to be included on the hospital's after hours roster if they want to continue to receive after hours incentive payments."[16] The last draft of the new PIP guidelines from the GPFG did not go as far as the article suggests in "tightening the rules", so it is as yet still unclear as to what changes will be implemented in July 2001.

The PIP figures for November 2000 indicated that of the 5,252 practices in the PIP, 100% were receiving Tier One, 71% were receiving Tier Two, and 29% were receiving Tier Three. By RRMA, this equates to:

	RRMA1	RRMA2	RRMA3	RRMA4	RRMA5	RRMA6	RRMA7
Tier 1	3453 (100%)	413 (100%)	309 (100%)	318 (100%)	620 (100%)	50 (100%)	89 (100%)
Tier 2	2201 (64%)	289 (70%)	254 (82%)	287 (90%)	584 (94%)	39 (78%)	79 (89%)
Tier 3	812 (24%)	110 (27%)	84 (27%)	133 (42%)	328 (53%)	26 (52%)	68 (76%)

[13] Commonwealth Department of Health and Aged Care; 2000; *General Practice in Australia: 2000;* Canberra.
[14] Stewart-Weeks, W; Cameron, I; Brooks, M; Patterson, K; Robson, J; Moore, L; 1996; *Integrating Consumer Views about Quality in General Practice;* In Albany Consulting Group (Ed); Australian Government Publishing Service; Canberra.
[15] Blue Moon Research & Planning Pty Ltd; 2000; *The Provision of After Hours Primary Medical Care – Exploratory Research Conducted with Members of the Community;* DHAC; Canberra.
[16] Australian Doctor; 2001; *'Unfair After Hours PIP Rules Changed'*; 16 February 2001.

ATTACHMENT C

RACGP STANDARDS

Ensuring adequate provision of after hours services to their patients is a RACGP standard and a requirement of registration. The provision of "reasonable 24 hour medical care" is a condition of the Entry Standards for General Practice that has been adopted by the Australian General Practice Accreditation Limited (AGPAL) for the purposes of General Practice Accreditation. In particular, Standard 1.1.6 states that:

> The practice ensures reasonable arrangements for 24 hour medical care for patients of the practice.
>
> Indicators:
>
> A. There is documentary evidence of one of the following:
> a) The practice doctor(s) provide(s) their own 24 hour cover either individually or through a roster; or
> b) Arrangements for cooperative after hours care involving one or more local practices; or
> c) Arrangements with a Medical Deputising Service accredited according to RACGP Standards for Medical Deputising Services by an appropriate accrediting body, or
> d) Arrangements with a local hospital or other after hours health care facility.
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> B. The patient records contain reports or notes of out of hours consultations and visits made by the practice, the deputising service, hospital or other medical practitioner.
>
> C. There is an after-hours message on an answering machine. Alternatively, the practice has call diversion, a paging system or a mobile phone.
>
> D. The practice information sheet describes after hours care arrangements including an after hours telephone number.
>
> E. There is a sign visible from outside the practice stating how to access after hours care (eg telephone number).