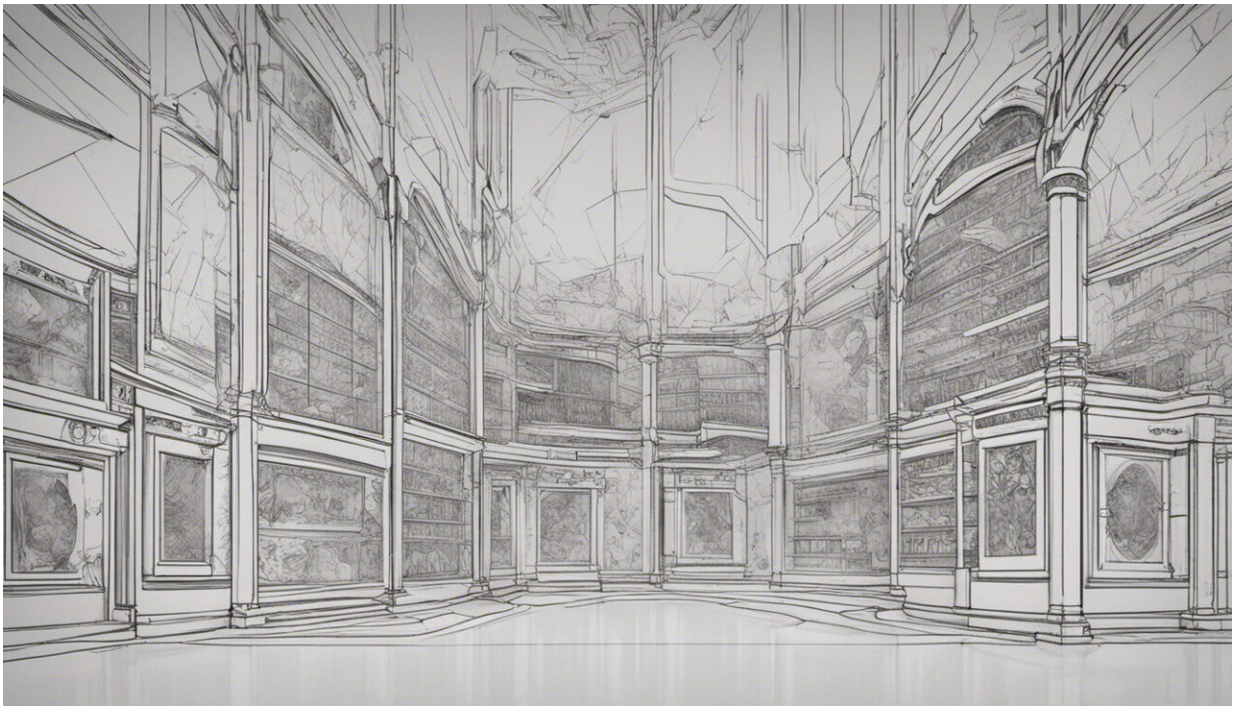
Our study found after-hours GPs actually do reduce visits to emergency rooms

June 9 2017, by Chris Ifediora



Credit: AI-generated image (disclaimer)

A task force reviewing more than 5,700 items covered by the Medicare Benefits Schedule (MBS) released a preliminary report this week on urgent after-hours GP services funded through the MBS.

The government-appointed task force reviewed these services amid

growing concern doctors were inappropriately using the "urgent" item (number 597) to bill Medicare, as it attracts a higher rebate than a standard consultation. Most commonly, the focus was on the inappropriate use of this item by medical deputising services (MDS) – companies that employ registered medical practitioners to provide after-hours care.

The task force recommended greater guidance on when and why urgent after-hours items should be used; and restrictions on the use of these items to GPs working predominantly in normal business hours who might be called out to see their patients in an after-hours emergency.

Supporters of after-hours home medical services say the growth in Medicare claims associated with urgent, after-hours GP services reduces government spending as fewer people use emergency departments. The task force panel stated it was:

… 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.

However, the results of our independent research suggest otherwise. In our survey of patients who had used deputising services, nearly half of them reported they would have attended an emergency room had an after-hours GP been unavailable.

What our study found

The number of government-approved deputising providers has grown from 16 in 2006 to 83 in 2014. Research has also shown a rapid increase in claims reported for all after-hours Medicare items. Calculations by some researchers found the number of claims for item 597 increased by 170% between 2010-11 and 2015-16.

Previously reported research in the Australian Family Physician showed that, rather than reducing the need to visit the emergency department, the rise of deputising services has been accompanied by a slight increase in visits. This is in stark contrast to what we found.

Our research, published in the journal Family Practice, explored whether after-hours home visits had an effect on patients' use of emergency department (ED) services in Australia.

The study was based on a survey of patients seen after hours by home doctors from MDS companies over the last week of January 2016. We reached out to all the registered MDS companies in Australia at the time of the survey, and identified eligible patients among those who agreed to participate. Anonymous questionnaires were sent out to these patients. We received a total of 1,211 valid responses.

We had no preconceived idea of what we might find. It is worth noting that our study design allowed for possible findings of either an increase, a decrease, or perhaps no impact at all on ED presentations.

Around 40% of our survey respondents (that is 486 patients) stated they would have gone to the ED on the day or night they used the after-hours home service had the service not been available to them. But we also found that, following the after-hours doctor visit, 103 patients, or 8.5% of the total seen, still ended up going to the ED (for the same ailment) within one week of being attended to.

This means 383 patients did not go on to use ED services, a decrease of 78.8% relative to the original 486. We found this decrease was Australia-wide and cut across all patient demographics.

Our findings show that after-hours home doctor services do have a significant impact on reducing the use of ED services in Australia, from

the patient's perspective at least.

Why use a patient survey?

Surveying the consumers of a particular service is an effective method of exploring its impact. Patients, or consumers, relay what their intentions were in using the service, what their options were, and how they rate the services received. In the case of the after-hours services, we believed the patients would give the best indicator of what they might otherwise have done had the service not been available to them.

We do acknowledge our approach may be limited in that it relies on self-reporting by the patients. This may introduce some elements of bias and potential accuracy issues, as they would have to recall their intentions and actions prior to and after the consultations with the after-hours doctors. This is why we conducted the survey within one week of the service the patients received. Our questionnaire also made clear the response was specific to the service received in the stated time.

Ours is the first study in this area using a patient-centred approach. Most publications, looking at the impact of after-hours care on ED presentations, either rely on ED records over time, or on Medicare billing data, to make assumptions about correlation. Findings based on these other methods may claim any identified increase or decrease in ED presentations could be attributable solely to the existence of after-hours services.

This is despite the fact other factors might influence these figures in that same period. For instance, periodic outbreak of illnesses, such as the recent "thunderstorm asthma" outbreak in Melbourne, might increase ED attendances, while the establishment of other medical services (such as telephone medical services or office-based after-hours services) might decrease such presentations.

Some of these studies also don't differentiate the severity (acuity) of the ailments of the patients in their analysis. After-hours home doctors generally see patients who are not severely sick (called low-acuity patients). These can include those experiencing vomiting, minor wounds, moderate pain or shortness of breath (classified in EDs as categories 3 to 5). So, any survey of the impact of after-hours GP services on ED presentations would need to focus on these categories – for equal comparison.

Most cases in categories 1 and 2 (such as major trauma or heart attacks) would likely call an ambulance, not the after-hours GP. For these reasons, while the approaches of other studies have some merits, we feel that results from such studies may not be wholly reflective of the actual impact of after-hours services.

We recommend the government and other stakeholders commission a larger (and perhaps longer) version of our study. This will provide a first-hand idea of the actual impact of these services, rather than relying on "assumed" impacts.

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