
Review of after hours primary health care

Report to the Minister for Health and Minister for Sport

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Executive Summary

Background

In response to a recommendation from the Review of Medicare Locals undertaken by Professor John Horvath AO in March 2014, the Minister for Health, the Hon Peter Dutton MP, announced this Review of after hours primary health care (the Review), to consider the most appropriate and effective delivery mechanisms to support ongoing after hours primary health care services nationally.

In his Review, Professor Horvath found significant stakeholder frustration associated with Medicare Local (ML) responsibility for funding after hours primary health care and considered it timely to reflect on the appropriateness and effectiveness of the current delivery strategy.

Contextually, the timing of this Review is pertinent, given the establishment of Primary Health Networks (PHNs) and the transfer of responsibilities from MLs from 1 July 2015.

Method

A variety of methodologies have informed this Review, including a stakeholder written submission process, analysis of the submissions received for the Review of Medicare Locals, interviews with many key stakeholders and opinion leaders, six targeted in-depth case studies, analysis of Medicare Benefits Schedule (MBS) and Practice Incentives Programme (PIP) data and a desktop review of international models of after hours primary health care.

Context

Across the country, availability and access to after hours services varies considerably. Both the Commonwealth and states/territories invest considerable resources to meet after hours demand. There is heterogeneity in arrangements, both across and within MLs, states and territories – particularly in rural areas. In addition, after hours service options are not well articulated nationally and consumers do not have visibility of an overall structure for appropriate after hours services.

The Commonwealth Government plays a significant role in directly funding and supporting after hours primary health care. In 2013-14, funding of approximately \$769 million was provided through the MBS (\$604.6 million), MLs (\$122.11 million) and Healthdirect Australia's After Hours GP Helpline (\$42.17 million). The Commonwealth also part-funds Healthdirect Australia's nurse triage helpline with all states and territories. This investment is on track to increase, with a 68 per cent increase in after hours MBS items over the six year period from 2008-09, particularly over the past 2 years. Whilst the MBS items themselves were not within the parameters of this Review, primary care after hours policy settings, delivery strategies, infrastructure and administrative arrangements which drive this expenditure, are.

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Key Themes

Key themes were evident across the Review.

Infrastructure

Medicare Locals

It is clear that the approaches employed by MLs to funding after hours services and their subsequent success, varied significantly across the country. The majority opted to continue with payments essentially mirroring those of the Practice Incentive Programme After Hours (PIPAH) incentive but with new contractual requirements set by the Department of Health. Such arrangements created additional red tape for practices, processes were needlessly complex and reporting obligations were onerous. This, and the approach by some MLs to directly compete with existing services, damaged General Practitioner (GP) goodwill locally.

However, innovative solutions addressing local after hours gaps and unmet need were also evident in some areas and the valuable lessons from these examples should inform future planning.

Medical Deputising Services

Medical Deputising Services (MDSs) play a critical role in accessible, quality after hours primary care, particularly in urban settings. The sector has seen much recent change, with many locations across the country experiencing an increase in numbers of, and competition between, MDSs. This parallels an increase in MBS after hours utilisation, particularly for residential aged care facilities (RACFs). Within this context, informants raised issues relating to medical support for RACFs (both in and after hours), optimal use of after hours care provided by MDSs and the financial drivers for most appropriate use.

After Hours Providers:

Most ML catchments described a complex array of after hours workforce providers, reflecting their historical service patterns, state government support and integration and location. It was clear that existing services and infrastructure could be utilised much more efficiently and effectively with a regional plan that drew all players together in a more integrated service delivery pattern. Improved promotion and integration of Healthdirect Australia (HDA) services and the National Health Services Directory (NHSD) was also seen as a priority.

It was also clear that a sharper focus on appropriate triaging for care that cannot wait until usual hours is necessary. Better utilisation of eHealth solutions to allow consumers to self-manage where relevant, enhance communication with the patients' regular general practice and improve continuity of care, were also seen as important.

Consumer expectations and needs

Most respondents indicated that consumers often had limited knowledge of the variety of services available to them and how to best utilise them to access the most appropriate after hours care. Consumers also expressed the need for better integration and coordination of existing services.

Better health literacy around which after hours services to use and how to access them would increase consumer knowledge, accessibility, appropriateness and efficiency. International

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evidence suggests that graduated access to after hours services through an understood national approach may assist consumers in accessing the right after hours option for their needs.

Central role of General Practice

General practice was seen by the majority of respondents to be the foundation of after hours care, with the ability to make rapid, appropriate and cost effective assessments of the after hours health care needs of known patients. The practice infrastructure in hours was also seen to impact on extended hours care, if consumers were unable to access same-day appointments with their regular GP.

Respondents indicated that the previous PIPAH incentive had not calibrated the tiered payments effectively to meet desired community outcome. Many suggestions were made concerning improvements, particularly related to remote access, eHealth and phone triage opportunities.

In the primary care setting, after hours services need to be provided by experienced and suitably qualified primary care physicians with appropriate clinical governance in place. This should support continuity of care and effective communication between after hours service providers and a patient's regular GP.

Delivery challenges in rural and remote locations

The experience of patients accessing after hours services in rural and remote areas differs considerably from metropolitan areas. General practices in rural and remote locations have a broad scope of practice and are managing increasingly complex patients, often with hospital admission responsibilities.

State and territory government support and service models, though highly variable, were seen to be extremely important in delivering optimal outcomes. Financial viability and workforce attraction and retention issues were also tied closely to after hours service responsibilities. The rural after hours workforce is heterogeneous - reflecting remoteness, mix of available clinicians and community need.

It is clear that the after hours role and funding certainty is central for rural and remote practice operation and that the link with hospital responsibilities and support is a critical one.

Appropriate and effective delivery strategies

Across general practice there is an overwhelming desire to return incentivising after hours service arrangements back to a PIP payment. However, support for a return to a PIP was seen by most respondents as an important but not complete solution to the appropriate provision of population based after hours support. Incentive funding for general practice should not negate a potential role for PHNs in local communities and PHNs could take a positive role in improving after hours service integration and innovation.

The Minister's announcement in May 2014 to streamline a number of the current PIP payments into a single incentive, focusing on continuous quality improvement, was also supported as a means to focus on the key domains of community general practice care of value.¹ Many

¹ Dutton, P 2014 speech presented at the Australian Medical Association National Conference – Global Practice, Australian Perspective, National Convention Centre Canberra, 23 May 2014.

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respondents indicated that after hours care whilst an integral component, is but one of a number of key practice roles, essential to high quality community health care.

Effective and deregulated administrative arrangements

An appropriately designed, targeted and implemented PIPAH incentive would greatly simplify current arrangements, reduce reporting burden, target most desirable practice after hours support and provide financial certainty to general practices who provide holistic care.

Of equal importance, is a clearly-articulated approach to link consumers appropriately with the myriad of options for local after hours support, particularly in urban areas. This would encourage much greater consumer awareness and choice, minimise unnecessary administration costs and increase effectiveness and appropriateness of available after hours care. This should be accompanied by appropriate consumer awareness initiatives, locally and nationally.

Appropriate mechanisms for information sharing and data collection

Established and emerging eHealth solutions have great potential to improve after hours health care. These should be locally relevant, support consumers to improve health literacy and self-manage, ensure communication with the patients' regular general practice where possible and improve continuity of care.

Providing after hours service providers with contemporary clinical information has the potential to assist with better understanding patient health care needs and most appropriate management. A timely feedback mechanism to the patient's usual 'medical home' (general practice, Aboriginal Community Controlled Health Service, rural multipurpose service etc) is also essential to maximise high quality, safe, ongoing care.

Opportunities to encourage the utilisation of the patient electronic health record in diagnosis, care design and clinical hand-over should be considered; this should include an Advanced Health directive where appropriate.

More broadly the integration of the NHSD with existing websites, to facilitate both consumer and provider education, awareness of services and appropriate use and access, has great potential. A model to underpin such consumer and provider awareness is at Executive Summary Attachment A, *Consumer After Hours Access Cascade*.

After Hours GP Helpline

The After Hours GP Helpline (AHGPH), funded by the Commonwealth through HDA, received a mixed evaluation with a number of concerns raised. These included: the suitability of conditions being referred to the AHGPH; advice resulting in unnecessary presentations to emergency departments; the high average cost per call; and limited consumer awareness.

A more detailed evaluation of the cost/benefit of the AHGPH is beyond the scope and timeframe for this Review.

Residential Aged Care Facilities

RACFs were consistently identified as high and increasing users of after hours primary care services, due to a complex interplay of workforce, compliance, organisation and accreditation related issues. In turn, the flow-on effects have a major impact on hospital utilisation, in

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particular hospital emergency departments. Many respondents considered after hours demand from RACFs to be a consequence of broader systematic failure of in hours medical support for the sector, which should be recognised and addressed proactively.

Potential solutions to RACF after hours care involve an ‘all-of-system’ approach, which should be tailored locally.

Conclusion

After hours primary health care is a central tenant of a high quality health care system. This Review has highlighted opportunities to improve the efficacy and efficiency of after hours primary health care coverage across the country and better empower health consumers to utilise the most appropriate supports.

Recommendations

The following recommendations are presented for the Minister’s consideration.

Recommendation 1

The Commonwealth resumes responsibility for after hours funding of general practice from Medicare Locals from 1 July 2015.

Recommendation 2

A revised Practice Incentives Programme (PIP) After Hours incentive is accessible for accredited general practices from this date.

The revised PIP should:

- appropriately remunerate general practices for after hours patient care;
- utilise tools such as the Standardised Whole Patient Equivalent (SWPE) to weight practice size, age and rurality; and
- reward practices providing telephone triage for their own patients.

Performance Indicators for this PIP should be outcome-focused and easily collectable.

The final design of the revised incentive should involve consultation as soon as possible with the PIP Advisory Group (PIPAG).

Recommendation 3

From 1 July 2015, Primary Health Networks (PHNs) receive funding to work with key local after hours stakeholders (including Local Hospital Networks (LHNs), Medical Deputising Services (MDSs), consumer groups, Aboriginal and Torres Strait Islander representatives, the private health sector and non-government organisations) to plan, coordinate and support population-based after hours health services. Their focus should be on gaps in after hours service provision, vulnerable groups and service integration.

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Recommendation 4

The Commonwealth works with key stakeholders to urgently examine the rapid escalation in utilisation of after hours MBS items. The Department of Health should identify the relevant drivers responsible and work with PHNs and local stakeholders to develop optimal utilisation of this resource.

Recommendation 5

The adoption of an expanding variety of eHealth applications to support consumer self-management and improved links between providers and after hours service delivery is recommended. This should involve input from after hours stakeholders, proven technology leaders, state and territory government telehealth directorates and the National E-Health Transition Authority and include opportunities to facilitate the transfer of clinical summaries via an electronic health record.

Recommendation 6

Residential aged care after hours service needs and provision are complex, with a high and increasing service utilisation, particularly from MDSs. This Review recommends the Department of Health engage with key clinicians from primary and acute care, residential aged care organisations, MDS and other relevant stakeholders to identify innovative solutions, applicable locally and consider an appropriate role for PHNs.

Recommendation 7

Palliative care involves a similarly complex interplay between patients, carers, families and service providers both in and out of hours. Palliative care should be a special focus for local service planning.

Recommendation 8

Consumers are frequently unaware of the many after hours support options available to them. A clearly articulated pathway for consumers to access high quality after hours advice and support should be developed. This should identify the many support modalities available (quality web-based self-help sites, after hours support via the family general practice, after hours cooperatives, MDSs, ambulance services and emergency departments) and indicate those most appropriate for the care required.

This pathway should be provided to PHNs for local customisation and broad community dissemination.

Recommendation 9

MDS accreditation should include a requirement for deputising services and others providing after hours care outside the practice to return clinical summaries within 24 hours to the patient's regular practice.

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Recommendation 10

As state funded after hours support plays an important role in rural and remote settings, after hours service planning should be integrated as part of PHN/ LHN local service delivery mapping.

States and territories vary widely in their rural after hours models of care. Best practice approaches should be identified at state level and discussed with a view to broader implementation via the National Rural Health Standing Committee or the Council of Australian Governments' Health Council.

Recommendation 11

MDSs play a critical role in after hours care. However, the rapid increase in deputising service utilisation of MBS items raises questions around the appropriateness of a purely fee-for-service funding model for the sector. Funding for MDSs should be considered to strike a better balance between infrastructure and activity based funding for a sector with unpredictable and uneven service demand.

MDSs are accredited deputising services and access to after hours should happen via a patient's regular general practice, rather than through direct marketing.

Recommendation 12

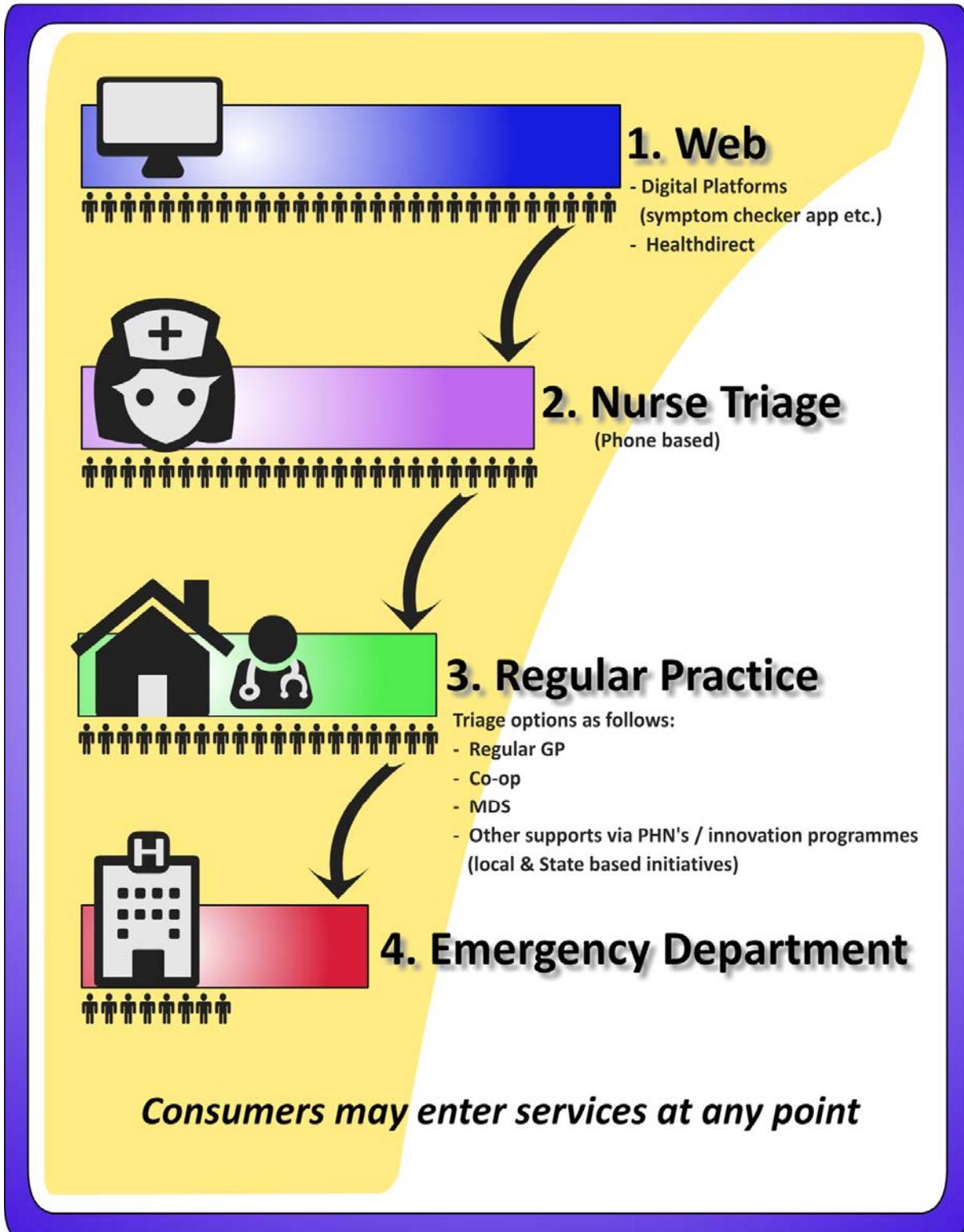
The After Hours GP Helpline (AHGPH) was incepted to relieve after hours pressure on regional and rural General Practitioners (GPs) and support GP continuity of care. However there is limited evidence that this has occurred. Direct Commonwealth funding to the AHGPH should not continue in its current form beyond the completion of the 30 June 2015 contract, with funding reallocated to support innovative after hours services delivery locally.

A need to relieve pressure on GPs in regional and rural areas and improve the continuity of care after hours remains a priority. Therefore population based after hours planning should identify the need for GP phone support, best linkages and application. Innovation funding for this purpose should be available for PHNs that submit appropriate applications, endorsed by local stakeholders.

Recommendation 13

Many stakeholders identified after hours care as only one component of high quality comprehensive general practice care. Other elements included in hours service flexibility, eHealth excellence, comprehensive chronic disease management and effective integration of care. This Review recommends the further development of the PIP to recognise and reward the practice infrastructure required to deliver to Australians high quality comprehensive primary care. This should be progressed by the PIPAG.

Consumer After Hours Access Cascade



1 Introduction

On 19 August 2014 the Minister for Health announced a Review of after hours primary health care services (the Review) to consider the most appropriate and effective delivery mechanisms to support ongoing after hours primary health care services nationally.

The Review is a response to a recommendation from the Review of Medicare Locals conducted by Professor John Horvath. Professor Horvath found significant stakeholder frustration associated with Medicare Locals (MLs) being responsible for funding after hours primary health care and considered it important to reflect on the appropriateness and effectiveness of the current delivery strategy.

Stakeholders from across the health system have actively supported this Review and have highlighted the challenges of delivering after hours services across a variety of providers, locations and funders. Contextually, the timing of the Review is pertinent given the establishment of Primary Health Networks (PHNs) and the transfer of responsibilities from MLs necessitates new funding arrangements for after hours primary health care from 1 July 2015.

This Report outlines the findings from the Review and offers the Minister 13 recommendations for consideration.

The Australian Government has a number of wider policy settings that are relevant to this Review. These include:

- the desire to reduce the administrative burden ('red tape') on health care providers;
- emphasising the primacy of frontline services and reducing the need for 'back office' functions;
- placing general practice at the centre of the primary health care system; and
- taking a system wide perspective that places the patient at the centre of the care and minimises any barriers that may impede patients who need to move across community, primary, secondary and tertiary sectors. This is particularly relevant for the increasing number of people with multiple chronic conditions.

2 Terms of Reference

The Terms of Reference for the Review included consideration of:

- the central role of General Practitioners (GPs) and general practice in delivering after hours services;
- the policy settings required to generate innovative solutions;
- appropriate and effective delivery strategies, taking into account current and available mechanisms;
- existing infrastructure and services;
- effective and deregulated administrative arrangements;
- appropriate mechanisms for information sharing and data collection;
- opportunities for improved engagement with the private sector;

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- delivery challenges in rural and remote regions;
- consumer expectations and needs;
- findings from previous evaluations of the After Hours Primary Health Care Programme; and
- any transition to new arrangements, including timing.

Note: After hours Medicare Benefits Schedule (MBS) items were not within the scope of the Review.

2.1 *Methods to address the Terms of Reference*

To inform recommendations for the consideration of the Minister, the Review drew upon a variety of methods including:

- *Stakeholder submissions:* The Department of Health invited selected stakeholders to make submissions to the Review. In total, 81 submissions were received (Attachment A provides additional information on the submissions).
- *Analysis of submissions for the Review of Medicare Locals:* All submissions to the Review of Medicare Locals were reviewed to identify comments relating to after hours. A total of 69 submissions were identified as making reference to after hours issues.
- *Interviews with key stakeholders:* Interviews were held with 33 key stakeholders and opinion leaders. Attachment B provides details of organisations and individuals interviewed.
- *Case studies:* six targeted case studies were conducted to provide in-depth analysis of after hours themes and issues. The case studies were conducted by Ernst & Young and included:
 - the After Hours GP helpline;
 - Central Coast New South Wales Medicare Local;
 - Country North South Australia Medicare Local;
 - Hunter Medicare Local;
 - Goldfield-Midwest Medicare Local; and
 - Metro South Brisbane Medicare Local.

Further information is included at Attachment C.

- *Analysis of MBS and PIP data:* MBS after hours and Practice Incentives Programme (PIP) after hours incentives payment data were assessed nationally, by jurisdiction and by ML. This is explored in further detail at Section 3.6.
- *Desktop review of international models of after hours (out of hours) health care:* a targeted international desktop review was conducted by the Department of Health to identify international approaches to after hours primary health care. This is explored in further detail at Section 3.4.
- *Desktop review of existing evaluations:* selected evaluations of the After Hours GP Helpline (AHGPH) and ML after hours initiatives were assessed as inputs to the Review.²

²The Review Terms of Reference include consideration of findings from previous evaluations of the After Hours Primary Health Care Programme. For the purpose of this Report these findings have been considered as an input into the key issues and recommendations.

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The Department of Health provided administrative support for the Review and participated in interviews with key stakeholders.

3 Background information

3.1 Review of Medicare Locals

In March 2014, Professor Horvath presented the Minister for Health with his key findings and recommendations from the Review of Medicare Locals.³

The Review of Medicare Locals was specifically tasked with considering the performance of MLs in administering programmes, including those relating to after hours. Professor Horvath found significant stakeholder frustration with the implementation of the Medicare Locals After Hours (MLAH) Programme associated with: service contract complexity and conditions; excessive additional reporting burdens for general practices; and, instances where MLs established services to operate in direct competition with existing general practices or duplicated state-funded services. In implementing their after hours arrangements some MLs damaged GP goodwill, something that organisations tasked with strengthening primary health care could ill afford.

Professor Horvath reported that it was timely to reflect on the appropriateness and effectiveness of the current delivery strategy of after hours incentives and recommended that the MLAH Programme should be reviewed to determine how it could be effectively administered. This Review is a result of the Minister's endorsement of all of the Review of Medicare Locals recommendations.

Attachment D provides additional information on the Review of Medicare Locals.

3.2 National Context

When people become ill outside normal business hours they often need to access after hours health care services or advice. Choice of which service to access are influenced by a range of factors such as where they live, the time of day and the accessibility of health care services and mode of delivery. Primary health care is often the first port of call in meeting after hours health care needs across the country and in so doing reducing health inequity, lowering rates of avoidable hospitalisation and improving health outcomes.

Primary health care is considered to be the cornerstone of strong health care systems that produce better health outcomes at a lower cost.⁴ The organisation and provision of after hours primary health care services is both an important element of the overall health care system and a challenging policy area. Access to primary health care, including after hours, is considered an important element of high quality health care.^{5,6}

The after hours period has traditionally been defined as: being before 8.00 am and after 6.00 pm on weekdays, before 8.00 am and after 12.00 pm on Saturday and all day on Sunday and public holidays.⁷

³ Horvath, J 2014, [Review of Medicare Locals: Report to the Minister for Health and Minister for Sport](#), viewed 9 September 2014.

⁴ World Health Organisation 2008, [The World Health Report 2008: Primary health care \(now more than ever\)](#) viewed 12 September 2014.

⁵ Shi L, 2012, "The Impact of Primary Care: A Focused Review", *Scientifica*, vol 2012 (2012), Article ID 432892.

⁶ As reflected in the Royal Australian College of General Practitioners (RACGP) standards for general practices for care outside normal working hours (Criterion 1.1.4) in: RACGP 2010, *Standards for general practice (4th edition)*.

⁷ These hours are also categorised into the following periods: 6.00 pm to 11.00 pm as the 'social hours' and

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Contemporary society businesses, including general practices, are increasingly open earlier and remain open later, extending their hours into the defined after hours period. For example, in the community pharmacy sector, extended and seven day trading hours are required to meet the health care demand of customers and patients.⁸ Data from the Pharmacy Guild of Australia's census shows the following national average extended hours for community pharmacies:

- Saturdays – 96 per cent are open, with 61 per cent open all day;
- Sundays – 42 per cent are open all day;
- Public holidays – 35 per cent are open all day;
- Thursday – 46 per cent are open during late night trading hours; and
- Friday – 42 per cent are open during late night trading hours.⁹

After hours primary health care is defined as 'accessible and effective care for people whose health condition is urgent and cannot wait for treatment until regular services are next available'¹⁰. Within this definition, after hours primary health care is to meet the urgent patient needs that cannot wait until the time a patient's regular general practice is open, it is not intended to be a substitute for medical care that could otherwise occur 'in hours'.

A number of national strategic documents over recent years have discussed the challenges of providing efficient, accessible and appropriate after hours services for all Australians. Australia's First National Primary Health Care Strategy highlighted the significant disparity in the level of access to after hours primary health care across Australia and the importance of achieving the right balance of financial incentives and funding arrangements to deliver effective and flexible services at the local level.¹¹ The National Strategic Framework for Rural and Remote Health reflected on the role of after hours strategies to improve recruitment, retention and distribution of rural GPs.¹²

The primary care sector itself has a number of policy documents related to after hours service provision. The Royal Australian College of General Practitioners (RACGP) 4th Edition *Standards for General Practice* (the Standards) identify an after hours responsibility for general practices as part of their accreditation requirements.¹³ Almost 6,000 Australian general practices currently meet these Standards.

The Standards also set specific criteria related to accreditation for Medical Deputising Services (MDSs). Most MDSs are accredited to these Standards.

In 2012 the RACGP released its vision for the general practice sector to 2020. 'A Quality General Practice of the Future' identifies after hours care for the practice population as an integral element of practice.¹⁴

All jurisdictions have individual policy frameworks regarding after hours access to emergency departments for non-admitted patients.

11.00 pm to 7.00 am as the 'unsocial hours'.

⁸The Pharmacy Guild of Australia, 2014, [Pharmacy Guild Submission to Productivity Commission – Issues Paper: Relative costs of doing business in Australia: Retail Trade Industry](#), viewed 16 October 2014.

⁹Ibid.

¹⁰Australian Government 2013, *Guidelines for after hours primary care responsibilities until 30 June 2013*.

¹¹Commonwealth Government 2010, *Australia's First National Primary Health Care Strategy*.

¹²Commonwealth of Australia 2012, [National Strategic Framework for Rural and Remote Health](#), viewed 12 September 2014.

¹³RACGP 2010, *Standards for general practice (4th edition)*.

¹⁴RACGP 2012, [A quality general Practice of the Future](#), viewed 12 September 2014.

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In 2013, the funding model for after hours care underwent significant change, with the redirection of all funding from both the PIP After Hours (PIPAH) incentive and the grants based General Practice After Hours (GPAH) to MLs. Under the revised arrangements, MLs administered funding to incentivise and support general practices to be available to deliver after hours services and more broadly to fill gaps in after hours primary health care services. In addition, the Commonwealth also funded an extension to the nurse helpline provided through Healthdirect Australia (HDA), the AHGPH, to provide telephone access to a GP in the after hours period.

3.3 Existing after hours infrastructure and services

Across the country availability and access to after hours services varies considerably. Both the Commonwealth and states/territories invest considerable resources to meet after hours demand. There is heterogeneity in arrangements, both across and within states and territories – particularly in rural areas where arrangements range from medical officers with rights to private practice (e.g. Queensland) to other states that delegate after hours responsibility to Commonwealth funded services, with a multitude of after hours options for consumers. After hours service options are not well articulated nationally and consumers do not have visibility to an overall structure of after hours services. In 2013/14 there were approximately 9.7 million after hours medical services provided by the MBS, equating to expenditure of \$604.6 million.¹⁵

In addition to these services, there are emergency department presentations during the after hours period.¹⁶ During 2012-13, about 3.8 million presentations in public hospital emergency departments commenced after hours (56 per cent). The percentage of after hours activity varied between triage categories. About 28,300 “Resuscitation: Immediate” triaged emergency department presentations (63 per cent) commenced after hours. For the remaining triage categories, about 413,800 “Emergency” triaged presentations (58 per cent), 1.3 million “Urgent” triaged presentations (58 per cent), 1.7 million “Semi-urgent” triaged presentations (57 per cent) and 304,600 “Non-urgent” triaged presentations (46 per cent) commenced after hours.¹⁷ In 2011/12, the Independent Hospital Pricing Authority calculated the average cost per admitted emergency department presentation to be \$1,037 and the average cost per non-admitted emergency department presentation to be \$422.¹⁸

Conceptually, after hours arrangements can be considered in terms of six models that are utilised either alone or in various combinations:¹⁹

Practice Based Services

Most general practices choose to provide their patients with after hours access, either through phone triage, consultations in the practice, via MDSs or through home visits. As at June 2013 under the previous PIPAH incentive, approximately 4,600 practices (66 per cent of all general practices) put in place arrangements for their patients to access after hours care. Of these practices, approximately 1,600 (23 per cent of all general practices) provided at least ten hours of

¹⁵ Unpublished Department of Health MBS statistics

¹⁶ The after hours definition with regard to emergency department presentations is slightly different to that employed under the MBS. After hours services are defined as physical presentations to an emergency department which occur: on a public holiday; on a Sunday; before 8 am or after 1 pm on a Saturday; or before 8 am or after 8 pm on any other day.

¹⁷ AIHW 2014, [Non-admitted Patient Emergency Department Care National Minimum Data Set](#), viewed 17 October 2014.

¹⁸ Commonwealth of Australia, Independent Hospital Pricing Authority 2014, [National Hospital Cost Data Collection Australian Public Hospitals Cost Report 2011-2012, Round 16](#), viewed 21 October 2014,

¹⁹ Anikeeva O, 2012, *After-hours primary care*. RESEARCH ROUNDup, [Issue 25 Adelaide: Primary Health Care Research & Information Service](#).

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after hours care to their patients, while a further 1,200 (17 per cent of all general practices) provided 24 hour care to their patients.²⁰

Rural practices participating in the previous PIPAH incentive were much more likely than metropolitan practices to provide 24 hour care to their patients, with 68 per cent of remote practices (RRMA7) providing full access, dropping down progressively by RRMA category to 18 per cent of metropolitan practices (RRMA1).²¹

Medical Deputising Services

As defined by the National Association for Medical Deputising Services, a MDS is an organisation which directly arranges for medical practitioners to provide after hours medical services to patients of Practice Principals (registered medical practitioners) during the absence of, and at the request of Practice Principals.²² A registered medical practitioner may externally contract the after hours components to a MDS to ensure continuous access to care and continuity of care to practice patients. A MDS is required to operate and provide uninterrupted access to care, including home visits, for the whole of the after hours period.

While exact figures are not known, it is clear that there has been significant growth over recent years in the numbers and population coverage of MDSs. Many locations have experienced an increase in the number of these services that now bulk bill.

The growth in MDSs has been reflected in the growth of the number of service providers approved under the Department of Health's Approved Medical Deputising Services Programme (AMDSP). The purpose of the AMDSP, which was established in 1999, is to expand the pool of available medical practitioners who may work for MDSs. Under the AMDSP otherwise ineligible medical practitioners can provide a range of restricted professional services, for which Medicare benefits will be payable, where the medical practitioner works for an approved MDS. The number of providers approved under the AMDSP has more than quadrupled from 16 in 2006, to 83 in 2014.²³

Cooperatives

Cooperatives involve general practitioners from a number of different practices working together to provide care to patients, outside the normal opening hours of their practices, often via roster arrangements. Patients who receive care via these arrangements are then referred back to their regular practice for ongoing monitoring. Practice GPs who participate in cooperatives were able to count this service towards their practice's Tier 2 eligibility (to provide at least ten hours of care per week) under the previous PIPAH incentive.

Telephone Triage and Advice Services

Healthdirect Australia

HDA commenced operation in July 2007. HDA (trading name of the National Health Call Centre Network Ltd) was established and is jointly funded by the Australian Government and the governments of the Australian Capital Territory, New South Wales, Northern Territory, South Australia, Tasmania and Western Australia to deliver the Network's services. The services currently provided include:

- a 24/7 telephone-based nurse triage, information and advice service operating in all states and territories except Queensland and Victoria which operate state-specific services;

²⁰ Unpublished Department of Health PIP statistics.

²¹ RRMA: Rural Remote and Metropolitan Areas.

²² National Association for Medical Deputising Services 2012, [Definition of a Medical Deputising Service](#), viewed 20 October 2014.

²³ Unpublished Department of Health NAMDS Statistics.

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- the national Pregnancy, Birth and Baby Helpline and website service which provides access to information, support and counselling for women, partners and their families 24 hours a day seven days a week in relation to pregnancy, birth and the first 12 months of a baby's life;
- an After Hours GP Helpline which provides a telephone-based GP medical advice service for people who require medical advice and who cannot access their usual health service;
- online symptom checkers which provide information and guide people to the appropriate type of care at the appropriate time;
- mindhealthconnect, which facilitates access to a range of trusted mental health resources and services; and
- the National Health Services Directory (NHSD) which provides easy access to reliable and consistent information about health services.

After Hours GP Helpline

The AHGPH, operated by HDA, is funded solely by the Commonwealth and was implemented as an extension to the telephone-based nurse triage service. As detailed at Section 3.6.3, funding of \$42.17 million was provided for the operation of the AHGPH in 2013-14.

The AHGPH is intended for people whose health condition cannot wait for treatment until regular general practice services are next available, cannot see their usual GP out of hours, do not know where to access after hours care or are not sure what they should do. The AHGPH operates from 6 pm-8 am Monday to Saturday, from 12 noon Saturday to 8 am Monday, and 24 hours on national and state/territory public holidays.

With the exception of Queensland and Victoria, patients who call the AHGPH are initially triaged by an HDA registered nurse and transferred to a telephone GP if determined appropriate.

Callers from Tasmania, once triaged by an HDA nurse as needing to speak with a telephone GP, access an after hours GP through the Tasmanian GP Assist service, delivered by the Tasmania Medicare Local appointed service provider.

Callers from Queensland and Victoria can access the after hours GP helpline through the HDA national phone number (which diverts to the relevant state based service) or through 13HEALTH and NURSE-ON-CALL respectively.

Private Health Insurance Providers

Some private health insurance providers link members specifically with after hours support via MDSs and/or designated 24 hour nurse triage and advice services. Others expect members to utilise their existing after hours supports e.g. regular general practice or public or private emergency department services.

Internet Based Services

In addition to the services provided by HDA there are a number of reliable websites operated by jurisdictional governments (eg Better Health Channel, <http://www.betterhealth.vic.gov.au/betterhealth>) and non-government organisations which provide people with 24 hour access to information which may be of assistance.

Emergency Departments

Consumers requiring high acuity or inpatient care are on-referred to local emergency departments. Consumers may also self-refer depending on the nature of their problem, their understanding of available options and convenience.

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3.4 International Context

Each country approaches its after hours service provision model differently. A short summary of the model used in a number of countries is provided below.

Denmark

Danish GPs are the frontline of Danish health care, 24 hours a day, seven days a week. Services include the primary care out-of-hours service which is run by GPs on a rota basis on weekdays and throughout weekends and public holidays.²⁴

In 1993, a national system of telephone assessment by fully qualified GPs was introduced. This system provided callers with over-the-phone advice and became the entry point to after hours care. Calls to the after hours service via one single telephone number in each region are answered and triaged by GPs. The GPs either complete the call as a telephone consultation or refer the patient to either a clinic consultation or a home visit. In some locations, access to after hours services within local health systems is restricted to patients that have been triaged by GPs. The after hours service is part of a fully computerised patient record system and all patients are registered by their unique personal identification number.²⁵ An electronic copy of the after hours record is sent to the patient's own GP and data are transmitted to the regional administration for remuneration purposes and to the Danish National Health Service Register for Primary Care. The out-of-hours service is funded by the local commissioning organisation, a local state organisation which also funds the other parts of the GP system. Reforms to remuneration of GPs supported the reforms of after hours – fees were designed to encourage telephone handling rather than home visits.

UK

Traditionally, all after hours primary care was provided by the patient's GP. With the introduction of new National Health Service (NHS) contracts from April 2004, GPs have been able to opt out of responsibility for after hours care (at an average cost of £6,000) in favour of Primary Care Trusts (PCTs). PCTs generally underestimated the costs of delivering after hours services – provisions of £322m were provided to PCTs to reflect the known costs of the existing service, but the costs of the new service were higher (costs were estimated to be 22 per cent higher overall which had considerable financial implications for PCTs). NHS data show that some 10 per cent of GP practices have retained responsibility for after hours services. Opted-in GP practices receive more funding than others given their extra responsibilities, typically equivalent to 6 per cent of their total budget (around £4 per registered patient).

After hours primary care is now part of a wider system of NHS urgent and same-day care services, including NHS Direct, walk-in centres, minor injury units and NHS 111. The plethora of different services and often fragmented delivery, causes confusion amongst patients about which services to access and when.²⁶ There are many examples of GP-led organisations, sometimes based on former after hours cooperatives, providing excellent after hours care for commissioners or opted-in practices. These services frequently integrate different aspects of the local urgent care service with local general practice. Overall the performance of after hours services is considered to be improving and access to services is easy and rapid.²⁷

²⁴ Flarup L, Moth, G, Christensen, M, Vestergaard, M., Olesen, F and Vedsted, P 2014, "A feasible method to study the Danish out-of-hours primary care service", *Danish Medical Journal*, vol 61, no. 5, A4847

²⁵ Ibid

²⁶ NHS England 2013, [High quality care for all, now and for future generations: transforming urgent and emergency services](#), viewed 20 October 2014.

²⁷ Clay, H 2012, [Benchmark of out-of-hours: An overview across the services](#), Primary Care Foundation, United Kingdom.

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Since April 2013, the usual route for people to access after hours GP services is to call NHS 111. Non-clinical call handlers use a clinical assessment tool called 'NHS Pathways' to get information about the caller's symptoms and direct them to the appropriate service (e.g. arrange for a clinician from the after hours GP service to call the patient back, book the patient an appointment at the nearest after hours clinic, or arrange for an after hours GP to visit the patient at home). Shortly after implementation of NHS 111, major problems were experienced that put both after hours services and emergency departments under additional pressure, in particular issues relating to inexperienced staff following a script based algorithm, which leads to highly risk-averse outcomes. Emergency department attendance is reported to have increased in some areas as a result of the introduction of NHS 111.²⁸ In one area, 999 call volumes are said to have increased by 8 per cent after NHS 111 went live.²⁹

Netherlands

The GP contract in the Netherlands requires 24 hour patient cover. After hours primary care in the Netherlands is available from 5 pm to 8 am on weekdays and all weekend and conducted on a relatively large scale. Primary care physicians (PCPs) undertake after hours services in cooperatives of 40 to 250 physicians.³⁰ Physicians who choose to participate in a cooperative receive per-hour salary compensation. Each cooperative, usually situated near or in a hospital, serves populations ranging from 100,000 to 500,000 citizens.³¹ Most cooperatives require patients to contact a triage nurse by telephone (a single, regional telephone number) prior to attending the cooperative in person.

Patients seeking after hours services call the cooperative and are triaged by nurses (usually with a physician at hand) whose advice includes self-care, visit their GP the next day, visit a GP at the cooperative or refers the patient to either an emergency department or ambulance service.³² Patients reported high levels of satisfaction with the after hour services, though those who received only self-care advice tended to be less satisfied. The GP after hours workload has reduced to an average of around four hours per week. Issues identified in after hours services include the use of nurses for triage and the lack of information exchange between GP practices and the cooperatives.

New Zealand

In New Zealand's 'dual system' of health care services, care provided in public hospitals is free to users. However primary and acute care services delivered in the community require user co-payments that are set by the primary care provider. High levels of co-payments are still common for after hours services. Two related problematic consequences of high co-payments have been identified. Firstly, co-payment levels for after hours services may lead patients to opt for emergency departments where there are no user charges for health needs that can be addressed in primary care, contributing to stresses on emergency department capacity. Secondly, the level of patient co-payments may deter appropriate primary care utilisation, particularly for high needs populations.

²⁸ British Medical Association 2013, [Developing Out of Hours Care in England. A position paper from the BMA General Practitioners Committee](#), viewed 20 October 2014.

²⁹ Ibid

³⁰ Giessen, P, Smits, M, Huibers, L, Grol, R. Wensing, M 2011, "Quality of after hours primary care in the Netherlands: a narrative review," *Ann Intern Med.* 155:108-113.

³¹ Commonwealth Fund n.d., [Spotlighting International Innovation Ensuring Access to After-Hours Care](#), viewed 20 October 2014.

³² Ibid

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Auckland

Auckland Region After-Hours Network (ARAHN)³³ consists of 11 Accident and Medical (A&M) centres, three District Health Boards and seven Primary Health Organisations (PHOs). These ARAHN organisations collectively fund two interventions in the Auckland region that were introduced on 5 September 2011. The first of these is the A&M intervention which covers subsidisation of patient co-payments for medical visits to 11 A&M medical clinics across the Auckland region for eligible patients and extension of opening hours of some of these participating A&Ms to 10 pm.

The second ARAHN-sponsored intervention is the telephone triage intervention which involved the expansion of access to an after hours telephone triage service offered by HomeCare Medical Limited (HML), a company owned by Auckland's largest PHO, ProCare³⁴. Under the After hours Initiative, 11 participating A&Ms contracted with ARAHN to guarantee access every day of the year between 8 am and 10 pm. Many of the participating clinics already opened until 10 pm, but these opening hours became a condition for participation in the after hours initiative. HML is set up as a service which is an extension of GP within hours care. It is not the only provider of telephone triage advice in Auckland, other well-established services including HealthLine and Plunketline are also in this space. However, HML is the only large service attached to general practice. HML reports its patient contacts back to the GPs.³⁵

USA

Huge variations exist in after hours service availability and accessibility across the US. Five models of after hours primary care models have been identified³⁶:

- same PCP all of the time – e.g. solo practices;
- PCP plus practice partners, usually limited late hours and 24/7 phone coverage e.g. small practices;
- PCP plus small local cross-coverage network e.g. rural practices;
- PCP plus large cross-coverage network (owns urgent care centres) e.g. integrated delivery systems; and
- PCP plus quasi-exclusive relationship (contractual arrangement) with a third party urgent care centre or after hours clinic.

Many of the Health Plans and Managed Care Organisations have introduced nurse led telephone advice services. These seek to ensure patients access the most appropriate level and type of care, including self-care. Some insurers do not cover the cost of self-referral to emergency departments.

Kaiser Permanente in Northern California uses 'video visit technology' enabling physicians working in the Appointment and Advice Call Centre to conduct visits to patients.³⁷ These visits often provided immediate and convenient solutions for people who otherwise would have had to

³³ Tenbenschel T 2014, *Evaluation of A&M HML Telephone Triage, and St John Transport Initiatives* (Prepared for: Research Partnerships Health Research Council of New Zealand and The Ministry of Health), University of Auckland, Auckland.

³⁴ Ibid

³⁵ Ibid

³⁶ O'Malley, A.S, Samuel, D, Bond, A.M, Carrier, E 2012, "After hours Care and its Coordination with Primary Care in the U.S., *Journal of General Internal Medicine*, Vol. 27, No. 11, pp. 1406–15.

³⁷ Pearl, R 2014, "Kaiser Permanente Northern California: Current Experiences With Internet, Mobile, And Video Technologies," *Health Affairs*, Vol 33, No. 2, pp. 251-257.

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travel to an emergency department for a clinical evaluation. Patients requiring immediate in-person care were directed in the video visit to seek care at a nearby emergency department – the physician then placed the information in the patient’s electronic health record, facilitating treatment when the patient arrived at the emergency department.

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Canada

The administration and delivery of healthcare in Canada are the responsibility of each province (state) or territory. Canada has thirteen provincial and territorial health care systems that operate within a national legislative framework, the Canada Health Act 1984.³⁸

Canada defines after hours care, in the context of family practice, as providing care to all practice patients outside of normal office hours.³⁹ While there are no legal requirements for GPs to work after hours, there is an incremental fee structure to incentivise them.⁴⁰ Canada also uses public hospital emergency departments as a service provider for after hours and as a result public hospitals are over-run, with long wait times. Centralised telephone health advisory systems have also become one of the available options and are now often the first point of contact for patients seeking after hours care in Canada.

3.5 National after hours service delivery environment

3.5.1 Practice Incentives Programme

The PIP provides payments to general practices to support activities that encourage continuing improvements and quality care, enhance capacity and improve access and health outcomes for patients. To be eligible to participate in the PIP, a practice must be accredited, or registered for accreditation, against the RACGP *Standards for general practices*. Practices must achieve full accreditation within 12 months of joining the PIP and maintain full accreditation thereafter.

In 2013-14, almost 5,400 practices participated in the PIP. There are currently ten incentives in the PIP: they link with asthma; cervical screening; diabetes care; eHealth; GP aged care access; Indigenous health; rural loading; procedural GP payment; quality prescribing; and practice-based teaching.

The PIP Advisory Group (PIPAG) is a committee that provides advice and assistance to the Department of Health on the development, implementation and modification of PIP incentives. The group currently comprises representatives from: the Australian Medical Association, the RACGP, the Australian College of Rural and Remote Medicine, the Rural Doctors Association of Australia, the Australian Association of Practice Managers and the National Aboriginal Community Controlled Health Organisation.

The PIPAH incentive was introduced in August 1999 to encourage general practices to make sure their patients have access to quality after hours care. The incentive included three cumulative tiers as outlined in the table below:

³⁸ Hutchison, B, Levesque, J-F, Strumpf, E, and Coyle, N 2011, "Primary Health Care in Canada: Systems in Motion," *The MilBank Quarterly*, Vol. 89, Issue 2, pp256-288.

³⁹ Craighton, E, Bordman, R, Wheler, D, Franssen, E, White, D, Bovert M, Drummond, N 2005, "After hours care in Canada," *Canadian Family Physician*, Vol. 51, pp. 504-1505.

⁴⁰ NAMDS 2014, *After Hours Medical Care Services in Australia*, *NAMDS After Hours Primary Medical Care Summary Paper*, viewed 12 September 2014,

<http://www.namds.com/assets/files/After%20Hours%20Medical%20Care%20in%20Australia%20FINAL.pdf>

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Table 1 Practice Incentives Programme After Hours Incentive payment levels

Level	Activity required for payment	Annual payment per SWPE*
Tier 1	The practice makes sure that all regular practice patients have access to 24 hour care from a GP, seven days a week, which may be through formalised cooperative arrangements and must include out of hours visits (at home, in residential aged care facilities and in hospitals), where safe and reasonable.	\$2.00
Tier 2	Practice GPs must provide the minimum level of after hours cover (dependent on practice size) for all regular practice patients. At all other times, practice patients must have access to after hours care through formalised cooperative arrangements. Practices with a SWPE* value of 2000 or less Must provide their practice patients with at least ten hours of after hours cover per week, on average. Practices with a SWPE* value of more than 2000 Must provide their practice patients with at least 15 hours of after hours cover per week, on average.	\$2.00
Tier 3	The practice GPs must provide all regular practice patients with 24/7 care, including out of hours visits (at home, in residential aged care facilities and in hospitals), where safe and reasonable.	\$2.00

* SWPE is used to measure practice size and includes a weighting factor for the age and gender of patients. As a guide, the average full-time GP has a SWPE value of around 1000 SWPEs annually.

The PIPAH incentive was ceased as part of the 2010-11 Budget Measure to “Establish Medicare Locals and Improve After Hours Primary Care”. This measure established a national after hours telephone-based GP medical advice service and tasked MLs with ensuring that face-to-face after hours needs were met. The PIPAH incentive was ceased on 30 June 2013, with final payments made in August 2013.⁴¹

3.5.2 Accreditation

General Practice Accreditation is not compulsory in Australia. However, for a general practice to be eligible to participate in the PIP, it must be accredited, or be registered for accreditation, against the RACGP *Standards for General Practice*. Practices must achieve full accreditation within 12 months of being registered for accreditation and maintain full accreditation thereafter.

The RACGP *Standards for general practices 4th edition* includes Criterion 1.1.4 Care outside normal opening hours. Practices are required to make and be able to demonstrate reasonable arrangements for access to primary medical care services for their regular patients within and outside normal opening hours. Some practices use their own GP to provide care or alternatively use a local cooperative of GPs or a MDS. Where a deputising service is not available, especially in rural areas, practices may have an agreement with a local hospital. Some practices use a combination of all these arrangements.⁴²

⁴¹ Tier 1 of the PIP After Hours Incentive was initially due to cease on 30 June 2011, however was extended for 24 months and was ceased in line with tiers 2 and 3.

⁴² RACGP 2010, [Standards for general practice \(4th edition\)](#), viewed 10 September 2014.

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In July 2013, MLs became responsible for the coordination of after hours medical services within their local areas. In response to this, the RACGP adopted a position in relation to Criterion 1.1.4 of the *Standards for general practice 4th edition* as follows:

- Practices are required to demonstrate that they are aware of the arrangements in place for their patients to access after hours care; and
- Practices are required to have processes in place to alert their patients to these arrangements.

The change to MLs being responsible for the coordination of after hours medical services within local areas created a perception that after hours responsibility was with MLs and no longer with local general practices.

3.5.3 Medical Deputising Service accreditation

To receive accreditation, MDSs must meet the requirements of the RACGP accreditation standards (as outlined in Section 3.5.1). They must also meet the definition requirements for a MDS. The definition of a MDS is outlined at Attachment E.

3.6 Commonwealth investment in after hours primary health care

The Commonwealth Government plays a significant role in directly funding and supporting after hours primary health care. In 2013-14 funding of \$768.9 million was provided through three streams:

- MBS: payments made directly to GPs for patient services which in 2013-14 totalled \$604.6 million;
- MLs: to plan and support face-to-face after hours primary health care services in their regions which in 2013-14 totalled \$122.11 million; and
- HDA: through the joint funded (with the jurisdictions) of the 24/7 telephone-based nurse triage, information and advice service operating in all states and territories (except Queensland and Victoria which operate state-specific services) and the AHGPH which enables after hours callers to be triaged to talk directly to a GP (funding for the AHGPH component totalled \$42.17 million in 2013-14.).

3.6.1 Medicare Benefits Schedule

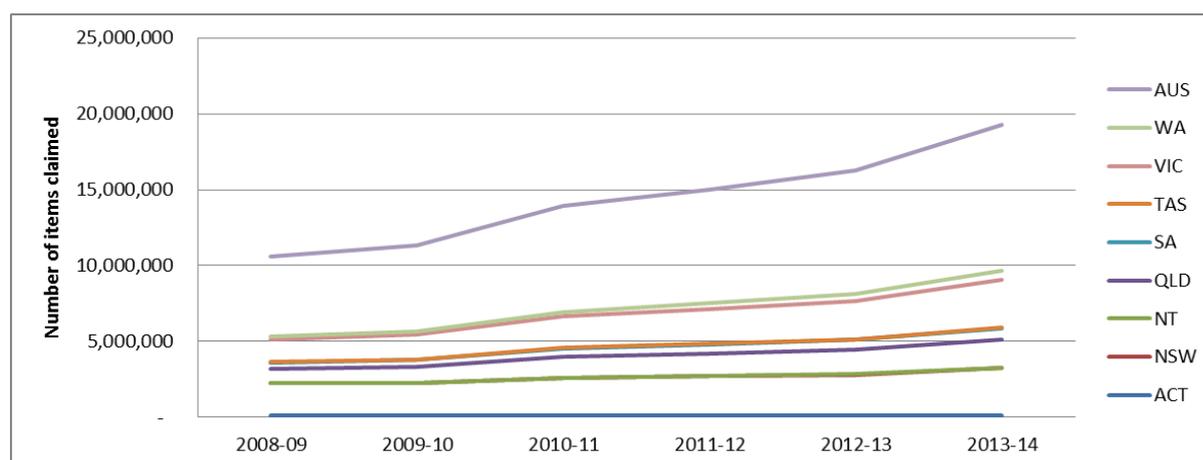
The Commonwealth funds after hours primary care services through MBS items that provide higher rebates for after hours consultations by GPs and medical practitioners.

In 2013-14 there were approximately 19.7 million after hours items (services) that cost the Commonwealth \$604.6 million. Over the six year period from 2008-09, the number of after hours items increased by 68 per cent from 24,683 services per 100,000 people in 2008-09 to 41,393 in 2013-14 with a steep increase from 2012-13.

Figure 1 provides details of the after hours MBS items claimed between 2008-09 and 2013-14.

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Figure 1 after hours MBS items 2008-09 to 2013-14



In summary, the following observations of after hours MBS items at national, jurisdictional and ML levels are noted below.

National

- Urgent attendance MBS services increased by 58 per cent between 2010-11 and 2013-14 from 3,320 services per 100,000 (the first full year of availability) to 5,248. The cost to Government of urgent attendance items in 2013/14 was nearly \$159 million.
- After hours clinic items increased by 41 per cent from 23,470 services per 100,000 people in 2008-09 to 32,994 in 2013/14.
- After hours home visit items – items where the patient’s condition is not urgent and could potentially be delayed until another period – increased by 112 per cent between 2008-09 and 2013-14.
- The most significant increase in utilisation occurred with after hours items provided within RACFs, with an increase of 201 per cent between 2008-09 and 2013-14.
- A significant amount of the growth in urgent attendance items, after hours home visit items and items provided in RACFs are attributable to growth in recent years in MDSs that provide home visiting after hours services on behalf of general practices.

Jurisdictions

- Use of after hours items vary considerably between jurisdictions. Jurisdictions with the largest populations tend to have the highest rates of services per person. For example in 2013-14 in NSW there were 41,842 services per 100,000 people at a total cost to the Commonwealth of \$178.5 million, Victoria 53,619 services (\$190.2 million) and Queensland 38,826 services (\$125.8 million), in contrast the NT had 22,259 services per 100,000 people (\$2.9 million), the ACT 28,073 services (\$5.6 million) and Tasmania 12,869 services (\$4.0 million).
- The rate of growth in after hours items was also variable. For instance, growth experienced from 2008-09 to 2013-14 in the ACT (9 per cent) Tasmania (23 per cent) and NSW (36 per cent) were noticeably less than national growth (68 per cent), whereas the growth in WA (167 per cent) and the NT (132 per cent) were considerably higher. Tasmania is an outlier in that it has the lowest rate of servicing per 100,000 people (about a third of the national average) and the second lowest growth rate; this may be associated with their ongoing GP Assist initiative.
- Urgent attendance MBS items are highly variable across jurisdictions:

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- In 2013-14 in SA, 12,621 services were provided per 100,000 people, whereas only 233 services were provided per 100,000 people in the ACT and 238 in the Northern Territory.
- There have been decreases in services between 2010-11 and 2013-14 in the Northern Territory (-43 per cent growth), ACT (-29 per cent) and Tasmania (-11 per cent), whereas the growth in WA (154 per cent) and Queensland (86 per cent) were much higher than the national average (58 per cent).⁴³
- After hours clinic items varied across jurisdictions, with Tasmania providing the fewest number of services per 100,000 people (10,161) and experiencing the lowest growth (2 per cent between 2008-09 and 2013-14). Victoria and NSW provided the most services per person, whilst NT and WA experienced the highest growth.
- After hours home visit items are available for those consultations that are provided at a place other than consulting rooms, hospital or a RACF. Typically they are provided at the patient's premises. These items are different than the urgent attendance items in that the patient's condition is not urgent and could potentially be delayed until another period.
- There was considerable growth within jurisdictions for after hours home visit items.
 - SA had the highest number of services (2,129 per 100,000 people), followed by Queensland (1,957). The NT (122) and ACT (169) had the lowest rates of services per 100,000 people; and
 - In terms of growth, the ACT is a clear outlier, with growth of 738 per cent (however, the absolute numbers were small), with the lowest rates of growth in NSW (45 per cent) and SA (68 per cent).¹⁵
- Consultations provided within RACFs in after hours periods exhibited considerable growth from 147 per cent in Queensland to 411 per cent in the NT. In 2013-14, the most services were provided in NSW (158,681) and Victoria (156,723) and the least in the NT (404) and ACT (1,861).

3.6.2 Medicare Locals

In the 2010-11 Commonwealth Budget, the former government announced its intention to develop new funding arrangements for after hours primary care services, with MLs funded to 'plan and establish face-to-face after hours services in their region' by 2013-14.⁴⁴ Funding for MLs included the redirection of over \$75 million of expenditure from the PIPAH incentive and the GPAH Programme and just under \$45 million in new money.⁴⁵ Table 2 details the funding provided to MLs through the MLAH Programme.

⁴³ Note: Due to smaller populations, the number of services provided in ACT, Tasmania and NT is comparably smaller than other jurisdictions which make percentage changes more variable.

⁴⁴ Australian Government 2010, *Budget Portfolio Statements 2010-11: Budget Related Paper No.1.11 Health and Ageing Portfolio*, Commonwealth of Australia.

⁴⁵ In 2013-14 a total of \$117.77 million was allocated to Medicare Locals and in 2014-15 \$127.48 million. These allocations became somewhat blurred to Medicare Locals because funding from multiple Commonwealth programmes was pooled into the Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund (Medicare Locals Flexible Fund) with greater freedom given to Medicare Locals to determine the allocation of funding.

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Table 2 After hours funding provided to Medicare Locals

	2011-12	2012-13	2013-14	2014-15
Funding to Medicare Locals	\$8.06 million	\$44.05 million	\$122.11 million	\$127.48 million

The Department of Health outlined the after hours responsibilities of MLs in two documents: *Guidelines for after hours primary care responsibilities until June 2013*⁴⁶ and *Supporting Guidance Developing a stage two plan to commence 1 July 2013*⁴⁷. These guidelines detailed a two stage approach:

- Stage one: up until 30 June 2013 MLs commenced after hours activities and addressing 'priority gaps' including:
 - undertaking after hours primary care needs assessment; and
 - developing and implementing plans to address priority gaps in after hours care; and
- Stage two: from July 2013 MLs were fully responsible for after hours funding, with funding reallocated from the PIPAH incentive and the GPAH programme and additional funding provided to support local after hours services.

Each ML received funding from the Department of Health to plan and support face-to-face after hours services within their region:

- Stage one: funding took into account a number of factors within a region such as rurality, socio-economic status, population age profiles, Aboriginal and Torres Strait Islander populations and culturally and linguistically diverse communities; and
- Stage two: funding was based on an approach where MLs were grouped according to their population level and density, the proportion of people aged 65 years and over, the average and spread of socio-economic indexes for areas (SEIFA) categories, Aboriginal and Torres Strait Islander populations and remoteness.

Approaches adopted by MLs to incentivise and support after hours services varied widely. Many adopted mixed approaches, with the replication of the PIPAH incentive payment for general practices and a combination of grant processes or direct sourcing after hours primary health care services. The case studies conducted as part of this Review provide insight into the methods utilised by MLs to address Department of Health contractual requirements (refer to Attachment C for further information on the case studies).

An evaluation of the After Hours Primary Health Care Programme was conducted by the Centre for Health Policy, Programmes and Economics (University of Melbourne) and reported in September 2013 (Attachment F provides additional information on the evaluation).

The Review of Medicare Locals reported that each ML approached the task of funding after hours services differently. Some adopted mock practice incentive payment methodologies, others used simple grants and others applied regional approaches that negated the need for specific practice support (i.e. via MDSs). In addition the Review of Medicare Locals concluded that:

- The timing of the transition of this programme to MLs to be a significant issue, with the majority of MLs enmeshed in establishment activities while at the same time attempting to implement a complex and controversial reform. For many MLs this was their first

⁴⁶ Australian Government 2013, *Guidelines for after hours primary care responsibilities until 30 June 2013*.

⁴⁷ Australian Government 2013, *Supporting Guidance - Developing a stage two plan to commence 1 July 2013*.

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significant attempt at purchasing and with the benefit of hindsight, given the sensitivities attached to the issue it was probably not an ideal starting point.

- MLs were tasked too early with this sensitive programme reform and it resulted in many of them having to learn their purchasing/commissioning skills by experimenting on after hours GP services.
- The outcome for some catchments appears to have damaged GP goodwill.

The introduction of MLs does not appear to have had a major impact on the provision of after hours MBS services, as growth was relatively consistent throughout the whole period, both before and after the commencement of the MLAH Programme.

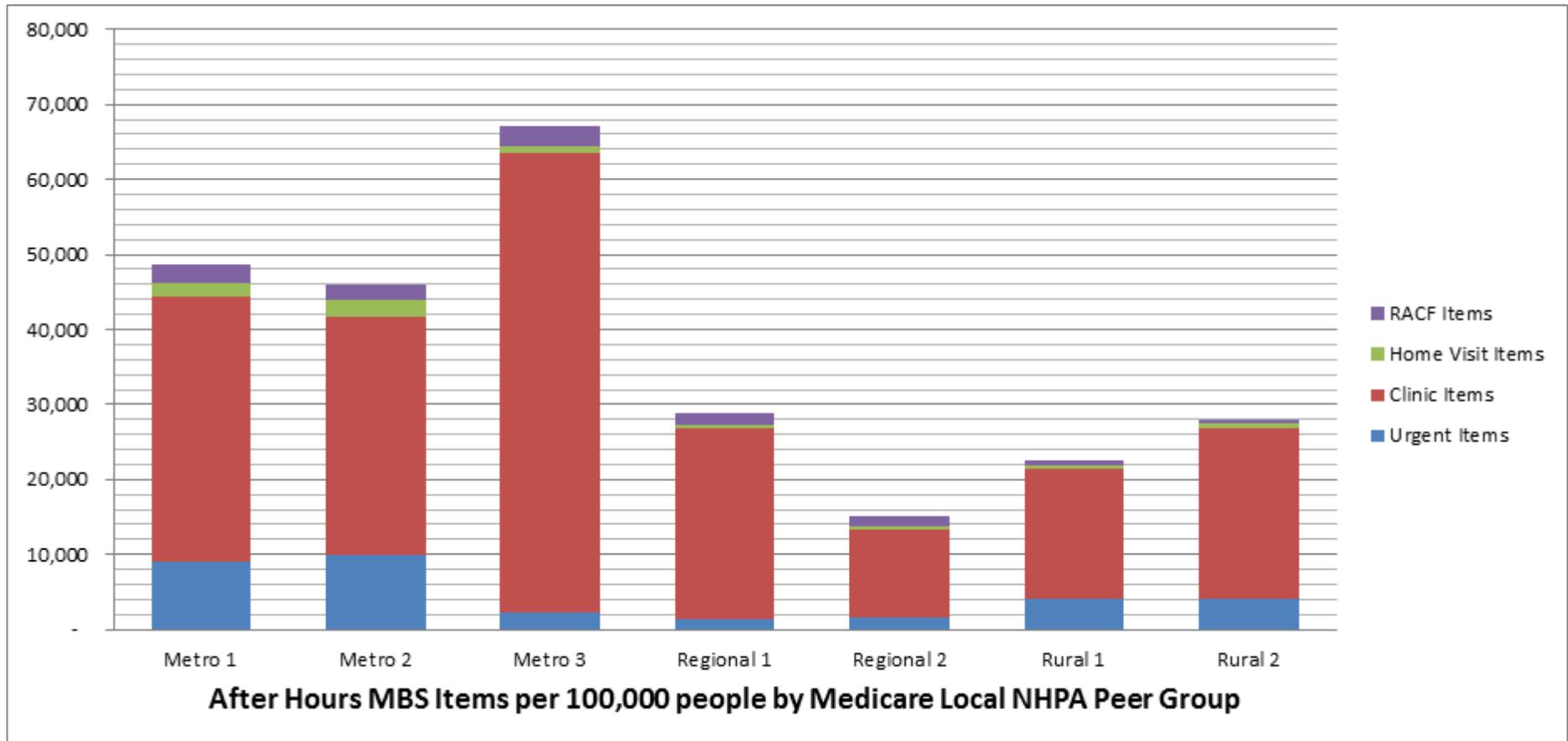
Analysis of MBS usage at the individual ML should be undertaken with caution as the data has been compiled on the location of the organisation providing the service, not the location of the patient receiving the service. As a result the data does not accurately reflect patient services within ML boundaries. This is particularly relevant to metropolitan MLs and large services (such as MDSs) that often provide coverage over a whole region or city, but attribute billings to a single geographic location in one ML. Figure 2 summarises an analysis of Medicare Local MBS usage by National Health Performance Authority (NHPA) Medicare Local Peer Group. As shown, there are considerable differences in MBS usage between the Medicare Local Peer Groups.

- After hours MBS items ranged from 15,010 (Regional 2) to 67,200 (Metro 3) per 100,000 people.
- All urgent after hours ranged from 1,452 (Regional 1) to 10,008 (Metro 2) per 100,000 people.
- Clinic after hours items ranged from 11,721 (Regional 2) to 61,152 (Metro 3) per 100,000 people
- After hours home visits ranged from 359 (Regional 2) to 2,145 (Metro 2) per 100,000 people.
- RACF after hours services ranged from a total of 3,614 (Rural 2) to 132,613 (Metro 3).

The difference in urgent after hours usage is particularly striking, with between 9,000 and 10,000 services per 100,000 people in Metro 1 and 2 Medicare Local Groups at a total cost to Government of \$122.3 million in 2013/14, compared to between 1,000 and 4,000 in all other groups, at a total cost of \$36.1 million. The increased role of MDSs (and the large number of urgent items they claim) in metropolitan areas is likely to account for much of this difference.

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Figure 2 After hours MBS items by Medicare Local (NHPA peer groups)



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3.6.3 Healthdirect Australia and the After Hours GP Helpline

HDA commenced operation in July 2007. HDA (trading name of the National Health Call Centre Network Ltd) was established and is jointly funded by the Australian Government and the governments of the ACT, NSW, NT, SA, Tasmania and WA to deliver the Network's services. The services currently provided include:

- a 24/7 telephone-based nurse triage, information and advice service operating in all states and territories, except Queensland and Victoria, which operate state-specific services;
- the national Pregnancy, Birth and Baby helpline and website service which provides access to information, support and counselling for women, partners and their families 24 hours a day seven days a week in relation to pregnancy, birth and the first 12 months of a baby's life;
- an AHGPH which provides a telephone-based GP medical advice service for people who require medical advice and who cannot access their usual health service;
- online symptom checkers which provide information and guide people to the appropriate type of care at the appropriate time;
- mindhealthconnect which facilitates access to a range of trusted mental health resources and services; and
- the NHSD which provides easy access to reliable and consistent information about health services.

After Hours GP Helpline

The AHGPH was announced in the 2010-11 Commonwealth Budget and commenced operation on 1 July 2011. The AHGPH is intended for people whose health condition cannot wait for treatment until regular general practice services are next available, cannot see their usual GP out of hours, do not know where to access after hours care or are not sure what they should do. It operates from 6.00 pm - 8.00 am Monday to Saturday, from 12 noon Saturday to 8.00 am Monday, and 24 hours on national and state/territory public holidays.

With the exception of Queensland and Victoria, patients who receive assistance through the AHGPH are triaged by a HDA registered nurse and transferred to a GP if determined appropriate.⁴⁸ Callers from Tasmania, once triaged by a healthdirect nurse are transferred to the GP Assist service that is delivered by the Tasmania Medicare Local appointed service provider.

Health professionals who identify themselves when calling the AHGPH can access a fast track service as a way of providing collaborative, professional support, if the call meets the following criteria:

- that there is a nurse with access to the patient;
- that the nurse has already made some clinical assessment;
- that the GP and nurse will have a direct clinical interaction to facilitate care; and

⁴⁸ Callers from Queensland and Victoria can access the AHGPH through the Healthdirect Australia national phone number (which diverts to the relevant state based service) or through 13HEALTH and NURSE-ON-CALL respectively

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- stable airway breathing circulation must be established and an emergency call excluded. The nurse can then be transferred through to the Telephone GP for advice.

If the call originates from an RACF but the caller is either a carer or family member then the Triage Nurse would process the call using the standard call process. (i.e. triage and offer transfer to AHGPH if eligible).

The AHGPH is currently delivered by Medibank Health Solutions.⁴⁹

Since its inception on 1 July 2011 to 30 June 2014:

- a total of 2,570,945 calls have been handled by the Healthdirect nurse triage service;
- of these calls, 532,140 calls were transferred and handled by an after hours service. On average 80-85 per cent of calls are from metro areas;
- of these, 407,274 were handled by the AHGPH, 8,569 were transferred to the Queensland after hours service and 116,297 were transferred to the Victorian after hours service;
- 15.8 per cent of total nurse triage calls have been transferred to the AHGPH (this percentage has been consistent throughout the year); and
- 71.5 per cent of total calls made to the nurse triage service are made during the after hours period.

Table 3: Data on state/territory basis of calls handled by an after hours service since the inception of the after hours helpline

Period	No. of calls	NSW	WA	SA	ACT	NT	VIC	TAS	QLD
1 July 2011 to 25 June 2012	152,595	46.8%	27.5%	16.0%	4.2%	1.6%	2.9%	0.3%	0.1%
26 June 2012 to 17 June 2013	164,270	40%	23%	13%	4%	1%	17%	0.2%	0.5%
18 June 2013 to 30 June 2014	215,275	40%	20%	12%	3.2%	1.2%	22%	0.1%	0.8%

⁴⁹ Contracted until 30 June 2015.

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Table 4: After Hours GP Helpline - top 20 clinical conditions addressed between January – June 2014⁵⁰

Rank	Clinical issue
1	Medication queries
2	Diarrhoea
3	Rash / hives / eruptions
4	Cough (P)
5	Dizziness / vertigo
6	Nausea / vomiting
7	Vomiting (P)
8	Croup (P)
9	Headache
10	Gastrointestinal bleeding
11	Chest Pain
12	Ear - pain/injury/foreign body
13	Diarrhoea (P)
14	Hives (P)
15	Bloody urine
16	Sore throat / hoarseness
17	Postoperative problems
18	Flank pain
19	Earache (P)
20	Constipation (P)

(P) represents paediatric conditions.

Table 5: The most frequent types of advice given by GPs on the After Hours GP Helpline, January - June 2014

Recommendation / advice	%
Self care advice and see a doctor / health provider within normal operating hours	52.2
See a GP immediately	26.3
Self care at home	10.9
Emergency department immediately	6.0
No recommendation / advice reached	4.0
Transfer to Triple Zero (000)	0.6
Mental health referral	0.1

The Commonwealth is the sole funder of the AHGPH.

Table 6 provides details of the Commonwealth funding up until June 2015 when the contract ceases.

Table 6 AHGPH funding

	2011-12	2012-13	2013-14	2014-15
Funding to after hours GP helpline	\$65.00 million	\$1.00 million	\$42.17 million	\$46.00 million

The NHSD is not a component of the AHGPH but it plays a key role in ensuring that consumers and health practitioners have access to accurate and current provider service information. This is essential in the after hours context where location and opening hours of

⁵⁰ Healthdirect Australia 2014, [Biannual Report January – June 2014](#), viewed 10 October 2014,

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services can have a significant impact on the service choices available to both the nurse triage and GP.

Further information on the AHGPH can be found at Attachment G.

4 Key Themes

Drawing on the consultation strategy, which was multifaceted and included 33 interviews with key stakeholder organisations, 81 written submissions (comprising 38 Medicare Local submissions and 43 submissions from interested organisations and individuals) and six in depth case studies, a number of key themes have emerged over the course of the Review regarding after hours service provision, including:

- Overall support for a national approach to facilitate accessible after hours care, however respondents identified the need for after hours service provision to include flexibility to allow for regional differentiation and be responsive to local community need.
- Future funding arrangements should encourage improved integration and coordination amongst relevant health organisations and models should support innovation in a sustainable and efficient way with a focus on improved patient outcomes.
- Accountability for the use of after hours funding via clearly articulated policy objectives within a revised funding model.
- Mixed reactions to the previous PIP funding model. The most notable criticisms of this model included disparity of funding across regions, poorly targeted service provision to particular groups with high or unmet need, inappropriate support to practices that assumed the greatest burden i.e. single practice communities. However respondents indicated support for a 'revised' PIP funding model that addressed these issues. Suggestions included funding transparency, a nationally consistent process for delivering after hours incentives, reduced administrative burden and practices funding certainty.
- While there was some criticism of the SWPE funding model, the general consensus identified it as the most equitable approach.
- GP Workforce was consistently highlighted as the biggest challenge in the provision of after hours primary care arrangements, particularly finding GPs who are willing to provide after hours services on a regular basis.
- Arrangements should also consider that face-to-face primary care after hours practice service provision is not always financially viable for general practice, particularly in rural and remote locations.
- The potential for implementation of incentives for telephone triage, digital platforms and/or incentives that enable GPs and patients to utilise telehealth services where applicable.

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Consultations suggest that telehealth is slowly gaining momentum in the primary care setting, although a supporting business case is currently absent.

- After hours policy should not be looked at in isolation to ‘in hours’ service provision as one impacts the other. This was a particularly strong point made during the consultation process in relation to access to services in rural and remote Australia and in the residential aged care setting. Improving the capacity of RACFs, general practice and local clinicians to work collaboratively to foster innovation was seen to lead to optimal patient access in hours.
- Continuity of care was identified extensively in the consultation process, noting that improved coordination and integration of services should be put in place to ensure that when a practitioner other than an individual’s regular GP provides after hours services, notification of the event should be communicated back to the regular GP as soon as possible to facilitate follow-up and continuity of care.
- Issues impacting the provision of after hours services to RACFs was a consistent theme throughout the consultation process. This was seen as a ‘whole of system’ issue, although the current impact is seen largely on MDSs, and emergency departments in the after hours period.
- After hours service delivery challenges in rural and remote locations were highlighted repeatedly, requiring service delivery models to be tailored to meet the specific needs of each community.
- Respondent’s perspectives on the AHGPH were varied. Themes conveyed included a lack of knowledge regarding the service and understanding of what the service offers patients, a perception by stakeholders that the service often results in unnecessary presentations to the Emergency Department, its high load of low-acuity conditions, that the cost of the advice provided is very high and does not often suit the local context. However, respondents noted its role in ‘gap filling’ in the ‘unsociable’ after hours period and the support it offers rural and remote communities and RACFs.

This information can be further classified into a number of key themes and a closer analysis of all of the information collected to inform this Review against these themes follows.

4.1 Infrastructure

4.1.1 Medicare Locals involvement in after hours

Each ML approached incentivising and supporting after hours differently (case studies at Attachment C provide further details). Models adopted included continuation of the PIPAH incentive in reduced, similar or increased funding amounts, contracts with MDSs, grants programmes, innovative programmes for vulnerable groups and initiatives involving RACFs.

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4.1.2 After hours versus extended hours – the role of Medical Deputising Services

Stakeholders reported that up to 90 per cent of Australia's population now have access to a MDS. Many locations have experienced a recent increase in numbers of and competition between MDSs, consistent with the timeframes of increased MBS utilisation. There was some scepticism from informants regarding the MDS financial model and its impact on the conversion of calls into visits. This highlighted two issues. First, the differentiation between usual hours and after hours within the context of more extended hours services, with submissions suggesting that further clarity is required regarding what constitutes appropriate use of after hours care and how this differs from extended hours. Second, the financial incentive to deliver adequate, appropriate and innovative after hours care.

4.1.3 Improving the effective use of existing services and infrastructure

A consistent theme which emerged from respondents was that the key infrastructure to support after hours service provision is often already in place, however refinement is necessary as well as much better coordination between the existing services. Gains could be made by better linking Commonwealth and state/territory programmes across populations as well as improved community promotion of these services. In particular:

- improved promotion and better integration of Healthdirect, the NHSD, nurse and GP helplines with the aim of facilitating more appropriate patient access to available services, particularly lower acuity options where appropriate;
- appropriate triaging to ensure patients do not use after hours home visiting services for convenience and services are only provided for urgent need. Improved key performance indicators, monitoring and audit could also better target the use of these services for urgent care;
- increased utilisation of eHealth solutions to facilitate timely and comprehensive communication of patient presentation and treatment to the usual GP following consultation; and
- expanding the capacity of locally relevant telehealth for after hours consultations.

4.2 Consumer expectations and needs

4.2.1 Understanding needs and developing local solutions

Consumer awareness of available after hours services is essential to appropriately meet the after hours health care needs of patients and to ensure that after hours resources are utilised effectively and efficiently. After hours utilisation is influenced by many factors including knowledge of available services, availability of the right kind of care and accessibility issues, including cost, time and resources required to access.

The Department of Health required MLs to conduct comprehensive health needs assessments and targeted assessments of after hours services in their regions. This increased their understanding of the after hours needs of communities, awareness of after hours services and expectations of both consumers and providers. However, as highlighted by Professor Horvath, this increased understanding did not always translate into effective programme administration by MLs, with significant stakeholder frustration associated with: service contract complexity and

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conditions; excessive additional reporting burdens for general practices; and instances where MLs established services to operate in direct competition with existing general practices or duplicated state-funded services.

Consumer perspectives on after hours services have been drawn from both key stakeholders and the case studies.

Consumers generally were seen to have limited awareness of the services available to them in the after hours period or how to access the most appropriate care. In part this is associated with a 'needs to know' basis of after hours services. The default option for consumers is often to go to the hospital or call an Ambulance. One consumer indicated that her first point of call in the after hours was ambulance, she didn't necessarily want to call them as she knew it wasn't always appropriate, but she didn't know what other options she had (she had called the ambulance 11 times in the last year).

Consumers from the Hunter region found it confusing that there are two helplines available to them to call in the after hours period. They couldn't understand why there would be two helplines doing the same thing and felt frustrated with the journey when passed between the helplines and having to repeat the same information.

There was mixed awareness amongst the consumers of the HDA's nurse triage line and AHGPH – some were aware and had used it. Others had never heard of it.

When consumers had used both the HDA helplines and GP Access After Hours in the Hunter, they had found it useful to speak to someone but didn't necessarily follow the advice provided. However, frustration was expressed when the nurse wanted to speak directly to the patient, rather than themselves as carers, especially when the patient is not well enough to talk.

Some consumers knew that they could call their GP in the after hours period. However, they were reluctant to do so as they did not want to disturb their downtime. Therefore they would often wait until the next morning if they could. However, they felt reassured knowing that they were there should they need them.

Consumers noted that they were noticing new services popping up (specifically home visiting GP services) and there was generally good awareness of these as they had been heavily marketed on radio and television etc. However, one consumer noted that when she had used one of these services, two clinicians had attended, following which an ambulance was called and she was charged over \$400.

Consumers indicated that the internet is often the first point of call if it's a non-urgent situation – they feel it's a quick and easy way to get reassurance. They also feel there needs to be greater use of social media in raising awareness of consumers.

Consumers felt the services in the after hours period were fragmented and a more coordinated approach is required to provide timely access to services. As summarised by one consumer: "we have hospitals, healthcare and GPs doing good work. If they can coordinate all of this and fill the vacuum and rationalise services effectively, then they can make significant difference."

Access issues for the Indigenous and non-Indigenous populations do not appear to differ, with the primary barriers being cost of services and distance to travel.

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It was indicated that their community often does not feel comfortable calling their GP in the after hours period, so they will call the hospital or ambulance, or present to the emergency department. This is what they feel most comfortable with. The HDA helplines had been used but consumer informants indicated that it was not likely they would use it again, as the few times they have called they have been told to go to hospital emergency departments.

4.2.2 Informing consumers

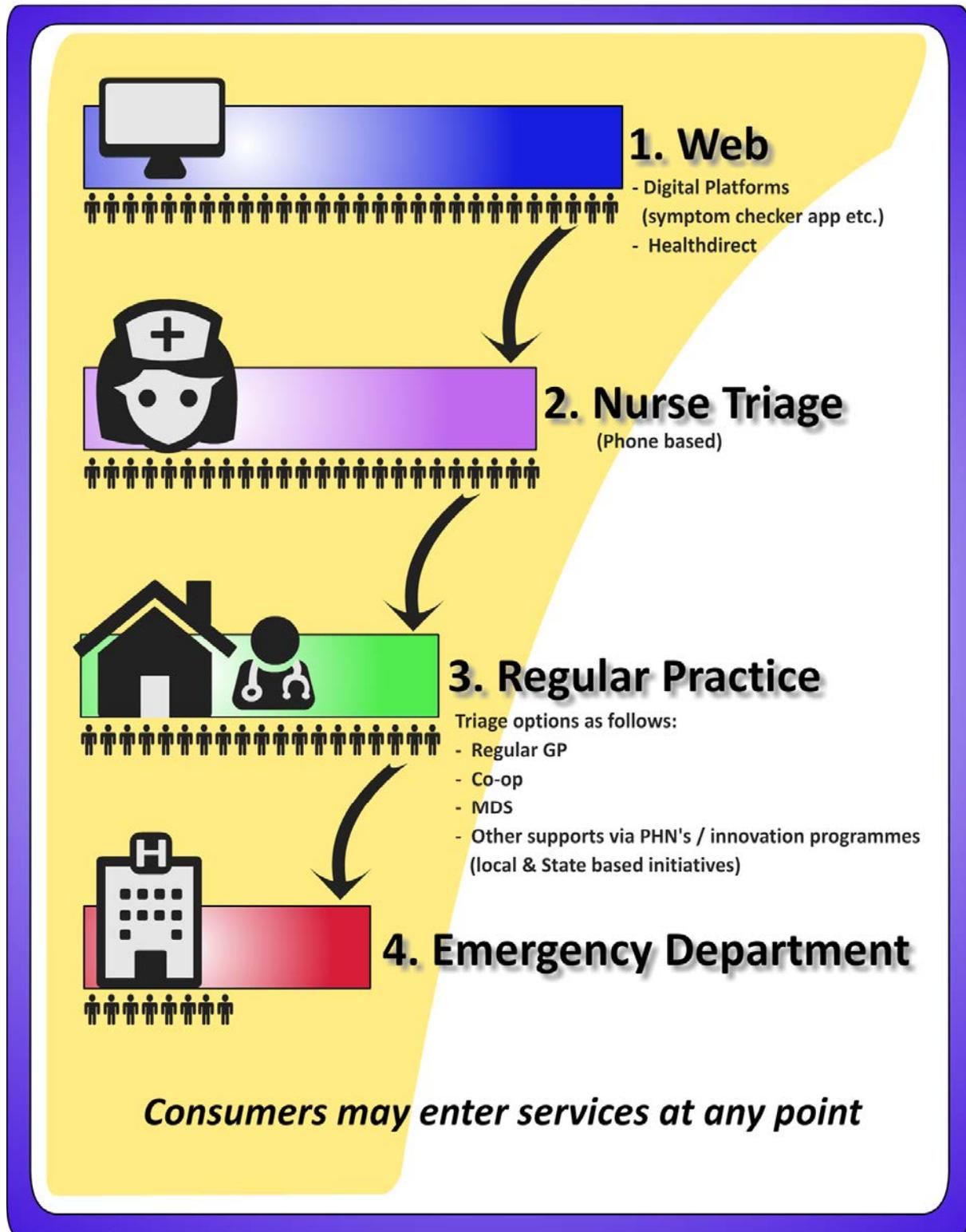
Community awareness of after hours services was identified as a common issue, often the first reaction in a medical emergency is to call an ambulance or present at an hospital emergency department, although there is variability across the country. Health literacy regarding after hours care across the community is generally considered to be poor, with significant opportunities existing to better educate consumers on which after hours services are available and when to access them. This includes which services to utilise and in what order. Some perspectives offered suggested that consumers in rural and remote regions have a better knowledge of after hours arrangements in their communities and know which services are available and when it is appropriate to access them (for example, only contacting the rural GP for urgent after hours issues where no alternative services exist).

International evidence suggests that graduated access to after hour services through an understood national approach may assist in accessing the right after hours services at the right time.

Some MLs pursued information campaigns to improve community awareness on local after hours services, but this was not universally undertaken. Improving community awareness enables consumers make informed decisions about appropriate after hours utilisation. Ultimately consumers need awareness of all entry points to after hours services to ensure the right service is delivered by the right person, at the right time and in the right place.

Both general practice and PHNs considered to have a role to improve community awareness of after hours services. Community education is critical to provide increased confidence to patients on which services to access and when. This will improve the appropriateness of after hours utilisation and deliver improved value for money for the tax payer and the Commonwealth and states and territories. A model to underpin consumer education and awareness, the *Consumer After Hours Access Cascade* is presented below.

Consumer After Hours Access Cascade



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4.3 The central role of General Practitioners and general practice in delivering after hours services

4.3.1 Recognition of the central role of GPs and general practice

Throughout the Review many respondents stated the belief that after hours primary care services should be a core component of general practice from both professional and ethical perspectives. General practice is considered to be the foundation of after hours care with the ability to make rapid, appropriate and cost effective assessment of the after hours health care needs of their patients. Respondents recognised that patients were likely to benefit most when their after hours care was provided by their regular GP, or their regular GP was involved in the directing of after hours care options.

Flexibility in after hours arrangements is considered crucial to ensure services appropriately meet the needs of the patient. Respondents indicated that general practice and individual GPs should ideally take a key role in determining the most appropriate after hours support or options for their patients. However after hours is a whole of system responsibility and after hours services were seen to need to work collectively at local levels to deliver the most cost effective and efficient after hours services. This included better coordinating the different modes of already-established after hours services and better informing consumers of their availability and optimal utilisation.

In the primary care setting, after hours services need to be provided by experienced and suitably qualified PCPs with appropriate clinical governance in place. Some respondents raised issues regarding the quality of care provided in some situations, in particular where services are provided by deputising services.

Some jurisdictions have more closely involved GPs in regional after hours service delivery particularly in rural and remote areas. There are opportunities with state-based care and through eHealth technology to further develop this role.

4.3.2 After hours versus extended hours

Concern was raised by many respondents in relation to the increase in utilisation of after hours services considered not to be urgent and the proliferation of services that essentially offered extended service hours for non-urgent care. They believed that after hours services should be reserved for genuine emergencies rather than for non-urgent care that could be managed in hours. In part this may be associated with consumer preferences (demand driven) but also with the increase in supply of after hours primary care services (supply induced demand), many of whom now bulk bill, as well as in hours pressures within general practice that restrict the ability of consumers to receive rapid access to required care.

4.3.3 Continuity of after hours patient care

It was widely recognised that after hours services should be integrated and coordinated to achieve continuity of care between after hour service providers and a patient's regular GP – this was identified as particularly important where patients are elderly or where patients have chronic and complex conditions where medication management is paramount. To achieve continuity of care, systems must be in place to support effective communication across providers of after hours services, in particular with general practice. To some extent it was considered that the Personally Controlled Electronic Health Record (PCEHR) could contribute to improve the

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continuity of care through providing enhanced access to patient information in the after hours period and supporting the flow of information between providers.

The extent to which continuity of care is achieved varies considerably across after hours service providers. Examples were provided of practices referring patients to MDSs and receiving patient reports the next morning, whereas in contrast, patient contacts with HDA and the AHGPH did not provide this continuity.

4.4 Delivery challenges in rural and remote regions

4.4.1 Rural context has implications for after hours service delivery

The experience of patients accessing after hours services in rural and remote regions was seen by respondents to differ considerably from metropolitan areas. General practices in rural and remote locations have a broad scope of practice and are managing increasing complex patients, often with admission responsibilities. Broadly, the characteristics of rural general practice which have implications for after hours service delivery include:

- **Patient care settings:** Rural GPs are often relied upon to provide a range of services, including primary care, acute care, after hours and emergency services in both the general practice and hospital settings. These multiple roles fall under multiple payment arrangements including as state funded Visiting Medical Officers.
- **Financial viability:** Rural practices are often small and are geographically isolated. The cost of running these practices can be higher compared to their urban counterparts. This in turn impacts on their capacity to adapt their business models to respond quickly to market circumstances, including the provision of after hours care, which can ultimately impact on their long term financial viability.
- **Workforce issues:** Rural practices are often small or run by sole practitioners and it can be difficult to find a replacement when a doctor is on leave, resulting in a heavy reliance on locum services, especially where practices provide after hours and emergency care. In addition, rural areas have an ageing GP workforce, who are relied upon by their local community to provide after hours services and are generally more willing to make lifestyle sacrifices. As these GPs retire and are replaced there may be a change in workforce supply whereby younger GPs may not have the same willingness (in the absence of financial compensation) due to higher personal costs and work/life balance issues. Rural GPs often work longer hours and have a higher on call workload than some of their metropolitan counterparts.

In rural areas, patients were reported to have increased awareness of their GPs availability and more broadly the after hours services to access – often the choices are more limited, but much better defined and understood locally. Critically, given demand on GPs in rural areas, systems existed with Regional and Isolated Practice Endorsed Registered Nurses and paramedic support to ensure only genuine emergencies are seen after hours.

A one size fits all approach was seen by respondents as unlikely to work in rural and remote areas. The after hours model was seen to depend on numerous factors including size of the community, number of GPs, and other services availability. In addition, infrastructure and staff resourcing to support rural doctors to provide after hours care needed to be supported where access to appropriate services is limited.

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Funding certainty for rural general practices was also seen as crucial to ensure financial viability of the practice overall. Funding needed to be considered within the context of the entire package of care rather than looking at one aspect in isolation. There was also a need to ensure that rural GPs did not walk away from providing after hours – as once a GP ceases after hours service provision, it is difficult to reengage them.

4.4.2 Workforce and recruitment

After hours services in many rural communities are challenging, contribute little to a practice's overall income but require local doctors to devote considerable personal time to participate in an after hours roster. The opportunity to establish an after hours roster is not available in many locations as rural and remote doctors are often solo practitioners and the responsibility rests solely with them. Multiple stakeholders identified that:

- rural GPs often have more complex workloads, combined with professional isolation resulting in higher 'burnout' rates, reduced job satisfaction and ultimately an earlier exit from rural practice;
- the absence of MDSs reduces after hours capacity and increases workload pressure on the existing rural workforce;
- the lack of 'in hours' GP availability has flow on effects into the after hours periods;
- the ageing workforce in rural locations places increased risk on after hours service provision, with the replacement workforce less evidently associated with providing after hours services, particularly in the absence of appropriate financial compensation; and
- video consultations have an important role to play. They cannot replace a face to face consultation but work well under some circumstances. There are issues in rural and remote regions regarding the viability of the technology - in particular with bandwidth and eHealth support.

4.4.3 Service delivery models

To address the challenges of rural after hours services, additional service options were considered necessary, including telehealth, use of advanced or extended practice or registered nurses, as well as offering incentives for geographic expansion of deputising services who presently do not cover these regions.

4.4.4 Transport

Many respondents also referred to the lack of affordable after hours community transport options which mean that the most disadvantaged within the regions either do not attend after hours care or opt to call for an ambulance – diverting important ambulance services to attend category 4 and 5 emergency department presentations.

4.4.5 Inequity in some emergency department presentations

In some areas, inconsistency exists between rural and metropolitan patients presenting at emergency departments. Rural hospitals in some jurisdictions require patients that are not admitted to pay a gap as their presentation is claimed through the MBS. In metropolitan areas all emergency department presentations are provided at no cost to the patient.

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4.5 The policy settings required to generate innovative solutions

Respondents believed that after hours services should be developed and managed in a way that is efficient, appropriate and effective, which supports and encourages flexibility, innovation and encourages regional specificity. At the same time, a national service delivery model should ensure access to after hours services and apply national consistency to funding, without placing an unnecessary reporting burden on general practice.

Challenges and Gaps

Overall, the key challenges and gaps in the provision of after hours primary care arrangements included:

- community awareness of after hours services - after hours services are often accessed on a 'needs to know' basis, resulting in emergency departments being the default option;
- after hours services are often fragmented and not connected - there is no clear pathway for consumers of how, and when, to access appropriate care based on health need ('right care, right person, right time'). This is compounded by a lack of information and data flows between services which impact the continuity of care;
- improved integration between Commonwealth and state/territory funding of after hours services and supporting infrastructure;
- the impact of residential aged care on emergency departments - access to after hours primary care for RACFs is variable. Improved access to a GP in the after hours period, particularly for phone orders for medicines, would assist staff to manage residents in the facility;
- managing change fatigue from the GP workforce - consultations indicated a lack of confidence by GPs regarding after hours services and given the burden of providing after hour services, GPs require funding certainty;
- the impact of after hours service provision on rural and remote GPs - who often provide general practice, hospital and emergency care, they also have a higher on call workload;
- the changing GP workforce - the new medical workforce is less inclined to provide after hours services and want to be substantially incentivised;
- after hours models (where applicable) to consider GP alternatives - not all patients will have the need to see a GP in the after hours period and GP models may not always be available in certain areas;
- a lack of consistent service data collected by MLs in the short amount of time they had to establish data collection arrangements; and
- a national AHGPH: which, whilst achieving the requirements set for it by the Commonwealth, is costly and appears not to be having the impact originally sought.

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Key components for future arrangements

The Review identified a number of characteristics of current arrangements that are working well, innovative and/or having their desired impact. These include:

- an overarching quality framework outlining both mandated and flexible outcome-based performance measures;
- a means of incentivising appropriate after hours service provision both in terms of the GP workforce and other appropriate health care professionals;
- the ability to address gaps and market failure within a region to provide accessible and responsive services for the community;
- connected services providing information and data flows and a care pathway for consumers;
- investment in digital infrastructure and approaches to improve connectivity for those with poorer access and facilitate self management;
- addressing the burden of RACF patients on emergency departments through improved primary care support; and
- educating and improving the health literacy of consumers on the appropriate use of after hours.

4.5.1 Guiding principles for after hours service delivery

Significant resources are invested in after hours services by both Commonwealth and state/territory governments and by consumers themselves. After hours services are considered to be frequently fragmented, resulting sometimes in inefficient service delivery. Improving the integration and coordination of after hours services is considered to be a significant opportunity to improve after hours access and patient outcomes.

The Review identified the following underlying principles for future after hours service provision:

- a clear policy direction and intent for after hours services with a long term view and a balance of consistency in approach at the national level with local flexibility;
- patient-centred service design, which is focused on improving access for the community;
- incentives which are administered in a transparent way to maximise certainty and administrative efficiency and minimise administrative burden on practices;
- governance and accountability mechanisms that best support service delivery, including reporting requirements that are not onerous or in any way detract from the effective delivery of appropriate services;
- outcomes based performance measures developed specifically in relation to the needs that services should be addressing;
- having continuity of care which links a patients back to their 'home' or usual GP with timely reporting back of information;

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- meaningful engagement with GPs and general practices through robust consultation and communication mechanisms;
- change management processes taking into account current attitudes and levels of acceptance for different forms of delivering and accessing health care;
- addressing gaps and market failure through targeted (and collaborative) programmes;
- coordinated and linked services with mechanisms to facilitate information flow between service providers;
- effective partnerships between after hours primary care providers and other organisations and sectors;
- making the most efficient and effective use of the available health workforce in delivering the most appropriate care in the after hours period – recognising the complementary role of other health professionals during the after hours period;
- GPs working together to provide services (e.g. cooperatives and clinic rosters) to share the burden for geographical areas;
- targeting community awareness and health literacy to optimise appropriate use of after hours options using methods tailored to audiences and delivered through appropriate channels;
- proper assessment, evaluation and ongoing refinement of future service delivery options;
- increasing the role and use of telehealth/digital approaches to optimise equity of access; and
- effective commissioning focused on improved effectiveness, efficiency, appropriateness, accessibility and outcomes – driving providers towards providing services focused on the outcomes that matter to the patients.

After hours services need to work within a common policy framework, where services work collaboratively towards meeting after hours health care needs. Considerable support exists for the guiding principles for ML after hours services, including after hours services being accessible, appropriate, timely, equitable and affordable. However, services require flexibility to enable local tailoring and to accommodate regional differentiation – one approach to after hours services does not fit all contexts. To some extent there has been an ongoing tension in after hours funding between local flexibility and national consistency, reflected in views relating to MLs responsibility for after hours services compared with the national PIPAH incentive.

State and territory governments are also large contributors to after hours care and it is important to align resource allocation and delivery models, particularly at regional levels, to achieve better accessibility and efficiencies. Developing effective local solutions to after hours services requires supportive government policy and funding frameworks that support effective after hours models. The Review identified numerous opportunities for innovation, subject to an ‘all of system’ approach and funding, with local applicability.

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4.5.2 Informing consumers

Patchy community awareness of after hours services was identified as a common issue across the country. For after hours services to deliver improved patient outcomes and improve efficiency patients need to know which after hours services are available and when to access them.

Some MLs pursued information campaigns to improve community awareness on local after hours services, but this was not universally undertaken. Improving community awareness enables consumers make informed decisions about appropriate after hours utilisation – ultimately consumers need awareness of all entry points to after hours services to ensure the right service is delivered by the right person, at the right time and in the right place.

Local and national consumer groups, general practices, pharmacies and PHNs are considered to have major roles in improving community awareness of after hours services.

4.6 *Appropriate and effective delivery strategies, taking into account current and available mechanisms*

MLs were funded to incentivise and support general practice and broader primary health care after hours services. General perceptions on the performance of MLs after two years is that results are variable, with a small number of successes across the country and with some respondents believing that many MLs had added little, competed with existing services, and have not, to date, had the intended impact on after hours services.

The majority of MLs opted to continue with payments to general practices that essentially mirrored those of the PIPAH incentive they replaced. ML arrangements were characterised as creating red tape for general practices, making processes needlessly complex and onerous and increasing reporting obligations. Issues with GP contracts being overly extensive and prescriptive plagued some MLs and took some time to be resolved. In many instances general practices reported additional work to receive the same level of services and payment.

Some practices were reported to have ceased to provide after hours services or changed their delivery approach to deputising services, because of MLs involvement in after hours, as evident in the following statements provided during the consultation process:

“ML involvement has been very mixed. It ranges from successful models to situations where local organisations, like RACFs have no understanding of the role of the ML’. MLs are seen to have taken a disproportionately high amount of already scarce funds to administer the after hours programme and have substantially increased the reporting burden and uncertainty in a number of cases.”

“If the payment from the MLs are not changed then it will be difficult to get doctors to provide on call services and we will be in a position where we will no longer be able to offer 24 hour call services, especially for patients in palliative care and nursing homes.”

“The lack of engagement with GPs and the contracting process has disenfranchised many GPs.”

“For smaller general practices in particular, it is not cost effective to deliver after hours services without access to additional funding. As a result of these changes, GPs and general practices have continued to vacate the after hours space.”

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This appears to be associated with two issues: first, the significant increase in administration and reporting requirements; and second, increased funding uncertainty. Some MLs appear to have created services in competition to existing general practices, which have impacted on service delivery and severely damaged relationships with their clinicians.

Most MLs consider they consulted sufficiently and appropriately on their after hours arrangements. However, this view was not universally shared – consultations were considered to be limited and failed to adequately engage GPs, residential aged care providers and pharmacy. Communication between MLs and some practices were also considered to be problematic, with practices receiving limited explanation of their funding allocations – this contributed to funding uncertainty.

MLs contended that they were ideally placed to deliver tailored after hours solutions to the local community, with the flexibility to encourage innovation, effective partnering and care coordination. There is some evidence of MLs demonstrating innovation and filling gaps in after hours services, particularly for vulnerable populations and other groups not well served by historical after hours arrangements. In addition, MLs have supported the increased availability of after hours radiology, pathology and pharmacy.

A number of MLs have engaged local general practice stakeholders to develop new incentives and support funding mechanisms for the regions. These new mechanisms attempt to offer more equitable local solutions, particularly for rural GPs who carry an increased after hours burden of responsibility. Where new approaches have been developed there is limited information available as to assess their success.

4.6.1 Stakeholder Support for the PIP after hours incentive

Across the general practice sector, there is an overwhelming desire to return incentivising after hours service arrangements back to a PIP payment. Support for this is strong, particularly from rural doctors who cite the imperative for financial certainty to ensure the sustainability of their practices.

Preferences for a PIP payment centre on perceived advantages over the ML arrangements. Cited examples of advantages include:

- reduced administrative burden – both in terms of simplified registration arrangements and reduced reporting;
- increased certainty – general practices knew what income they would receive from the PIP and when; and
- increased transparency through a nationally consistent application to incentivising and supporting after hours service provision;

In general, the reintroduction of a PIPAH incentive was prefaced by the requirement to better target the incentive payment. The previous PIPAH incentive received criticism in relation to:

- the lack of flexibility which does not support innovative approaches to after hours services – it did not adequately support the targeting of after hours services to particular groups with unmet after hours needs and this was considered to be particularly relevant in rural and remote regions;

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- the SWPE methodology rewarded the size of the practice rather than the volume of face-to-face of after hours services;
- its inability to appropriately recognise practices providing comprehensive after hours services – this severely disadvantaged rural practices;
- the tiered system (particularly tier 1) meant incentives were paid to general practice that did not result in service provision – in particular where practices directed patients to a MDS; and
- the absence of audit or validation of after hours services provided.

4.6.2 The Future – A hybrid model to incentivise and support after hours

The support for a return to a PIP was seen as an important but not complete solution to the appropriate provision of population based after hours support. There was general acknowledgment that incentive funding for general practice should not negate a potential role for PHNs in local communities and that PHNs could improve after hours service integration and develop innovative local solutions where local communities experience after hours access issues.

Good support exists for a hybrid model that both provides payments directly to general practice through a PIPAH incentive; and funds PHNs to facilitate integrated and effective local after hours services.

In addition to the advantages outlined above in relation to a modified PIPAH incentive, the following advantages were identified for a hybrid model:

- arrangements would allow local solutions to be developed that recognise the regional context;
- the diverse service requirements across Australia require a mix of funding arrangements and incentives to enable providers to meet the challenges of after hours care; and
- PHNs would not be thrown into agreeing contracts with general practices during their establishment period.

Quality incentives – for comprehensive general practice care

Many respondents made the observation that high quality after hours service provision is but one of a suite of core functions linked with high quality primary care. Others include the ongoing coordination of care for chronic conditions, care planning and supported access (including e-access) to practice consultations, resources and self management tools and integrated service provision with health professionals across the community and hospital. A number of respondents identified the improvements in after hours care that have accompanied the introduction of the patient-centred medical home model over the past 10 years in the US.

The PIP currently rewards many of these roles – either directly or indirectly (PIP guidelines). A number of respondents suggested a more mature bundling of PIP incentive payments associated with a comprehensive ‘quality incentive’. This would encourage a focus on the key domains of community general practice care of value, independent of the individual patient consultation.

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4.6.3 Improved utilisation of eHealth

There was a consensus that telehealth has enormous potential to improve health outcomes especially in rural and remote locations. Telehealth is considered to be slowly gaining momentum, with further work required to improve accessibility and the necessary system change. The business case for eHealth should include a focus on infrastructure, training, supportive financial levers and smooth interface with face-to-face consulting. It was noted that video conferencing cannot replace face to face consultations in acute presentations requiring physical examinations e.g. many paediatric presentations, productive cough and trauma.

The role of video conferencing was considered to have an important role to play in after hours access, particularly in RACFs. One of the most significant benefits raised is that video conferencing could allow GPs to communicate effectively across after hours providers. Differences were identified in the utility of video conferencing across locations, with limited benefit in metropolitan areas. Importantly, video conferencing was regarded as a support mechanism for on the ground professionals and not a replacement for face-to-face interaction with patients.

The adoption of telephone and video conferencing requires significant cultural change in primary health care, with some resistance noted amongst nursing staff and older members of the workforce.

Connectivity issues were raised as a particular concern in rural and remote areas, in particular bandwidth (especially where using satellite), which currently limits the viability of tele and video conferencing in some settings.

4.6.4 Streamlining processes to reduce red tape

Compared to the PIP model general practices receiving incentives via MLs experienced an increased contract complexity, increased reporting burden and greater uncertainty around payments.

From a policy perspective it is unclear if the former government expected MLs to implement fundamental payment reform to general practice. If this was intended in the short term this was not achieved and the replication of the PIPAH incentive approach resulted in duplicative and inefficient processes across many MLs.

4.7 Appropriate mechanisms for information sharing and data collection

4.7.1 The potential of eHealth in after hours

Electronic health solutions have great potential to improve after hours health care but these are thus far to be realised. Providing after hours service providers with enhanced patient information has the potential to assist with understanding patient health care needs. It also has the potential to improve continuity of care through providing a feedback mechanism to usual GPs on the after hours services provided – this is most relevant for patients with chronic and complex conditions and for patients that would benefit from subsequent in hours medical care.

The challenges of establishing the PCEHR are well documented and the solution may be sometime away, however, incentives to encourage the uptake and utilisation of the PCEHR need to be considered.

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4.8 Opportunities for improved engagement with the private sector

Many respondents expressed apprehension over potential private health insurance (PHI) sector involvement in after hours services. The primary concern discussed related to the potential for such involvement in after hours to result in a two tiered system, where patients with private health insurance membership receive priority treatment over non-members irrespective of clinical need.

PHI companies engaged in the Review reported limited current interest in after hours primary health care issues for their members. Some insurers have established arrangements with MDSs although these appear to have limited additional benefits for members where these services can often be directly accessed.

Some PHI offer call centres and advice lines for their members after hours. One example raised highlighted advanced arrangements for members where a nurse acts as a concierge for GP referrals, discussing with a GP the need for an after hours appointment and referring patients to their usual GP or the closest after hours service available.

There were mixed responses from s to the HDA nurse triage helpline and AHGPH. One insurer was of the view that the nurse triage line could be better connected with existing after hours services and hence there is no need for the AHGPH, whereas one noted the role that the AHGPH could play in regional and rural areas where access to services outside of hospitals in the after hours period may be limited

4.9 Transition to new arrangements

4.9.1 Support for a PIP – after hours incentive

Transitioning to a PIPAH incentive received strong support. There were a number of views on the structure of the PIPAH incentive previously administered. Generally, views on Tier 1 were divided between the need for a payment to encourage involvement in the after hours incentive through to it was not sufficient to justify a payment of equal weight to the other tier levels. This highlighted the opportunity to reflect on the appropriateness of the tiers and to consider the best approach to incentivising after hours to achieve greater involvement of the patient's regular GP in the provision of after hours care.

The approach of using SWPE continued to be well supported. No viable alternatives were raised. There is potential for some tweaking on the weights used in the incentive but it is acknowledging that rural weights apply across all PIP incentive payments. There is also potential to accommodate the different disease and service utilisation profile of Aboriginal and Torres Strait Islander peoples possibly through the number of patients registered at practices. However, this may be problematic as this information may not be routinely collected.

Views were that there is sufficient time to establish a revised PIPAH and provide advice to general practice on the characteristics and payment amounts prior to 1 July 2015.

4.9.2 Local role for Primary Health Networks

Some MLs have made significant inroads to improve the appropriateness and equity of after hours incentive payments. These need to be recognised and lessons drawn to inform the next

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iteration of after hours incentive and support funding. Many MLs consider the regional approach to funding after hours as being superior to the previous PIPAH incentive alone.

4.9.3 Timing issues

Commonwealth funding to ML ceases on 30 June 2015. Uncertainty surrounding incentives and support funding for after hours arrangements were identified as potentially destabilising general practices providing after hours, particularly in rural and remote locations where the financial viability of both practices and after hours services are more volatile. Funding certainty, ideally of at least 12 months, is required to inform the business planning cycles of general practices and MDSs.

4.9.4 Lessons for the Department of Health

An examination of the transition process from the previous Divisions of General Practice to MLs highlighted a number of important future considerations for the Department of Health in managing similar processes in the future.

Some MLs expressed that a lack of articulated policy objectives and expected outcomes communicated by the Department of Health significantly hampered their ability to develop responsive initiatives to enhance local service delivery through improved integration and coordination. This situation was further hampered by short implementation timeframes which did not allow significant time for consultation and service delivery planning.

Reporting requirements were also identified as a hindrance to effective implementation. As noted in Section 4.6, the increase in administration and reporting requirements lead to some general practices ‘opting out’ of providing after hours services completely, or contracting out services to MDSs or other private providers. Care needs to be taken to ensure that governance and accountability mechanisms support service delivery and that reporting requirements are not onerous or in any way detract from the effective delivery of appropriate services.

The Review has again highlighted that there is not a ‘one size fits all’ approach to after hours service provision and that future models should address the key issues identified, in particular providing an element of funding certainty to GPs and their practices, while supporting flexibility and local level community driven responses based on the population needs of particular communities and regions.

4.10 Other after hours considerations

4.10.1 After hours GP helpline

The AHGPH received a mixed evaluation from many respondents. A number of issues were raised including:

- incomplete ‘local’ after hours service knowledge and understanding which resulted in inappropriate treatment options – this was particularly important in rural and remote areas where services can be more difficult to access;
- the suitability of conditions being referred to the AHGPH – for conditions such as coughs, colds and rashes;

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- anecdotally, unnecessary presentations to emergency departments associated with the absence of strong links with primary care services at the regional level and conservative treatment algorithms;
- inadequate accountability and transparency regarding decisions;
- the cost to operate the service, in particular the high average cost per call;
- optional pass through of information to usual GPs on patient access of the service; and
- limited consumer awareness and service awareness – this applies more broadly to both HDA and the AHGPH.

The review identified that after hours GP telephone support can play an important system level role. More advanced approaches to general practice involvement in helplines demonstrate additional value to patients and general practices alike, for example GP Assist in Tasmania is associated with improving patient outcomes and reducing after hours pressure on GPs.

A number of potential incremental improvements to the AHGPH were identified:

- improved continuity of care systems;
- improved the triaging and algorithms underpinning the service;
- increased integration and linkages to local service provision arrangements, including the potential to directly refer patients or link them with regional approaches and processes that provide a deeper local knowledge of after hours services; and
- improved community awareness.

More broadly a fundamental question mark remains over the cost/benefit of the AHGPH which is beyond the scope and timeframe for this Review.

4.10.2 Residential Aged Care Facilities

RACFs were consistently identified as experiencing significant difficulties achieving timely access to after hour GPs for their residents and for placing demand pressure on after hours services, in particular hospital emergency departments. Many consider after hours demand from RACFs to be a consequence of broader systematic failure of access to in hours GPs which has the potential to be better managed to contain health system costs. Anecdotally, a high proportion of after hours episodes from RACFs are for advice, prescription orders and the implementation of treatment plans rather than emergency care. Some RACFs also contribute to after hours demand through their limited availability of appropriately trained medical personnel and the engagement of lower skilled workforce. Many RACFs have a risk averse culture where the appropriate after hours response is to call an ambulance for issues that could be managed out of hospital.

Residents of RACFs should have an after hours plan in place, should the need arise to contact after hours services. Many residents enter a facility with a regular GP but do not have after hours plans established with that GP; patient expectation is that their GP is accessible, but often this is not the case.

Improving timely access to RACFs across all hours and increased collaboration between RACFs, GPs, emergency departments, ambulance services and primary health care services could foster innovation and local models of care to improve access. The potential to utilise locum and deputising services in hours was identified by MDSs as a potential solution to improve access to

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GPs which would have a positive impact on after hours demand from RACFs. Opportunities exist for RACFs to increase their utilisation of telehealth and video conferencing but this can only be achieved through collaborative approaches and appropriate financial incentives. Further opportunities were identified to improve after hours care through the increased utilisation of nurse practitioners in RACFs.

4.10.3 Medical Deputising Services

MDSs are recognised as having a critical role in meeting after hours needs, providing valuable support for GPs already working long hours, access to home visits and in many cases good continuity of care.

MDSs provide an important service to people in need, however it is considered that existing policy, regulatory and financial settings may not encourage judicious or targeted use of such services. Anecdotally, views presented suggest some MDSs are overzealous in turning calls into home visits. The expansion in utilisation of MBS items and the value for money for government from MDSs is unclear. The potential tightening of MBS after hours services conditions was identified as providing savings to government that could be re-invested in more appropriate after hours services.

4.10.4 Palliative care

Palliative care has unique after hours needs which require patients, palliative care service providers and after hours services to be closely linked. Sadly, this often does not happen. Empowering palliative care patients to better predict their after hours needs is essential and this can be achieved through a range of approaches including, for example, care planning to anticipate issues that might arise and providing patients with after hours solutions specific to their circumstances and location. Through effective planning and organisation of after hours services, emergency department presentations and emergency admissions can be minimised. Drawing on existing local resources and knowledge may be more appropriate than utilising national resources to meet the specific needs of palliative care patients. Some states and territories currently have well established palliative care frameworks and processes in place that provide holistic responses for after hours services and lessons from these should be shared.

5 Conclusion and Recommendations

Whilst this Review is concerned with providing recommendations to the Minister on the optimal arrangements for after hours incentives and support involving \$164 million of Commonwealth funding, it has provided an opportunity to consider many aspects of after hours service delivery and the recommendations that follow are based on consideration of all methodologies utilised during the Review.

The establishment of PHNs and the transfer of responsibilities from MLs necessitate new funding arrangements for after hours primary health care from 1 July 2015. There is an expectation that PHNs will have a significant focus on reducing emergency department presentations and avoidable hospital admissions. With this focus, it is critical that sufficient funding is provided to PHNs to enable them to develop flexible, locally-effective solutions to after hours access difficulties— a one size fits all solutions across PHNs is unlikely to succeed. A clear tension has been evident in this Review between national consistency and transparency to incentivising after hours in general practice and the opportunities for PHNs to effectively achieve their organisational goals.

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5.1 Policy position for after hours primary health care

There are a clear set of principles on which after hours services should be based. These include: **accessible care** – that is appropriate, timely, available, affordable and equitable; and **effective care** – that is coordinated, high quality, safe, efficient, sustainable and supports the continuity of care.

These principles should be considered within the policy context for after hours services which from a Commonwealth perspective involves general practice at the centre of after hours services and where the system focus is on reducing unnecessary hospital emergency department presentations and admissions. Consequently, Commonwealth funding must adequately support both the general practice contribution and local initiatives that reduce after hours demand pressure on hospitals.

5.2 Proposed new arrangements for incentives and supporting after hours

The transformation of the after hours funding model under the former government occurred at a time when the majority of MLs lacked the organisational maturity to comprehensively and effectively engage and negotiate with their organisational primary health care stakeholders, particularly GPs. Many MLs appear to have adopted a default position that replicated the previous PIPAH incentive, but with increased administrative costs for both MLs and providers. General practices experienced increased contractual and reporting complexity to essentially receive the same amount of funding through MLs as they had via the PIP funding model. A minority of MLs supported the development of services in direct competition with existing general practices. Some MLs adopted a significant gap filling role and developed broader primary health care after hours service arrangements. Over the course of time, some of the initial issues experienced with MLs have been resolved.

The Review has heard from a wide range of stakeholders. Consensus amongst clinicians supports a return to a nationally consistent PIPAH incentive.

Taking into account the timing for the establishment of PHNs and the possibility that an unknown number of existing MLs will progress to PHNs, it is essential that funding certainty is provided to general practice with urgency. To achieve this, it is appropriate for the Commonwealth to take responsibility for funding general practice after hours from 1 July 2015 through a new PIPAH incentive. This approach will build on existing infrastructure and reduce the administrative burden on general practice as well as providing funding certainty and transparency.

The PIPAG should be engaged in the development of the new incentive payment. This group provides advice and assistance to the Department of Health on the development, implementation and modification of PIP incentives. The group currently comprises representatives from: the Australian Medical Association, the RACGP, the Australian College of Rural and Remote Medicine, the Rural Doctors Association of Australia, the Australian Association of Practice Managers and the National Aboriginal Community Controlled Health Organisation.

The key principle on which the incentive payment should be remodelled is to provide a greater proportion of the funding to practices that are actually available to provide a variety of after hours services to their patients.

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In light of the considerable support for developing local solutions to specific after hours issues, PHNs should have a role in developing solutions to after hours problems in a coordinated population-based approach. This would involve working with all relevant local providers to offer a system response to after hours services. This approach aligns with the priorities of PHNs and builds upon the work of some MLs.

5.3 Vision for a quality incentive for general practice

The transition to a broader quality incentive should be pursued by 2017-18.

Many respondents made the observation that high quality after hours service provision is but one of a suite of core functions linked with high quality primary care. Others include the ongoing coordination of care for chronic conditions, care planning and supported access (including e-access) to practice consultations, resources and self management tools and integrated service provision with health professionals across the community and hospital.

The PIP currently rewards many of these roles, either directly or indirectly. However, a more mature bundling of PIP incentive payments associated with a comprehensive ‘quality incentive’ as foreshadowed by the Minister’s announcement in May 2014, focusing on continuous quality improvement, should be pursued in the medium term.

5.4 Reassessing the role of the after hours GP helpline

This review identified the need to consider the future role of the AHGPH and how it may be targeted in the future to increase its efficiency and effectiveness. To date, the AHGPH has been delivered based on the requirements of the Australian Government. It is widely acknowledged that the helpline is now operating in a different service delivery environment to the one in which it was established. Consultations highlighted mixed stakeholder views regarding the AHGPH, most notably a lack of knowledge and profile, a perception that the service results in unnecessary presentations to emergency departments, that the advice does not always fit the local context and that it has a high load of low-acuity conditions.

However, feedback also highlighted the important role the AHGPH has in addressing ‘gap filling’ in the unsociable after hours period and the support the service provides to rural and remote communities and RACFs.

Opportunities for improved efficiencies may include implementing a call-back service rather than an inbound model, disposition refinements, reserving the use of the AHGPH for those whom face-to-face services are unavailable, improving continuity of care and assessment and if appropriate implementation of e-prescribing – this will be of particular benefit to supporting RACFs during the after hours period.

5.5 Extended hours versus after hours

The Commonwealth funds after hours primary care services through MBS items that provide higher rebates for after hours consultations by GPs and medical practitioners. Whilst the utilisation of after hours MBS items from 2008-09 to 2013-14 has increased, the value for money from Commonwealth funding for after hours MBS services is difficult to measure. Additionally, the increase in service utilisation from MDSs providing care in RACFs is representative of the complex after hours needs of this population group.

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A key role of a MDS is to provide after hours medical services to patients of GPs in their absence or at their request. The growth in deputising services and MBS utilisation generates concern as to whether MDSs are evolving into an alternative for after hours general practice providers.

5.6 Residential Aged Care Facilities

A theme that occurred across submissions was the role of GPs in after hours service provision in RACFs, in particular the difficulties with timely access and the demand RACFs put on after hours service delivery. In particular, it appears from the submissions that the sector believes residential aged care is an environment with a set of specific after hours issues which need to be addressed, including:

- improving capacity of RACFs to work collaboratively with general practice and primary care organisations to foster innovation and local models of care to support patients access; and
- providing better support to encourage timely RACF and home visits by GPs across all hours. A significant proportion of current after hours demand reflects systematic issues in accessing home and facility visits during usual hours, which if addressed may significantly reduce the cost of after hours services in these locations.

In addition, submissions highlighted the growing potential of telehealth systems, which where appropriate, can play an important role in the aged care environment. Submissions supported and identified the value of video conferencing, noting that telehealth systems should enable integration with all aspects of after hours care from hospitals, RACFs, MDSs and general practices.

5.7 eHealth potential

Improvements in the utilisation of eHealth have the potential to benefit health outcomes, particularly in rural and remote areas. While limitations exist, such as issues with connectivity in rural and remote locations, the development of telehealth applications is pivotal to better patient information at the time of accessing after hours services. The role of video conferencing was considered an important aspect of after hours access, particularly as a support mechanism for on-the-ground professionals. Although it cannot replace face-to-face consultations in presentations requiring a physical examination, video conferencing could allow GPs to communicate effectively across after hours providers.

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5.8 All Recommendations

The following recommendations are presented for the Minister's consideration.

Recommendation 1

The Commonwealth resumes responsibility for after hours funding of general practice from Medicare Locals from 1 July 2015.

Recommendation 2

A revised Practice Incentives Programme (PIP) After Hours incentive is accessible for accredited general practices from this date.

The revised PIP should:

- appropriately remunerate general practices for after hours patient care;
- utilise tools such as the Standardised Whole Patient Equivalent (SWPE) to weight practice size, age and rurality; and
- reward practices providing telephone triage for their own patients.

Performance Indicators for this PIP should be outcome-focused and easily collectable.

The final design of the revised incentive should involve consultation as soon as possible with the PIP Advisory Group (PIPAG).

Recommendation 3

From 1 July 2015, Primary Health Networks (PHNs) receive funding to work with key local after hours stakeholders (including Local Hospital Networks (LHNs), Medical Deputising Services (MDSs), consumer groups, Aboriginal and Torres Strait Islander representatives, the private health sector and non-government organisations) to plan, coordinate and support population-based after hours health services. Their focus should be on gaps in after hours service provision, vulnerable groups and service integration.

Recommendation 4

The Commonwealth work with key stakeholders to urgently examine the rapid escalation in utilisation of after hours MBS items. The Department of Health should identify the relevant drivers responsible and work with PHNs and local stakeholders to develop optimal utilisation of this resource.

Recommendation 5

The adoption of an expanding variety of eHealth applications to support consumer self-management and improved links between providers and after hours service delivery is recommended. This should involve input from after hours stakeholders, proven technology leaders, state and territory government telehealth directorates and the National E-Health Transition Authority and include opportunities to facilitate the transfer of clinical summaries via an electronic health record.

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Recommendation 6

Residential aged care after hours service needs and provision are complex, with a high and increasing service utilisation, particularly from MDSs. This Review recommends the Department of Health engage with key clinicians from primary and acute care, residential aged care organisations, MDSs and other relevant stakeholders to identify innovative solutions, applicable locally and consider an appropriate role for PHNs.

Recommendation 7

Palliative care similarly involves a complex interplay between patients, carers, families and service providers both in and out of hours. Palliative care should be a special focus for local service planning.

Recommendation 8

Consumers are frequently unaware of the many after hours support options available to them. A clearly articulated pathway for consumers to access high quality after hours advice and support should be developed. This should identify the many support modalities available (quality web-based self-help sites, after hours support via the family general practice, after hours cooperatives, MDSs, ambulance services and emergency departments) and indicate those most appropriate for the care required.

This pathway should be provided to PHNs for local customisation and broad community dissemination.

Recommendation 9

MDS accreditation should include a requirement for deputising services and others providing after hours care outside the practice to return clinical summaries within 24 hours to the patient's regular practice.

Recommendation 10

As state funded after hours support plays an important role in rural and remote settings, after hours service planning should be integrated as part of PHN/LHN local service delivery mapping.

States and territories vary widely in their rural after hours models of care. Best practice approaches should be identified at state level and discussed with a view to broader implementation via the National Rural Health Standing Committee or the Council of Australian Governments' (COAG) Health Council.

Recommendation 11

MDSs play a critical role in after hours care. However, the rapid increase in deputising service utilisation of MBS items raises questions around the appropriateness of a purely fee-for-service funding model for the sector. Funding for MDSs should be considered to strike a better balance between infrastructure and activity based funding for a sector with unpredictable and uneven service demand.

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MDSs are accredited deputising services and access to after hours should happen via a patient's regular general practice, rather than through direct marketing.

Recommendation 12

The After Hours GP Helpline (AHGPH) was incepted to relieve after hours pressure on regional and rural general practices (GPs) and support GP continuity of care. However there is limited evidence that this has occurred. Direct Commonwealth funding to the AHGPH should not continue in its current form beyond the completion of the 30 June 2015 contract, with funding reallocated to support innovative after hours services delivery locally.

A need to relieve pressure on GPs in regional and rural areas and improve the continuity of care after hours remains a priority. Therefore population based after hours planning should identify the need for GP phone support, best linkages and application. Innovation funding for this purpose should be available for PHNs that submit, appropriate applications, endorsed by local stakeholders.

Recommendation 13

Many stakeholders identified after hours care as only one component of high quality comprehensive general practice care. Other elements included in hours service flexibility, eHealth excellence, comprehensive chronic disease management and effective integration of care. This Review recommends the further development of the PIP to recognise and reward the practice infrastructure required to deliver to Australians high quality comprehensive primary care. This should be progressed by the PIPAG.

Abbreviations and Acronyms

Abbreviation	Name in full
A&M	Accident and Medical Centre
AHGP	After Hours GP Helpline
AMDSP	Approved Medical Deputising Services Programme
ARAHN	Auckland Region After Hours Network
COAG	Council of Australian Governments'
GP	General Practitioner
GPAH	General Practice After Hours
HDA	Healthdirect Australia
HML	HomeCare Medical Limited
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
MDS	Medical Deputising Service
ML	Medicare Local
MLAH	Medicare Locals After Hours
NHPA	National Health Performance Authority
NHS	National Health Service
NHSD	National Health Service Directory
PCEHR	Personally Controlled Electronic Health Record
PCP	Primary Care Physician
PCT	Primary Care Trust
PHI	Private Health Insurance
PHN	Primary Health Network
PHO	Primary Health Organisation
PIP	Practice Incentives Programme
PIPAG	PIP Advisory Group
PIPAH	PIP After Hours
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
RRMA	Rural, Remote and Metropolitan Areas
SEIFA	Socio-Economic Indexes for Areas
SWPE	Standardised Whole Patient Equivalent

Attachments

- A. [Submissions](#)
- B. [Stakeholders Interviewed – organisations and associations](#)
- C. [Case Studies – Executive Summary](#)
- D. [Review of Medicare Locals](#)
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A. Submissions

- ACT Health
- ACT Medicare Local
- Adelaide Medical Solutions
- Asquith Medical Centre
- Australian College of Emergency Medicine
- Australian College of Nurse Practitioners
- Australian College of Rural & Remote Medicine
- Australian Healthcare and Hospitals Association, Anne St Medical Services, George Town, TAS
- Australian Healthcare and Hospitals Association
- Australian Medical Association
- Australian Primary Health Care Nurses Association
- Australian Society of Physicians Assistants
- Australian Medical Centre
- Barwon Medicare Local
- Bayside Medicare Local
- Calvary Mater Newcastle
- Central Coast NSW Medicare Local
- Central Queensland Medicare Local
- Centre for Health Policy, University of Melbourne
- Consumer Health Forum of Australia
- COTA for Older Australians
- Darling Downs South West Queensland Medicare Local
- Department of Health and Human Services, Victoria
- Dr Kevin Sweeney, Hamilton NSW
- Dr Mark Foster - former CEO, Hunter Medicare Local
- Dunmunkle Health Service
- Eastern Melbourne Medicare Local
- Frankston-Mornington Peninsula Medicare Local
- Gippsland Medicare Local
- Gold Coast Medicare Locals

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- GP - Happy Valley SA
- GP Access After Hours (Hunter Medicare Local)
- GP Assist Hobart Tasmania
- GP Connections Toowoomba QLD
- Grampians Medicare Local
- Great South Coast Medicare Local
- Greater Metro South Brisbane Medicare Local
- Health Care Consumers Association Inc
- Healthdirect Australia
- Hume Medicare Local
- Hunter Medicare Local
- Inner East Melbourne Medicare Local
- Inner North West Melbourne Medicare Local
- James Cook University
- Leading Age Services Australia
- Loddon Mallee Murray Medicare Local
- Lower Murray Medicare Local
- Medibank Private - Health Insurance Fund
- Medics for Life
- Murrumbidgee Medicare Local
- National Association for Medical Deputising
- National Home Doctor Service
- National Rural Health Alliance
- Nepean-Blue Mountains Medicare Local
- New England Medicare Local
- North Coast Medicare Local
- Northern Melbourne Medicare Local
- Northern Sydney Medicare Local Ltd
- NSW Health
- Perth Central and East Metro Medicare Local
- Royal Australian College of General Practitioners
- Rural Doctors Association of Australia

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- Rural Doctors Association of South Australia
- Smith Street Medical Centre, NSW
- South Eastern Melbourne Medicare Local
- South Eastern Sydney Medicare Local
- South West WA Medicare Local
- South Western Melbourne Medicare Local
- South Western Sydney Medicare Local
- Southern Adelaide Health Institute
- Sunshine Coast Medicare Local
- Sydney North Shore & Beaches Medicare Local
- Tasmania Medicare Local
- Telstra Health
- The Pharmacy Guild of Australia
- Toowoomba 7 Day Medical Centre
- Townsville-Mackay Medicare Local
- University of Queensland
- WentWest Limited
- West Morton Oxley Medicare Local
- Western NSW Medicare Local

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B. Stakeholders interviewed – organisations and associations

- ACT Health
- Aged and Community Services Australia
- Australian College of Nurse Practitioners
- Australian College of Rural and Remote Medicine
- Australian Indigenous Doctors Association
- Australian Medical Association
- BUPA
- Consumer Health Forum of Australia
- Department of Health and Human Services, Victoria
- Department of Health, Western Australia
- GP Assist Hobart Tasmania
- HCF
- Healthdirect Australia
- Medibank Private
- National Aboriginal Community Controlled Health Organisation
- National After Hours Medical Deputising Services Australia
- National Home Doctors Service
- nib
- Northern Territory Health
- NSW Health
- The Pharmacy Guild of Australia
- Queensland Health
- Royal Australian College of General Practitioners
- Rural Doctors Association of Australia
- Rural Doctors Association of South Australia
- SA Health
- Tasmania Medicare Local
- Tasmanian Department of Health and Human Services

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C. Case studies

The final report from Ernst & Young, who undertook the case study component of the Review, is currently being finalised. As soon as it is available, the Executive Summary from the Report will be attached.

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D. Review of Medicare Locals

On 16 December 2013 the Minister for Health announced the Terms of Reference for the Review of Medicare Locals. The Review covered the operation and performance of Medicare Locals (MLs) including ‘the performance of MLs in administering existing programmes, including after hours’ (Term of Reference 2).

The Review of Medicare Locals was informed by four independent components of work:

1. A review of the functioning of MLs.
2. An independent financial audit of MLs.
3. Over 270 stakeholder submissions.
4. Interviews with key stakeholders and opinion leaders.

Professor Horvath reported a number of key observations and findings in relation to after hours:

- Widespread stakeholder frustration in how the MLs ‘after hours’ programme has been handled and implemented. Issues raised included: service contract complexity and conditions; excessive additional reporting burdens for general practices; and, instances where MLs established services to operate in direct competition with existing general practices or duplicated state-funded services.
- Each ML approached the task of funding after hours services differently. Some adopted a mock-practice incentive payment methodology, others used simple grants, and others applied regional approaches that negated the need for specific practice support (i.e., via MDSs). Some national or jurisdictional corporate service providers struggled to keep up with the different after hours solutions in each catchment.
- The timing of the transition of after hours responsibility to MLs appeared to be a significant issue, with the majority of MLs enmeshed in establishment activities while at the same time attempting to implement a complex and controversial reform. For many MLs this was their first significant attempt at purchasing and, with the benefit of hindsight, given the sensitivities attached to the issue it was probably not an ideal starting point.
- The outcome for some MLs appeared to have been to further damage GP goodwill.

Professor Horvath concluded that Government should review the MLs after hours programme to assess the appropriateness and effectiveness of the current delivery strategy. A review would garner considerable support and contribute to goodwill from general practice. It would also inform the implementation of other programmes in this sector.

Ten recommendations were presented to the Minister for consideration including:

Recommendation 8: Government should review the current MLs’ after hours programme to determine how it can be effectively administered.

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E. Definition of a Medical Deputising Service

An organisation will be deemed to meet this definition of a Medical Deputising Service (MDS) if it is accredited to the current Royal Australian College of General Practitioners Standards for General Practice, including supplementary materials for after hours care services (as determined by the Royal Australian College of General Practitioners from time to time) AND is accredited to confirm it meets all the additional criteria set out below.

Definition

1. A Practice Principal is a registered medical practitioner (vocationally recognised or not, full-time or part-time), who undertakes the continuing care of patients in a medical practice. The Practice Principal has a responsibility to arrange comprehensive care of patients 24 hours a day and engages the MDS.
2. A MDS is an organization 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 Principals.
3. A MDS is a means whereby a Practice Principal may externally contract the after hours components of both continuous access to care and continuity of care to practice patients
4. A MDS utilises facilities and processes which ensure continuous access to care and continuity of patient care.
5. A MDS comprises a physical facility which incorporates a control / communications / operations capacity, administrative services and, where applicable, a clinic.
6. A MDS must provide home visits and may also provide clinic and telephone triage / medical advice services. MDSs must ensure that they are always in a position to provide home visits as required for significant medical reasons or as requested by Practice Principals, throughout the entire after hours period.
7. A MDS responds to patient or principal-initiated calls only and must not provide planned or routine patient services unless agreed with the patient's principal practitioner.
8. A MDS must not schedule appointments beyond the after hours period in which the patient request was received.
9. A MDS is required to operate and provide uninterrupted access to care, including home visits, for the whole of the after hours period. The defined after hours periods that must be covered by the MDS are: any time outside 8am - 6pm on weekdays and all day weekends and public holidays. A MDS demonstrate that consultations and visits are provided during the unsociable hours from 11pm until 7am.
10. In providing complementary care on behalf of local, daytime general practice, a MDS must be independent of any individual or group of general practice(s). MDS premises must not be co-located with a general practice.
11. As MDSs do not offer comprehensive GP care, direct advertising to encourage patients to use MDSs for 'routine' or convenience purposes, thereby compromising their access to the full range of GP services, is prohibited.

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12. A MDS must have a control /communications operations capacity which must be operational within its premises during the majority of the defined after hours period.
13. A MDS which contracts out part of its control /communications /operations function may only do so to an MDS accredited control /communications /operations service.
14. The control /communications /operations room must, during the after hours period, be staffed by personnel appropriately trained in telephone triage, to guarantee maintenance of accreditation standards and ensure the appropriate management of urgent cases.
15. A MDS must have telephones attended 24 hours per day by trained staff so the Principals can access the service to communicate special patient information and facilitate continuity of care at all times.

Note As it is not presently recognised by Medicare Australia that the period Saturday 8am to noon Saturday is part of the recognised After Hours period with respect to the availability of Urgent After Hours Items, then this period is not included in the defined After Hours period that must be covered by the MDS. The National Association for Medical Deputising Services hopes to finalise negotiations with government to rectify this anomaly.

Source: NAMDS 2012, [Definition of a Medical Deputising Service](#), viewed 20 October 2014.

Review of after hours primary health care

F. Evaluation and review reports – summary

Evaluation of after hours primary health care programme – phase one

Centre for Health Policy, Programmes and Economics

28 March 2013

- After hours activity undertaken by T1 – Known Gap Filling (KGF).
- Eight categories of activity:
 - Awareness raising about after hours service availability;
 - Maintenance or extension of existing after hours service;
 - Establishing new after hours services;
 - Support for residential aged care facilities and community elderly in accessing after hours care;
 - Improving service coordination and continuity of care; and
 - Improving after hours access to medication.
- KGF activities provided a symbolic starting point for after hours service development in Medicare Locals (MLs).
- Overall effectiveness of KGF activities cannot be assessed at this point.
- Activity built foundations for the continued development of after hours and provided valuable learnings about the factors affecting change in the after hours care environment.

Evaluation of after hours primary health care programme

Centre for Health Policy, Programs and Economics

September 2013

- Strong regulatory frameworks are required to assure quality of after hours services.
- Consumer use of after hours services is influenced by media campaigns. Care must be exercised to ensure increased demand can be met.
- Rural General Practitioners (GPs) may still experience unscheduled after hours demand even when new arrangements are in place.
- The evidence on the costs of after hours services is limited and inconclusive.
- Intangible effects (peace of mind, value of retention etc) should be factored into after hours cost effectiveness assessment.
- After hours Medicare Benefits Schedule (MBS) has increased nationally over a four year period – item 5020 is the main driver of the increase – most pronounced in Eastern and South Eastern metropolitan regions.
- ACT, NT and Tasmania mostly static in after hours MBS items.
- No discernible effect of the after hours GP helpline or Medicare Locals After Hours (MLAH) programme on national MBS utilisation.
- Emergency Department (ED) Category 4 and 5 presentations have increased over an 8 year period (except in ACT).
- Hunter – lower rate of increase in ED primary care type presentations compared to rest of NSW.
- No discernible effect of the after hours GP helpline or MLAH programme on primary care type presentations to emergency departments.
- 254 approved ML stage one activities – predominantly social after hours period; a third of activities involved other settings in health care and the community.
- Strengths – leadership, staff, planning, involvement of non-medical primary care stakeholders.

Review of after hours primary health care

- Weaknesses – time to build new organisations governance structures, GP resistance, costs and time commissioning, slow plan approval, reporting processes, low community awareness.
- Opportunities – engagement with non-medical and community sector, localised innovation, integration with other programs, cross ML collaboration.
- Threats – uncertain funding environment, loss of GP trust, financial viability in low population areas, workforce issues, duplication of costly administrative and commissioning arrangements.
- Funding more geographically equitable in ML period – all MLs received funding.
- Some MLs were disadvantaged because regions did not receive funding for General Practice After Hours Programme in pre ML period.
- There is a greater diversity of projects including ones more broadly related to primary care and not directly related to general practice.
- The majority of providers feel they are currently meeting consumer after hours needs but feel less confident about meeting them in the future.
- Some providers feel undervalued in the role they play in after hours especially in rural areas.
- There is a high level of dissatisfaction with funding changes in after hours care provision.
- MLs are not widely seen as adding value to the after hours primary care environment – some non-medical providers welcome involvement in local planning.
- Barriers to consumers – lack of knowledge of available services, perceptions needs not urgent enough, concern about cost and transport/travel times. Using after hours services provides peace of mind to consumers.
- MLAH Programme implemented in an uncertain environment – external factors and organisational development influencing progress.
- Lessons from existing regional models – solutions work but require time, trust, cooperation and financial support.
- Overall, reform process to achieve accessible, equitable and appropriate after hours primary care system is well underway.

Recommendations:

- MLs should incorporate the after hours GP helpline as a ‘first line’ option in plans for unsociable hours.
- MLs should be encouraged to work collaboratively to address issues of regional or national importance in after hours care delivery.
- The Department of Health and the Australian Medicare Local Alliance should work with MLs to facilitate access to regional, state and national demographic and health services utilisation data.
- MLs should monitor closely the impact of new after hours activities and funding streams on the financial viability of existing providers, particularly in rural areas.
- Opportunities for the reduction of duplication in financial, administrative and legal arrangements for after hours services should be sought. The role of the Australian Medicare Local Alliance in the provision of common corporate services could be further strengthened.

Review of after hours primary health care

G. Healthdirect Australia

Background

On 10 February 2006, Council of Australian Government (COAG) agreed to establish a National Health Call Centre Network (the Network) as part of the \$1.1 billion National Health Reform Package – Better Health for All Australians.

Healthdirect Australia (HDA) is the trading name of National Health Call Centre Network Ltd.

HDA was established, and is jointly funded, by the Australian Government and the governments of the Australian Capital Territory, New South Wales, Northern Territory, South Australia, Tasmania and Western Australia to deliver the Network's services.

It is a public company limited by shares and is responsible for contracting service providers for the Network's services and managing the Network's operations.

All jurisdictions who have formally committed to the Network are equal shareholders of HDA. Whilst all jurisdictional governments gave their agreement to the development of the Network at COAG in 2006, Queensland and Victoria are yet to formalise this commitment by becoming shareholders.

Healthdirect Australia

(1800 022 222, [Healthdirect Australia](#))

HDA commenced operation in July 2007 and comprises:

- nurse-based telephone triage available 24 hours a day, seven days a week and supported by a single national set of electronic decision support software and algorithms;
- health advice and information, including support for the needs of rural and isolated communities; and
- caller referral to health services, supported by service directories.

Medicines calls that were previously handled by the National Prescribing Service's Medicines Line are now handled by HDA, except for calls from Queensland and Victoria.

HDA has handled over five million calls since its inception.

after hours GP helpline

(1800 022 222)

The after hours GP helpline was announced in the 2010-11 Budget, commenced operation on 1 July 2011, and is being delivered by Medibank Health Solutions until 30 June 2015. It operates from 6 pm-8 am Monday to Saturday, from 12 noon Saturday to 8 am Monday, and 24 hours on national and state/territory public holidays.

The after hours GP helpline is intended for people whose health condition cannot wait for treatment until regular general practice services are next available, cannot see their usual GP out

Review of after hours primary health care

of hours, do not know where to access after hours care or are not sure what they should do. People with life-threatening conditions, however, should dial '000' and/or attend an emergency department without delay.

With the exception of Queensland and Victoria, patients who call the after hours GP helpline are initially triaged by a HDA registered nurse and transferred to a telephone GP if determined appropriate.

- Callers from Tasmania, once triaged by a HDA nurse as needing to speak with a telephone GP, access an after hours GP through the GP Assist service, delivered by the Tasmania Medicare Local appointed service provider – Medical Practice Management Solutions trading as GP Assist.
- Callers from Queensland and Victoria can access the after hours GP helpline through the HDA national phone number (which diverts to the relevant state based service) or through 13HEALTH and NURSE-ON-CALL respectively.

Health professionals who identify themselves when calling the after hours GP helpline can access a fast track service as a way of providing collaborative, professional support to reduce the after hours burden on local GPs.

Video call access to the after hours GP helpline has been postponed, pending the outcome of the After Hours Review, currently being undertaken.

Pregnancy, Birth and Baby

(1800 882 436, [Pregnancy, Birth and Baby](#))

The Pregnancy, Birth and Baby helpline commenced on 1 July 2010 in response to the Maternity Services Review, which recommended improved access to birthing and pregnancy-related information to support informed decision making; and the establishment of a single, integrated pregnancy-related telephone support line for consumers, complemented by triage to a number of existing specialised support services.

The Royal District Nursing Service has been contracted by HDA until 30 June 2015 to deliver the Pregnancy, Birth and Baby telephone helpline.

HAD has developed video call capability that is easy-to-use, cost effective, reliable and clinically safe. Video calls to the Pregnancy, Birth and Baby Helpline commenced 23 October 2014. Pregnancy, Birth and Baby Helpline is one of the world's first services to offer a secure, high quality video call option as a genuine alternative to the telephone for 'unplanned, on-demand' access to health services.

The Pregnancy, Birth and Baby helpline has handled over 160,000 calls since its inception.

Since its re-launch on 14 January 2013, the Pregnancy, Birth and Baby online service has replaced, and improved on, the web portal that previously supported the helpline service and has had 628,029 unique visits and 1,605,233 page views.

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Mental Health Portal – [mindhealthconnect](#)

HDA developed and delivers mindhealthconnect on behalf of the Commonwealth. The portal commenced operation on 1 July 2012, and was launched on 5 July 2012.

Feedback from users of the site has been very positive, with comments that the design and user interface is clear, functional, makes it easy for people to find what they were looking for and a great way to help people understand where to go for trusted online mental health programmes and information.

New content and functionality was added in 2013. This includes an interface to the National Health Services Directory (NHSD); linking with 24 partners, including the e-mental health virtual clinic (MindSpot); and the addition of content on three new mental health disorders.

Since commencement to 30 September 2014, mindhealthconnect has received 951,298 unique visits to the site and 2,731,663 page views.

Further development of mindhealthconnect in 2014-15 is under consideration.

[National Health Services Directory](#)

The NHSD went live in August 2012 and is available online and as free smartphone applications on Apple and Android.

The NHSD was established to provide consumers and health practitioners with access to accurate and current provider service information such as location, opening hours and telephone numbers for general practices, pharmacies, hospitals and emergency departments.

Information for psychology, occupational therapy, speech pathology, physical therapy and dental services is now also being collected and collated.

The NHSD provides access to Endpoint Locator Services, aligning with the National e-Health Transition Authority requirements to support secure clinical messaging and the Personally Controlled Electronic Health Record adoption strategy.

The NHSD identifies those services available by telehealth. This assists GPs and specialist service providers to locate one another in support of patients with limited local access, particularly those who live in remote or regional communities. This information is currently provided through the Royal Australian College of General Practitioners website.

HDA has also developed a Health Planning Tool which supplements the NHSD with population health and Network data to support MLs, state and territory governments and Local Hospital Networks in their service planning.

From July 2012 to 30 September 2014 the NHSD database has received 2,335,492 visits and there have been 7,776 downloads of the mobile application.

Online Symptom Checker

HDA has developed an Online Symptom Checker to complement its telephone helplines. The Symptom Checker is an online tool for consumers to check their symptoms and get trusted information and advice on what to do next. The Symptom Checker:

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- guides people to the appropriate type of care at the appropriate time using an online system which can service a large number of consumers for a relatively low cost;
- encourages and supports reluctant, intimidated, embarrassed or geographically isolated consumers to seek medical attention at the appropriate time;
- provides focused guidance to self-care information to consumers of Healthdirect's website services, based on medically informed questioning, and so contributes to the overall objective of improving health literacy; and
- will become a complementary option for the core HDA nurse triage service.

The Symptom Checker is not a diagnostic tool or substitute for face to face care. It assists the user to work through their symptoms and determine the best course of action for treatment. It also helps to improve health literacy by providing clear and detailed information throughout the journey, with supporting information and self-care advice.

Consumers will be better informed when/if they need to see a health professional. This is especially helpful out of business hours if their local GP is not available and it's not an emergency but they need health advice on what to do.

On 11 July 2014, 14 Symptom Checkers were launched online by [Healthdirect Australia](#). An additional five were published on 31 July 2014. The Symptom Checker will continue to evolve to include more symptoms over time.