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OVERVIEW

This proceedings report provides a summary of the After Hours Primary Medical Care Symposium held in Canberra on Sydney on 3-4 April 2003. This was the 5th in a series of annual conferences.[1]

The symposium

The 2003 Symposium sought to identify key issues and stimulate innovative thinking to inform policy and system change in order to improve the delivery of after hours care. The Symposium was conducted as part of the four – year After Hours Primary Medical Care (AHPMC) program. The Symposium was divided into four key streams:

People – in order to address issues relating to workforce, including training, consumer expectations & behaviour, remuneration & incentives;

Systems – in order to address issues relating to policy, regulations, organisational structures, quality & sustainability;

Information – in order to address issues relating to communication, including IT functions, education & access; and

'24/7' industries – in order to consider the needs and practices of comparable services that operate on a requirement of being available and accessible 24 hours a day, seven days a week.

The Symposium consisted of a mix of plenary presentations and concurrent sessions. Abstracts of papers presented to concurrent sessions are included in this report. The agenda is outlined in Appendix A.

After hours primary medical care

The provision of After Hours Primary Medical Care (AHPMC) has emerged in recent years as an important element of the overall health care system. The Commonwealth is working towards the development of a national policy framework for the provision of AHPMC and identification of accessible and affordable after hours services.

The level and types of service that should be available after hours has become the focus of reviews both in Australia and overseas. In Australia, After Hours Primary Medical Care Trials (AHPMCTs), commenced in 1999 at four different sites around Australia, for a 12 month trial period to raise and test some of the issues surrounding this topic. A fifth trial in Western Australia commenced in late 2000. These trials provided opportunities to identify and address the broader implications for primary medical care, including workforce, finance and integration issues. A National Evaluation has assessed the effectiveness, financial sustainability and transferability of approaches taken by the individual trials, while local evaluations focused on regional issues.

As noted in previous reports, for many years the delivery of after hours primary medical care in Australia was largely dependent on individual general practitioners (GPs). Traditionally GPs provided after hours care to their own patients. However, over time there was a decline in own – practice care resulting from both changes in general practice and in the way general practice is organised and financed. GP cooperative rosters were commonly one way of addressing this, particularly in regional areas, and deputising services another, particularly in metropolitan areas.

1 Information regarding after hours primary medical care, including publications and reports of previous workshops can be found at www.health.gov.au/gpconnections

No matter what the response, a number of key barriers to the provision of after hours primary care services were identified. These included financial constraints that have not been seen as rewarding for GPs to do after hours work. However, these need to be seen in the context of other developments in GP lifestyle choices, changes to the nature of the GP workforce and provider number restrictions, safety concerns and business issues: all of which over time resulted in a decrease in the pool of GPs available and willing to work after hours.[2]

While workforce issues are critical, other problems were identified in the way in which after hours care is provided. These include both issues around continuity and quality of care, and funding issues. It is generally acknowledged that many people access hospital Emergency Departments (EDs) after hours due to a lack of other options and that in a number of cases this does not represent an appropriate use of ED services and infrastructure. In this context, after hours care was identified as an area requiring development to address fragmentation in service provision, the inappropriate use of services, inadequate communicate links, limited continuity of service, changing attitudes of service providers and consumers, and remuneration and funding issues.

Commonwealth programs

Since 1997 there have been a variety of developments in policy, funding, research, trialing and evaluation. It could be argued that the genesis of the program arose from the problems faced by the providers of after hours primary medical care – GPs, medical deputising services and hospital Emergency Departments – and the financial implications of providing after hours care. However, since then the scope of the program has both matured and broadened. Local experience has been transferred into policy responses, and policy and targeted funding used to develop best practice models for local communities.

A number of developments have occurred since 1997. An understanding of consumer preferences and attitudes has been documented through research and experience. Specific attention has been paid to the needs of marginalised and disadvantaged communities. Research has been expanded to use international evidence to inform the Australian experience. Evidence from the AHPMC trials has been widely distributed and discussed. Divisions of General Practice and State and Territory health agencies have commenced closer collaborations. The work of medical deputising services has been supported in policy and funding terms. A wide range of data on the demographics of communities and service providers has been collected and deployed. Attention has been paid to the roles and needs of the wider primary health care workforce in after hours care, and significant advances have been made in healthcare information technology to enable a better flow of information between providers and ensure greater continuity of care.

2 See Karabatsos G 1999 'After Hours General Practice Services: A Guide for Divisions of General Practice, Access SERU, Melbourne

Under the National After Hours Primary Medical Care Grants Development Program, a number of models of after hours care have been developed, tested and implemented. The key components of these models include people, systems and information – components that are integral to the development of quality after hours services.

Commonwealth perspectives

Commonwealth perspectives were provided by the Hon Kay Patterson, Minister for Health and Ageing, Mr Andrew Stuart, First Assistant Secretary, Primary Care Division, and Dr Rob Pegram, Principal Medical Adviser, Primary Care Division.

Senator Kay Patterson [3] emphasised that after hours primary medical care is a very important issue, and particularly relevant to people with chronic and complex needs. She drew attention to developments in information technology, including opportunities for greater sharing of medical records with patient consent. She endorsed the work undertaken to date, and announced a further round of funding under the program.

Mr Andrew Stuart [4] noted the significant financial support provided under the Grants Program, which has allowed a variety of models of care to be trialed and tested. The Grants Program comprises three phases, allowing for the strategic development and enhancement of after hours models of care:

- *Seeding Grants*, 54 grants to date which provide funding to conduct needs analyses and/or develop business plans with the aim of developing a full service proposal;
- *Infrastructure/IT Grants*, 12 grants to date which provide funding for projects that aim to assist with information management and/or information technology solutions for the delivery of efficient and effective services; and
- *Service Development Grants*, 20 grants to date which provide funding for after hours service implementation, delivering local solutions for after hours care.

As a result, after three rounds of funding the After Hours Grants Program has funded a total of 86 grants to a value of $12.08 million. The final round of funding is specifically seeking applications for Service Development Grants.

Mr Stuart stated that the aim of such grants is to enable the implementation of local solutions for the provision of quality after hours care, and funding will therefore be provided to support initiatives and innovative solutions that encourage collaboration and service integration.

Mr Stuart observed that significant lessons have been learnt so far, and a recent review of the information from the first round of funding had revealed some national trends worth noting. As an example, co-operative and collaborative models of after hours care are more likely to be viable where stakeholder commitment is high. Also, the benefits of telephone advice have become clear, helping to reduce the after hours workload and assisting patients to make more informed and appropriate choices for their after hours care. It has also become evident that the more successful funding projects have learnt from the previous after hours trials and have looked at ways to transfer successful models to their local situation.

3 Senator Kay Patterson is the Minister for Health and Ageing. Before entering the Senate she held academic appointments in behavioural science and gerontology in Australia and the United States.

4 Mr Andrew Stuart heads the Primary Care Division within the Commonwealth Department of Health and Ageing. He has a history of involvement with rural health, mental health, coordinated care, general practice, and aged care.

Mr Stuart noted that the aims of the After Hours Program are in accordance with the overall goals of the Primary Care Division, which seeks to create a culture of health care that supports consumers and providers by increasing the efficiency and effectiveness of the primary care sector. This involves supporting collaboration and integration, as well as developing financially viable and sustainable models of care.

Mr Stuart commended Dr Pegram for his successful leadership of the after hours agenda over a number of years.

Dr Rob Pegram [5] began his presentation by noting that enhancing the quality of after hours primary medical health care has become a key component of the Commonwealth's goal to provide quality health care to all Australians. In the 2001-02 Federal Budget, $43.4 million was provided over four years to fund the After Hours Primary Medical Care (AHPMC) Program - and it is worth remembering that there were five parts to that platform:

- existing trial extensions;
- new service developments;
- quality incentives for deputising services;
- health call centre policy development work (with the States and Territories); and
- research.

This commitment arose as it became clear that providing accessible and affordable after hours care raises a complex set of demand issues yet to be thoroughly examined, and it was evident that some aspects of after hours care were working well but that other areas were in need of significant improvement. The aim of the AHPMC program is to enhance after hours services for all members of the community, which includes health care providers as well as consumers. In this context, the program has developed new services and improved existing ones within a range of constraints. On one hand, there are now several better versions of an older model, the model itself needs maintenance, detailed additional work and careful analysis of its limitations. On the other hand perhaps a more complete rethinking is required, with new models, new ways of working, and new standards of performance.

To date, several improvements to after hours care have been made, and undertaken in partnership with EPAG as the stakeholder forum, major initiatives including;

- the Grants Development Program, with a number of models of after hours care are being developed, tested and implemented;
- Quality Innovation Funding, which has offered significant financial support to both existing and new after hours services with the aim of rewarding quality initiatives & innovative solutions;
- the enhancement of standards and accreditation, both of which are integral aspects of activities in the program;
- input into parallel workforce and financing programs across the Department; and
- research into consumer issues, which may lead to financial modelling.

There are five broad models of care operating across Australia:

- private practice models;
- models of co-location;
- cooperative models;

5 Dr Rob Pegram is a general practitioner, and is currently Principal Medical Adviser for the Primary Care Division, Commonwealth Department of Health and Ageing.

- medical deputising services; and
- telephone assisted services.

Testing these models enables advancements to be made in overcoming barriers, such as service integration. The research and information gathered to date indicates several barriers in providing after hours care. Most notably, these include a lack of financial sustainability within current systems, GP workforce shortages, inadequate GP remuneration, and a lack of service integration, notably at the hospital interface. This information is helping to build the evidence base, which is an important part of the learning process and is also vital for positive reform.

Dr Pegram provided data which, with some caveats, suggested that since the program commenced in 1999/2000 a 6% per annum decline in MBS after hours service claims had been reversed, and that there is currently a 2% per annum increase.[6] He also presented data on the various sources of funding available at present and their features, as discussed by EPAG during its deliberations on financing. These include funding from the MBS, the PIP, grants, and payments by patients. Not all are quantifiable or traceable, some are volume dependent, and there are questions about the sustainability of non-MBS or PIP funding. Dr Pegram argued that this data is consistent with evidence on the progress of new innovations, and the challenge now was to move this into systemic change.

Dr Pegram stressed the focus needs to be on what we are trying to achieve. He suggested that the key relationship was between a provider and a patient, and a perfect result linked the right patient with the right provider, and at the right time and place. Here there are multiple issues to be dealt with. For the provider, these include issues of workforce, remuneration, safety, lifestyle concerns and training and standards. For the patient, these include issues of access, affordability, quality and knowledge. In addition, after hours services are not isolated, must link to other providers, and operate within system constraints in an ongoing cycle of monitoring and adjustment.

The current AHPMC program has two more years to run, which allows for further testing of models, increasing the evidence base, and trialing opportunities to increase benefits and address barriers. EPAG is currently developing a compendium of works and recommendations to the Department, Minister and the profession to enhance after hours care based on principles of best practice.

Dr Pegram concluded by observing that there are other activities that will impact on after hours service, including budgetary measures, the outcome of broader government and Divisional reviews, and the Australian Health Care Agreements.

6 Between 1997/98 and 1999/2000 claims under this item fell from around 690,000 to 600,000. By 2001/02 this had risen to around 620,000.

PEOPLE

Presentations

Dr Ian Knox – General Practice Patients in Emergency Departments

Dr Ian Knox is an emergency physician in full-time clinical practice at the Wesley Hospital in Brisbane. He is president of the Australian College for Emergency Medicine and President of the International Federation of Emergency Medicine. Dr Knox discussed general practice patients in hospital Emergency Departments (EDs).[7] He focused on:

- access block and overcrowding in hospitals;
- the question of 'inappropriate attendance';
- co-location as a means of increasing after hours GP services; and
- priorities for Emergency Medicine.

Access block and overcrowding in hospitals

Access block occurs when patients have already been triaged through the ED, and are waiting for a bed in the hospital. Access block occurs as a result of a number of causes, including a decline in the number of hospital beds, decline in nursing staff numbers, decline in the capacity of nursing homes (including staff skills), inadequate funding arrangements and the ageing of the population. The consequences of access block include increased adverse incidents, increased length of inpatient stay, degradation of service availability and performance, and staffing issues.

He noted there were a number of causes of overcrowding, and while clearly access block was one, it is not clear whether it is caused as a result of other pressures in the health system, including changes in the GP workforce, the decline in bulk-billing, medical indemnity or 'epidemic' scares, such as with meningo-coccal.

Dr Knox suggested that there were two ways of measuring overcrowding:

- waiting time in the ED by triage category. Here it appears that in general, EDs are meeting their benchmarks; or
- access block, where the number of admissions where the ED time is less than 8 hours is measured as a proportion of the total number of admissions. Here it appears that there is considerable variation between hospitals, with the majority not meeting the 8 hour benchmark. It is worth noting that quite different data is used in measuring access block and waiting times.

Inappropriate attendance

He argued that there were many complex issues around the definition of 'inappropriate' attendances, and we must be careful not to blame the patient, that data on ED patients is by nature retrospective (ie, defined as a result of the triage process), and a recent study of low acuity patients presenting to a major metropolitan teaching hospital suggests that only 10-12% could be defined as inappropriate. [8] 'Inappropriate' attendances were also defined in terms of cost-shifting and that while there are many instances where GP type patients may be inappropriately accessing specialist clinics it only appears as an issue where costs can be shifted from State/Territory or private hospitals to Medicare funded services.

7 Note that a range of information, including policies and guidelines, can be found at the website of the Australasian College for Emergency Medicine, at www.acem.org.au

8 See Sprivulis, P Estimation of the general practice workload of a metropolitan teaching hospital emergency department, Emergency Medicine (2003) 15 32-37.

Co-location

Dr Knox noted that co-locating a GP service with an ED to increase after-hours GP services could have benefits in terms of efficient use of resources and safety and security. However, he also argued that this could increase demand, attract GP type patients to the ED, and raised questions around unequal levels of remuneration and the sustainability of the service.

Priorities for Emergency Medicine

Dr Knox concluded by noting that the priorities for Emergency Medicine were:

- balancing elective and emergency admissions;
- addressing access block;
- precision bed management at a regional as well as a hospital level;
- funding; and
- developing whole of government and whole of system approaches.

Dr Jill Maxwell – Developing and sustaining the workforce

Dr Jill Maxwell is a general practitioner in Adelaide. She is chair of the General Practice Partnerships Advisory Council (GPPAC), chair of the Medical Defence Association of South Australia, a member of General Practice Education Training, and a Senior Medical Officer at the Strathmore Centre for people with intellectual disabilities. Dr Maxwell addressed the issue of developing and sustaining the after hours workforce in the context of work undertaken through the GPPAC. She focused on:

- the role of GPPAC;
- rural and remote issues;
- the Access taskforce;
- the Chronic Diseases Integration taskforce;
- reforms to practice payments; and
- after hours care in South Australia.

GPPAC

Dr Maxwell noted that GPPAC was established in 1998 to implement findings from the GP strategy review, but that it is not a GP group per se. GPPAC provides advice to the Minister for Health and Ageing relating to the general practice partnership with a focus on monitoring the impact of policy and programs, developing policy options, developing a work program and establishing taskforces and standing committees as required, and ensuring effective communication and consultation with other relevant bodies. Until 2000-2001 GPPAC consisted of a number of standing committees focused on:

- consumers;
- quality;
- rural and remote issues;
- Aboriginal and Torres Strait Islanders;
- Divisions of General Practice;
- primary health care;
- research, evaluation and development; and
- workforce and financing.

In 2002 GPPAC was restructured, with two new taskforces addressing access, and chronic disease integration.

Rural and remote issues

In particular, Dr Maxwell discussed the work of the Rural and Remote standing committee, pointing to the Rural & Remote GP Program, the development of the GPARIA rurality index, and a range of rural retention incentives. She also noted there appeared to be little progress in the development of micro-simulation modelling that might be used in developing workforce policy.

The Access Taskforce

The goal of the *Access Taskforce* is to improve community access to quality general practice and primary health care, to consider how access affects health status and quality of outcomes, and how the current system be changed to improve access.

Issues include geographical access, timely access, and affordability. Consultations are being undertaken to examine these issues. Priorities for the taskforce include Aboriginal and Torres Strait Islander health, workforce and financing, and community infrastructure (such as transport, aged care, disability and allied health services). The taskforce is considering:

- the availability of GPs, and affordability to government and consumers;the impact of community infrastructure; andhow to direct health funding to those most in need.

Current activities include a focus on the issue of after hours access to pharmaceuticals.

In relation to the policy issues regarding the development and sustainability of an after hours primary medical care taskforce, Dr Maxwell suggested we need to look at:

- **price**, where there are many barriers for access, particularly for people with chronic and complex conditions, people in residential care and residential aged care facilities and low income earners;
- **availability**, which is patchy across geographic and demographic regions, and low in rural and remote areas and some outer-metropolitan areas;
- **community infrastructure**, which is often weak and overloaded; and
- **consumer education**, where the Access taskforce is recommending a consumer education campaign.

The Chronic Disease Integration Taskforce

The goals of the *Chronic Disease Integration Taskforce* are to improve general practice quality of care for people with chronic and complex conditions, and to improve integration and coordination of general practice with other health and community services. Issues include:

- practice structures and capacity;
- finance systems;
- targeting special needs groups and disadvantaged populations;
- IM and IT, and standards for terminology;
- patient linkages;
- encouraging multidisciplinary teams; and
- GP numbers and availability, and the role of practice nurses.

Practice payments

Dr Maxwell noted that GPPAC was considering proposing an annual Practice Infrastructure Payment based on a revised accreditation system to reform the current and complex blended payments system, where:

- practice accreditation is based on quality principles and indicators;a prospective annual payment is made to accredited practices;there are initiatives to support a locally relevant practice population approach.

This could support a multidisciplinary team approach and decrease the administrative load for GPs. It could be gradually implemented over a three year accreditation cycle, and there would need to be mechanisms to ensure that the practice payment ensured that employed GPs were properly remunerated.

After hours care in South Australia

In conclusion Dr Maxwell drew attention to some South Australian experiences with after hours care, noting that many 24 hour clinics have ended up closing between midnight and dawn, that GP collectives have not been that successful, and that there is a high frequency of locum visits. She suggested that the Danish model of telephone triage services staffed by GPs could be a possible option.[9]

Ms Robin Tchernomoroff – The role of nurses & a combined workforce

Ms Robin Tchernomoroff is employed by the Collaborative Health Education and Research Centre of the Bendigo Health Care Group. She is an instructor for the Trauma Nursing Core Course and the Emergency Paediatric Course. In 2001 she edited the 3rd edition of the Emergency Nursing Guidelines.[10] In the guest presentation on the first day Ms Tchernomoroff discussed the development of a telephone triage education program for nurses. She focused on:

- early challenges and strategies;
- the nature and practice of telephone triage;
- distinctive characteristics of rural triage;
- current challenge and strategies; and
- the future.

Early challenges and strategies

Ms Tchernomoroff began by noting that Australian data shows that the provision of telephone triage is a service rated highly by the community, compliance with advice is strong, and that most calls are after hours where paediatric calls predominate. She argued that experienced, educated staff give the best advice, and that protocols alone are not enough. [11]

Early challenges included addressing anxieties about the possibility of wrong advice and incorrect or incomplete assessment, caller mistrust or misunderstanding, and poor or incomplete documentation. People were also concerned that telephone triage was an unrecognised practice, there was a lack of professional practice guidelines so that advice was dependent upon the individual rather than protocols, informed practice was not available to determine content and there was a limited body of knowledge to draw from, both in Australia and internationally.

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9 See Christensen, M.B., Olesen, F., (1998) Out of hours service in Denmark: evaluation five years after reform. BMJ **316**: 1502-05.

10 Bendigo Health Care Group is a multi-campus, progressive health care organisation in regional Victoria, and the largest provider of acute, rehabilitation, residential and community care in the Loddon Mallee region. Within the organisation, the Collaborative Health, Education and Research Centre has the primary responsibility for nurse education, including development of relevant educational strategies to facilitate clinical practice.

11 See Fatovich, D.M. (1998). Emergency Department telephone advice. MJA **169**: 143-6; Edmonds, E. (1997). Telephone triage: 5 years' experience. *Accident & Emergency Nursing*. **5**: 8-13; Fifield, M. (1995). Telephone triage: protocols for an unacknowledged practice. *Australian Journal of Advanced Nursing*. **13**: 5-9. See also Crouch, C. (2003) Unpublished PhD, Hegney,D.G. (1996) *The windmill of rural health: a Foucauldian analysis of the discourses of rural nursing in Australia, 1991-1994.*Lismore, Faculty of Health Sciences, Centre for Nursing, Southern Cross University.

In addition, the most suitable instructional methods and sequencing of content was unclear.

Early strategies involved developing a focus on area of practice considered appropriate to inform content, particularly triage and emergency nursing practice within rural contexts. Knowledge was drawn predominantly from triage and emergency literature and clinical practice, and a lecture style with a focus upon information giving was utilised as the primary instructional method.

The nature and practice of telephone triage

Triage assessment is an initial, individually focused patient assessment, not always within the formalised framework of a designated triage area. Triage assessment may vary from hospital to hospital, but always remains a continual process, and is an integral part of the nursing process in any nursing location.

The triage decision is based on the current condition of the patient and potential for deterioration. Collation of the information then allows accurate identification of the patient's problem.

In order to determine the urgency of a telephone triage call, the nurse must understand and be able to apply the principles of triage assessment, appreciate the complexity of the communication and decision making processes inherent in conducting triage via the telephone and apply strategies to manage this process.

Naturally, there are differences between face to face triage and telephone triage. Face to face triage is quick, all senses are available for use and the patient's appearance is tangible. Urgency is addressed using normal assessment processes, and the environment, roles and relationships are clear. Once contact with the service is made, the patient role is inherently passive

Telephone triage contains a number of perils and pitfalls. These include the potential to stereotype or second guess callers or problems, failing to identify hidden agendas or provide reassurance, or collecting inadequate data or allowing inadequate talk time. Maintaining quality and monitoring requires continuing education on difficult issues as well as current issues and trends, auditing of documentation, use of protocols and monitoring the accuracy of advice provided. Experienced staff are essential, with the ability to adapt if the need arises.

Grossman has suggested there are six main components in the process of telephone triage: [12]

Step 1 Introduction of self and opening communication channels

Step 2 Perform the assessment via interview

Step 3 Make the triage decision

Step 4 Offer advice according to protocol or established guideline for care

Step 5 Incorporate follow up plans when concluding the call

Step 6 Document the call

In all the above, basic principles of practice are:

- established and approved protocols help provide consistency with a desired standard of care;precise documentation is mandatory;if patient attendance not required, advice on home care must be given;patient safety must always be balanced with efficient use of available

12 Grossman, V. (2002) *Telephone triage course.* Availsable at www.rnceus.com/triage/index.html

resources; andthe nurse must always be a patient advocate.

Distinctive characteristics of rural triage

Beyond the above, Ms Tchernomoroff noted that there are some distinctive aspects of telephone triage in rural settings. These include the fact that the triaging nurse will often know people in the community, and be known by them, resulting in a lack of anonymity. A broad range of knowledge and skills is required, there can be isolation from support services and a relative lack of other options for care. Decisions may carry enormous financial or geographical ramifications, and therefore consequences for carers.

Current challenges and strategies

Current challenges include developing an acknowledgment of the practice of telephone triage, education, research and debate, the informed development of different service models in association with standards in practice and professional profile, and in ensuring the system supports service providers.

Ms Tchernomoroff observed that the program is designed primarily for a 'triage' rather than an 'advice' model, and that education may be seen as representing explicit 'truths' rather than information that is viable at the time. There is a need to broaden our knowledge base of the Australian experience and its implications for education decisions to ensure the education meets the learner and service needs. As a picture of ideal characteristics for potential providers of the service is emerging, there is also a need to bring recognition for the level of expertise required to undertake this practice.

Current strategies are to ensure the program design continues to be a dynamic process, with instructional methods moving toward a greater use of practical exercises in decision making and managing the communication process. Expertise should be made explicit through the development of post-graduate and Masters level programs. Nurses are pioneering the practice, and identifying their own learning needs from experience. Gaps in early education programs are becoming apparent, as are the similarities and differences of telephone triage practice to that of emergency nursing and face to face triage, including more practical information related to handling the telephone triage episode and communication processes in general.

The future

The future holds the possibilities of undergraduate, postgraduate education and research opportunities, and developing a body of knowledge based upon the Australian experience driven by those in clinical practice, and where education content is being driven by the learning practitioner. It also provides new career path for nurses, and empowering and enhancing nurse/doctor relationships.
The development of the practice of nurse-led telephone triage is breaking new ground, and can improve health care access for rural patients.

Ms Tchernomoroff drew attention to models of assessment and data flow recently developed by Crouch. These are outlined in slides 34-36 of her presentation, provided in the Appendices.

Discussion

This section summarises the discussions and observations of Symposium participants during both plenary and concurrent sessions. The sessions on 'People' were facilitated by Ms Kathy Mott.[13]

There was consensus among participants that the current system was unsustainable in the longer term, with workforce and funding issues being critical. In broad terms, it was noted that while a national approach to the issue was required, this needs to be strategic, and not impose a single model or approach. A number of participants also drew attention to the time-limited nature of much of the available funding.

Participants also noted that the provision of after hours primary medical care was an essential public service, and drew parallels to the work of ambulance and police services, but also noted that these latter services are provided through models which are directly structured as public services, and where employees are salaried and unions play an important role whereas after hours primary medical care is largely provided through a private sector structure.

The issue of roles and responsibilities of professionals was also considered, particularly in whether or not paramedics or nurses and nurse practitioners could replace GP services, and there was general agreement that this was not a desired outcome.

Participants also drew attention to rural and remote issues, weaknesses in the PIP, and the need to remove financial barriers to accessing after hours services.

Abstracts

General Practitioners for Quality

Adelaide Central and Eastern Division of General Practice[14]

This After Hours Primary Medical Care Project was conducted by a group called General Practitioners for Quality. The project aim was to conduct a feasibility study in the eastern suburbs of Adelaide with the purpose of developing a sustainable and viable model for an after hours clinic.

Lessons

- the value of a private GP group running the project with strong GP Division support;
- the identification of the advantages and disadvantages of a privately owned versus a cooperative GP clinic; and
- the importance of dialogue between key stakeholders in after hours health care.

Obstacles

- GP apathy about after hours work;
- GP participation conditional on financial rewards;
- the concept of an after hours clinic being new, requiring marketing and promotion; and
- local resident resistance to late hours of opening.

13 Ms Kathy Mott has a long history of involvement with community development and social planning and has managed a number of consultancy and evaluation projects for the University of South Australia. She is an active consumer advocate at national and State levels, with a focus on primary health care, pharmacy, mental health and disability.

14 Dr Richard Hetzel, PO Box 420 Marden SA 5070 Phone 8363 1244.

There were a number of successes that encourage a promising future for this after hours clinic. We found the concept had strong media and community support. Surprisingly a basis to cooperate with the (privately run) GP locum service was discovered. State government showed a willingness to provide significant financial support. There was also substantial support demonstrated by a private hospital in providing a physical location for our clinic.

Better General Practice for Better Health

Ipswich and West Moreton Division of General Practice

The objective of this collaborative project is to provide high quality after hours primary care services for the Ipswich community and adequate remuneration and a reasonable after hours workload for GP co-operative participants. The new after hours primary medical care service will assist local GPs in meeting their duty of care after hours, will protect local GP interests and maintain a skilled GP workforce in acute medical care.

It will provide consumers improved access to AHPMC services in Ipswich with a central, well equipped, safe and secure after hours premises operating during peak hours of demand, as well as appropriate and timely care, as care is coordinated between GP after-hours and Emergency Department (ED) and improved continuity of care between services.

It aims to provide Ipswich Hospital relief for overburdened ED staff and cost sharing of resources for the Private Practice Clinic, as well as improved communication with GPs.

The service model developed for implementation provides a win-win situation for all key stakeholders.

This was a significant change management project in which all parties had to understand the wider issues, as well as their own, in order to develop a solution that could meet all needs efficiently and effectively. This paper discussed the obstacles, successes and key lessons learnt during this process. In Queensland, it is one of the few examples of how strong partnerships between local GPs and the District Health Service has resulted in a new after hours clinic located at the front entrance of a public hospital.

Needs Analysis in Rural and Remote areas

Mackay Division of General Practice[15]

This project aims to undertake a Needs Analysis in Rural and Remote areas of the Mackay Division in order to:

- identify the range of services currently providing after hours primary medical care in the Mackay rural areas and the hinterlands;
- identify the issues of after hours primary medical care service delivery and access to consumers in rural areas and the hinterlands and Indigenous and South Sea Islander peoples throughout the Division; and
- develop and produce a model for after hours primary medical care that meets the needs of consumers in Mackay rural areas and the hinterlands and Indigenous and South Sea Islander peoples throughout the Division.

15 email admin@mckaydgp.com.au website www.mackaydgp.com.au phone 07 4953 4491.

Lessons

Rural and hinterland consumers are severely challenged in their efforts to access care due to necessity to travel long distance in a time of crisis, cost and availability of transport, lack of knowledge of service options, lack of information on service availability, availability of service, and lack of advice to direct them to the most appropriate service. Local services, such as a resident GP, local hospital, pharmacy, radiology and pathology are not easily accessible and in some areas non-existent.

Indigenous and South Sea Islander people in the region share many of the same challenges in the Mackay urban area, in addition to heavily weighted cultural issues that hinder access to the current after hours service options.

The issues affecting the rural and Indigenous and South Sea Islander communities, in relation to accessing after hours care, cannot be underestimated. Extensive community consultation and feedback reinforces the importance of finding a local and workable solution.

A dependable resource for advice, reassurance and direction to minimise barriers to service can support consumer confidence. A nurse telephone triage line supported by an existing after hours service in the closest provincial city can provide this support.

Obstacles

- Cost; and
- Telephone service reliability and availability.

Successes

- Appropriate advice from a trained professional enables the rural consumer to travel directly to the most appropriate service;
- Patients and carers can be reassured in the decision to travel or wait; and
- Self-care is encouraged and supported.

SYSTEMS

Presentations

Dr John Aloizos – Striking a balance: the profession & the bureaucrats

Dr John Aloizos, AM has worked as a GP in Brisbane since 1977. He has held many senior positions in the past, including membership of the GP Strategy Review, chair of the ADGP (1998-2000), president of the Queensland Divisions of General Practice (1999-2002), and inaugural chair of Australian General Practice Accreditation Ltd (1997-2003). He is currently chair of the Australian Pharmaceutical Advisory Council and represents GPPAC on bodies concerned with chronic disease, asthma and information technology issues.

He suggested that the key questions concerned what:

- do we know about after hours primary medical care?
- is the evidence on the challenges and possible ways forward?
- can be done by Government to address the emerging challenges and issues?

- can the profession do to address the emerging challenges and issues?

He focused on:

- what we do know about after hours primary medical care;
- what we don't know about after hours primary medical care;
- key issues; and
- GPs and bureaucrats: the challenge of communication.

What we know about after hours primary medical care

Dr Aloizos outlined a number of emerging challenges for after hours primary medical care (AHPMC), including demand pressures as the population ages, affordability, overloaded acute care services, system fragmentation, workforce capacity and time limits on funding programs addressing this issue. He noted that while there had been a slowing of growth in MBS expenditure since the mid-1990s higher rates of growth had occurred within the PBS and with hospital expenditure.

In relation to after hours primary medical care he suggested we know that:

- there is no 'one system fits all' that works, and just as with primary medical care in general there is no shared vision for AHPMC;
- there is no clear responsibility or authority for emerging AHPMC issues and that the Commonwealth/State divide in health does not help;
- AHPMC policy needs to be linked with the broader primary health care policy framework, GPs are becoming burnt out and are walking away from AHPMC, and that we are reaching the limits of 'bit by bit' reform.

What we don't know about after hours primary medical care

There are many gaps in the data. Dr Aloizos suggested that:

- there is no accurate data on after hours service provision in the community, nor cross sector monitoring;
- we do not know if there will be more flexibility in the new Australian Health Care Agreements to allow better GP engagement with hospital EDs;
- we have little information on how PIP payments are working.
- we do not know where and how patients might get their after hours visit prescriptions filled;
- we do not know whether or not the trial sites are sustainable after dedicated funding expires; and
- we don't know what we don't know!

Key issues

Dr Aloizos identified a number of key issues. He argued that the relationship between AHPMC needs and the health workforce remains unclear, with a sense that AHPMC is no longer a part of mainstream general practice, whether or not all GPs working in the after hours sector should be able to access specified Medicare items, and the potential roles of OTDs and TRDs in areas of need.

He also drew attention to rigidities in the MBS in relation to after hours care, in that there are questions about whether it encourages home visits as opposed to clinic based care, and that it does not provide sufficient data to answer many pressing questions. He also noted that current Practice Incentive Payments were vague in terms of who was actually providing an after hours service as opposed to who claimed they were providing the service, and questioned the PIP's ability to build after hours capacity. There are also issues regarding standards for practices, medical deputising services, and the roles of bodies such as the RACGP and ACRRM.

GPs and bureaucrats: the challenge of communication

In conclusion Dr Aloizos pointed to the possibility of errors in thinking, and that it was incorrect to assume that the GP working environment was well linked with Commonwealth and State programs and thinking, which is not the case. He reported some of the findings from a qualitative GPEP project in 2000, which looked at the values of, and relationships between GPs and Commonwealth officers. This report suggested that:

- The data clearly demonstrates that GPs value their autonomy and independence, and that they explain it in terms of their work conditions and the nature of decisions they make on a daily basis.
- In contrast, bureaucrats operate within a hierarchy and a system of rules and regulations that attempt to ensure the decisions made are in the best interest of the broader community.
- Despite the best intentions of both groups, things can still go wrong, and the financial and procedural accountability required by the government proved a particularly thorny issue for both parties. Despite a decade of engagement, it seems that the two groups still don't always give the respect the other deserves.
- At the end of the day both GPs and federal health officers do their best to improve the health system. Both are accountable to the public, but the nature of that accountability differs, and in the case of bureaucrats, their actions take place several steps removed from the people it affects. [16]

Ms Victoria Chalmers – Health call centres – friend or foe?

Ms Victoria Chalmers is currently an Information Strategy Officer with Queensland Health, specialising in the areas of information management, strategic planning and information technology investment planning, and is the Queensland representative on the National Health Call Centres Jurisdictions Group. She has over 10 years experience in the disability and health sector in private, public and community based organisations, including the establishment and management of a telephone inquiry service. She focused on:

- trends in population growth, health funding and health trends;
- characteristics of future health care models;
- possible models for health call/contact centres; and
- funding options.

16 K Dwan, J Western, R Pegram and J Aloizos, GPEP Project, 2000

Trends

Ms Chalmers noted that one of the major trends in health and health care in the developed world is ageing populations, and that in 2006 the first of the baby boomers will begin retiring. While the majority of older people are relatively healthy, people over the age of 65 are four times more likely to require hospital type medical assistance than are people under the age of 65. The ageing of the population will put considerable pressure on the number of health care services to be delivered by 2020.

Our available labour force is getting smaller. The Australian health workforce has grown by 48 per cent since 1986, however we have significant shortages in the areas of nursing and some medical specialities. Health workforce shortages are being experienced across the western world. The ageing population and lower birth rates in Australia will place considerable pressure on the workforce over the coming decades. In Australia today, the workforce is growing by an annual rate of 170,000 per year. By 2020 this is predicted to be just 12,000 per year Australia wide.[17]

Ms Chalmers noted that while the costs of delivering health care are escalating every year, available funding is not matching the labour and non-labour cost escalations. One of the real challenges in coming years will be to ensure that any greater emphasis on private provision and payment for health services provides a cost effective means of providing health care for the Australian population as a whole.

In addition, death rates in the Australian indigenous population are higher than other indigenous populations in the world, and the much of the improvement in death rates among New Zealand Maoris and Canadian Indians in the last decade has been due to improvements in the delivery of effective primary health care services.

On current trends, all admissions for people 0-74 years to Queensland public hospitals are projected to increase by 28 per cent in the five years to 2006/07. However, preventable admissions and ambulatory sensitive admissions are both increasing faster than this, and based on current trends will increase by 52 per cent and 46 per cent respectively (48 per cent in total), in the five years to 2006/07. The Australian Institute of Health and Welfare estimates that between one-third and one-half of the burden of disease in Australia today is preventable. Overweight and obesity, sedentary lifestyles, low fruit and vegetable intake, smoking and alcohol and drug abuse increase the risk of heart attack, stroke, diabetes and some cancers. Changing high-risk lifestyles need to be a priority for all Australians. A continuation of the current health trends will see:

- increasing life expectancies;
- falling incidence and death rates for most causes;
- a further shift in burden from acute to chronic conditions;
- more frail or disabled older people;
- a sustained level of anxiety and depression, and a rise in the relative contribution of mental health conditions to the total burden of disease;

17 See the Intergenerational Report 2002-03, 2002 Budget Paper No.5

- increasing overweight and obesity in both children and adults;
- a persistence of the burden of tobacco-related disease, and that of alcohol and other drugs; and
- persisting or widening health inequalities.

Characteristics of future health care models

Many health system review reports over the past few years have documented how the health system should change from a predominantly acute, large institution environment to a health system more weighted to community and primary care.

Needed characteristics of future health care models include:

- an emphasis on health promotion and education, prevention, early detection and intervention across the life span;
- the expansion and integration of primary health care and community-based care;
- self-management of chronic conditions and the provision of information and services that enable or facilitate self-management;
- client-centred approaches to people's needs for rehabilitation, continuing care or palliative care; andnetworked communication and information systems to facilitate service delivery.

The National Health Performance Framework [18] argues that health care service delivery must be effective, appropriate, efficient, responsive, accessible, safe, continuous, capable and sustainable. If health services are delivering in these nine areas then a positive impact will be made on the health system.

Possible models for health call/contact centres

Ms Chalmers then addressed how health call/contact centres 'measure up' in this context, noting that there are many definitions, with:

- various types and sizes, including referral service, telephone enquiry service, advice/help/crisis lines, hot lines, and so on;
- various service providers, including government, non-government organisations, community-based agencies and private health insurers;the ability to manipulate large databases and repositories of information to provide consumers with reliable information customised to their specific needs in a very short time; and the technology used can handle high volumes of transactions for large catchments in one location.

Health call centres embrace many of the needed characteristics outlined above, including;

- having a core element of health promotion, education, prevention, early detection and intervention;
- the design to integrate various health services for people who have varying levels of health system knowledge;
- supporting and facilitating self-management through the provision of information and expert professional advice;
- being client-centred in responding to callers needs, and
- involving networked communication and information systems.

18 National Health Performance Framework Report (2001) www.aihw.gov.au/indicators/index.html.

In addition, health call centres align with the nine dimensions of health system performance, and are scalable in terms of consumer confidence and the types of health services offered. The aspect of a health call centre being scalable to the complexity and size of health services is very important.

Obviously not all health services are appropriate to be offered in this way. The service must be appropriate to the media channels of call/contact centres and the processes and practices must be re-engineered for these channels. The processes and practices of information privacy and security are addressed differently from a face-to-face encounter or an internet transaction. However, this does not mean that the process and practices are of any less quality or rigour. Many services have standards, procedure manuals, policies and guidelines so as to ensure a level of quality and consistency in their advice and operations, and most importantly they have skilled and often qualified employees delivering the service.

Over the past several years many reports, studies and evaluations have been published on client satisfaction, impact on the health system and consequences of advice provided. And the evidence is showing that HCC are a valued service and have a positive impact on the health system.

Today there are literally hundreds of call centre type services focusing on health and health related issues, such as:

- ambulance and emergency service dispatch services;
- peer support such as Nursing Mothers Line, Carers Support;
- counselling services such as Lifeline, Kids Help Line, Sexual Assault Line;
- advice/triage conducted by hospital emergency areas;
- information and advice services such as Poisons Information Centre, Cancer Information Line, Disability Information and Awareness Line, Independent Living Centre, etc. [19]

Most of these are independent services with specialised knowledge and/or catering to local community needs. However, they also duplicate high capital infrastructure costs and information resources, and one of the significant challenges in the near future is to design a business model and subsequent enabling technology to maintain the specialised knowledge and minimise duplication and inconsistency.

There are various reasons for the popularity of call centres in general, in particular an increased societal expectation of services offered on a 24/7 basis. The public is increasingly expecting services from grocery shopping to health care to be available beyond the traditional working hours because their working and personal lives go beyond traditional working hours. As with many health services what we are now witnessing with health call/contact centres is the expansion and enhancement of the concept to other types of health services which are conducive to a variety of online channels.

Ms Chalmers drew attention to the evolution of HealthDirect in Western Australia, which started with providing general information, referral and triage. Today it is expanding through considered process re-engineering and piloting to offer services in other areas,

19 Queensland Health alone funds and operates 50 referral/advice telephone lines and funds a further 22 services operated by community based organisations. Similar types of numbers are experienced in other jurisdictions.

including residential care facilities, mental health services, and relief to rural and remote nursing posts.

Funding options

Currently there are a number of stakeholders who contribute funding to the various types and sizes of health call centres. All levels of government in some form – non-government organisations who operate a significant proportion of health call centre type services, consumers who may pay the price of a local call, private sector organisations that may have assisted in the establishment cost, and some private health insurers which operate a call centre type service for their members.

However future trends in health care suggest costs are predicted to rise due to: increasing input costs caused by new technologies and equipment, increasing demand for health services, increasing consumer awareness of treatments, improved access to services, and a rise in medical litigation.

Therefore paying for the evolving health call centre model (like all other future health care models) will not be easy. However, as the developing model has potential business benefits at all levels of the health care system, all stakeholders should be contributing an appropriate proportionate amount:

- the Commonwealth, as there are short to medium term benefits in primary care;
- States and Territories, as there are medium to long term benefits in secondary care;
- the private sector, in a partnerships role at a minimum;
- local government and NGOs, which can contribute local and specialised knowledge; and
- consumers, though their contribution should be minimal, as in the cost of the phone call.

Ms Chalmers concluded by observing that all health care services and models change, develop and improve, and after hours primary care services and HCC type services are not exempt. Given the outlook of our future, we now have the opportunity to implement new models or enhance existing models in order to meet our health needs in 20 years time.

Discussion

This section summarises the discussions and observations of Symposium participants during both plenary and concurrent sessions.
The sessions on 'Systems' were facilitated by Dr Georgia Karabatsos. [20]

Participants observed that there were significant pressures on the health system as a whole as a result of hospital practices and acute care costs, and that the ageing population placed pressure equally on primary health care and community based systems. They noted that it was important not to change things for changes sake and lose things that are working well.

System issues need to focus on service provision to the patient rather than how services are organised, and that while after hours clinics provided a safe and secure environment there were viability problems where these rely on throughput and volume,

20 Dr Georgia Karabatsos is a Melbourne GP, and Chair of EPAG. Since EPAG was established she has played a key role in national activities such as research and grants funding with the aim of enhancing the quality of after hours primary medical care across Australia.

particularly when not co-located with hospitals. Home visits were also seen as an essential model of care, and telephone triage and advice very important, particularly in rural areas. In general, participants found a problem with throughput and competition, and questioned whether it was the case that the provision of extended hours services competed with the provision of all hours services.

In the short term, participants cited the need for reasonable remuneration, better cash flows and billing systems, the option of co-payment, and infrastructure and practice based funding tied to accreditation regimes which encompassed issues of integration, continuity of care, and the nature of patients' pathways through the health system.

In the longer term, participants argued for a holistic and community centred view, with an integrated and practical approach at the local level that builds partnerships between all stakeholders. It was also noted that at the funding level there appeared to be numerous programs running to some extent independently, and these need to work together to develop better funding models.

Abstracts

Taking a regional approach to after hours care

Canning Division of General Practice

Aims

- to coordinate a regional after hours primary care strategy to improve access to GP care across the Canning Division of General Practice region; and
- to develop a best practice model through improved practice systems, continuous improvement processes and ongoing continuous medical education in acute primary care that can be implemented in other after hours services.

Background

Canning Division is located in the Perth South East Metropolitan area and covers a population of 307 425, mostly of low socio-economic status. There is a chronic doctor shortage in the region, particularly in outer urban areas. Two after hours clinics were established in the Division in early 1999 in Armadale and Murdoch. The Division is now exploring the feasibility of establishing a third after hours clinic in Bentley, which will provide regional coverage.

The two GP After Hours Clinics are co-located in the local hospitals (one private, one public) and were established to meet a need in after hours service provision. The Division has received a service improvement grant for the Armadale clinic, which was used to develop a best practice model of after hours care.

Lessons

- a change management strategy is necessary to involve doctors in after hours care in areas of GP shortage;
- the management expertise of the Division has been a critical success factor in the establishment and ongoing management of the clinics;
- it was vital to involve stakeholders in the continuous improvement processes and the development/revision of clinic procedures;
- as the clinics operate with the reception staff and the doctors on rotation; communication processes and documentation of procedures is imperative; and
- the Division's involvement has ensured the longer term viability of the clinics.

Obstacles

The main obstacle to effectively run the after hours clinic in Armadale is attracting GPs to the roster due to the shortage of GPs, the unsociable working hours and the level of remuneration. Due to fee for service arrangements, fluctuating attendances can impact on the financial viability of the clinic.

Successes

It is estimated that these clinics have prevented approximately 10,000 inappropriate attendances at emergency departments each year. This GP cooperative model of after hours primary care has improved access in areas of high consumer need and doctor shortage. The practice manual and the communication processes have improved the quality of the service. Positive patient feedback demonstrates satisfaction with the level of access and the quality of the service provision. ED staff have reported a reduced workload enabling them to provide a higher quality of care to patients of higher acuity.

Models for after hours care

Mackay Division of General Practice [21]

Aims

- to explore options for expanding the current after hours primary medical care service at the Mater Hospital into a model to address the after hours support needs of GPs and consumers in the rural areas of Mackay; and
- develop and produce a model for after hours primary medical care that meets the needs of consumers in Mackay rural areas and the hinterlands and Indigenous and South Sea Islander peoples throughout the Division.

Lessons

- a system that has its base in an existing, well established after hours service is well placed for expansion to support outlying areas with inconsistent or no service;
- systems are needed to support rural areas as 80 per cent of rural GPs are over 55 years old and a complete change of workforce will occur over the next 5–15 years; and
- a model that addresses the issues of consumers will be a system that supports the rural GPs.

Obstacles

- funding and achieving long term financial viability;
- complexity of consumer education on the use of the nurse telephone triage service;

21 email admin@mckaydgp.com.au website www.mackaydgp.com.au phone 07 4953 4491.

- telephone number issues, 1800 toll free or user pays 1900;
- cultural issues;
- lack of interest from Queensland Health presents potential obstacles to successful integration; and
- engaging rural GPs in planning and support for changes to practice.

Successes

- successful collaboration of three agencies, Mackay Division of General Practice, Mater Misericordiae Private Hospital and Mackay After Hours Service;
- development of a model applicable to other provincial cities surrounded by rural areas;
- building on local resources to address regional issues; and
- active collaboration between key stakeholders to develop a framework for a model of service delivery.

Residential care, GP and hospital interfaces in after hours care

North West Melbourne Division of General Practice

Aims

A partnership approach to improve the service system of after-hours primary medical care for residents of residential care facilities, and to:

- assess needs, barriers and potential solutions for AHPMC to residents; and
- develop a service plan that will meet identified needs of residents, minimise demand for usage of hospital emergency departments, be part of the continuum of care provided by GPs and be part of general AHPMC services.

Method

A service plan was developed based on consultation with key stakeholders, a qualitative assessment of AHPMC needs, barriers and solutions with residents and their relatives, GPs, residential care staff, medical locum services, ambulance services and hospital staff providing emergency, acute and aged care services.

The methodology also included service mapping, quantitative data collection and analysis of service utilisation and a literature search of relevant issues and interventions.

Lessons

- The paper describes the decision pathway when a resident in a residential care facility needs medical care after hours, and factors influencing care that impinge before a person needs AHPMC, at the time of the acute episode and afterwards.
- AHPMC morbidity and service utilisation data are reported for a population of 2,598 residents in 66 resident care facilities in the northwest Melbourne area.
- Residential Care Facility residents form a large and growing population group with complex medical needs related to dementia, chronic illness and physical disability. Neither the residential care reforms nor the general practice reforms over the past decade address these needs. Our findings confirm that improving access generally to quality care in residential care facilities requires system change at a national level.

- However, significant improvements to AHPMC for residents potentially may be achieved through regional partnerships of service providers to address interface issues through improved information management and care coordination. This would facilitate continuity of care, reduce hospital presentations and bed days, and avoid the morbidity associated with movement of frail elderly patients from their familiar environment.

Obstacles and successes

Service providers did not routinely identify when a service was provided for a resident. Therefore data collection systems were initiated with the participating ambulance service, locum services and hospital. This is essential for further work on identifying needs and monitoring service delivery for residents. Partners have been funded to implement the service plan, which involves four interrelated initiatives:

- RCF/service provider partnership strategy to link residential care, hospital and community services, and to develop alternatives to hospital-based care;
- a patient information sheet to improve communication and clinical decision-making by RCF, locum, ambulance and emergency department staff;
- acute care plans for residents; and
- protocols to guide staff, and service providers in resident initiated AHPMC assessment, triage and referral, local symptom or disease management after hours, and the development of Key Performance Indicators to measure outputs of timely and appropriate care.

Systemic issues hampering the provision of after hours primary medical care

The Townsville Division of General Practice

The Townsville Division of General Practice established a co-operative of local GPs, and a partnership with the Queensland Ambulance Service, to support after hours general practice. The cooperative provides an integrated service of telephone triage, a GP clinic, secure site visits, and home visits. The aims of the Cooperative are to ensure that: the community had access to quality GP services 7 days a week, 24 hours a day; and that GP workforce and lifestyle issues are addressed by reducing the need for each GP practice, including many solo GP practices, to provide extended care and on call services for each of their particular patient groups.

Although the majority of patients presenting to the AHGP clinic attend one of the practices belonging to the co-operative, the GPs on roster are generally new to them. To ensure quality of care in this circumstance, the Townsville model's pricing structure is designed to ensure that GPs are not required to see more than 4 patients per hour. This decision was based on literature that showed that effective communication is vital to good patient outcomes and that time is the key to establishing clear communication and understanding between parties. Time to allow for patient information to be faxed back to the patient's regular GP is also factored into the figure of 4 patients per hour.

The fees charged are also designed to reflect: the actual costs associated with opening a clinic after hours which are 1.5 times greater than normal hours, and the need to support the majority of GPs who run fee for service practices 'in-hours'. Any shift from this 'fee for service model' after hours will skew services away from normal hours of service delivery.

Given the GP/population ratio in Townsville/Thuringowa, all GP practices are well attended and attract waiting lists 'in hours' regardless of whether they bulk bill or charge a fee for the service. Patients are prepared to pay the extra costs associated with a quality, 'fee for service', when the gap payment involved is approximately $25.00. They clearly are not prepared to outlay double this amount for after hours care regardless of quality. This fact has been clearly demonstrated in Townsville, when throughput dropped dramatically with the opening of an extended hours bulk billing GP service.

Waiting time at the AHGP was minimal and the patient satisfaction with the service was high. The $45 gap is the problem. Whilst the cost factor is seen as a barrier to after hours service abuse, the cost to patients needs to be comparable with 'normal hours' and 'call out services' costs. If this issue, along with the associated issues around methods of managing the rebate payments, are not addressed the Townsville experience will be one relegated to the history books. The Commonwealth must explore alternative funding approaches that support fee for service after-hours cooperative arrangements or these services will not survive.

The Townsville model makes best use of available workforce and has the potential to provide equity of access to all sectors of the community. The current system will not allow us to achieve financial sustainability without compromising quality or by expecting either the patients or individual GPs to provide financial subsidies above the norm.

Quality frameworks for telephone triage

Ms Alicia McGrath, West Vic Division of General Practice

With a significant move towards the provision of a variety of After Hours Services in Australia, lessons learned and quality frameworks need to be shared. The West Vic Division of General Practice is experienced in the area of quality improvement through their work in clinical risk management with small rural hospitals. Using this work as a basis, a quality framework for telephone triage has been developed.

Whilst critical evaluation and peer review are not new to the health industry, the development of organisational systems to improve 'quality' in after hours services is innovative in that it engages both general practitioners and the nursing workforce in quality improvement activities across a rural area.

The framework developed involves recommendations on governance, triage nurse qualifications, protocols, documentation, clinical review and establishing non-punitive environments for continuous quality improvement.

This framework will continue to improve and at this time provides a foundation for discussion and further application in the pursuit of quality improvement in rural health services.

INFORMATION

Presentations

Ms Irene Krauss – National approaches to health information

Ms Irene Krauss is Director, National E-Health Policy Section in the Commonwealth Department of Health and Ageing. She provides policy advice and support to the National Health Information Management Advisory Council (NHIMAC), and has played key roles in the development of *Health Online: A Health Information Action Plan for Australia, A Health Information Network for Australia* for the National Electronic Health Records Taskforce (2000) and *Electronic Decision Support for Australia's Health Sector,* under the guidance of the National Electronic Decision Support Taskforce (2002). [22]
She focused on:

- the nature of information and the importance of Information and Communication Technology (ICT); and
- national approaches.

The nature of information and ICT

Ms Krauss noted that while information includes business and financial information, her focus was mostly on information used to support clinical care, consumer empowerment and choice, business processes, professional development, and research, health policy and public health. She noted that this is held in a wide variety of media, much of it only paper based, and with difficulties in transferring data and information between different electronic systems.

Benefits of better access to information include improved patient safety, improved quality of care and greater efficiency in health care delivery.

ICT provide the tools enabling quick access to and exchange of up-to-date clinical information, and key issues include privacy and security, authoritative information sources, standards, user confidence and skills, cost-effectiveness and investment in infrastructure.

National approaches

The National Health Information Management Advisory Council was formed in April 1999 and developed *Health Online: A Health Information Action Plan for Australia*.
A 2nd edition was released in September 2001.
The mission of the NHIMAC is *'better use of health information to improve the delivery of health care and achieve better health outcomes for Australians.'*

The Health Online Vision is for:

- online, ready access to information anywhere in Australia;
- access to information held in lifetime electronic health records;
- personal information integrated into decision support systems;
- data available for developing performance information;
- online, real-time transactions; and
- data gathered to provide a foundation for health policy.

22 For further information see www.health.gov.au/healthonline, or email nhimac.secretariat@health.gov.au

Ms Krauss discussed the following national initiatives:

HealthConnect is Australia's proposed network of Electronic Health Records (EHRs). It allows consumer information to be collected electronically and safely stored and exchanged, within a strict privacy framework, and with consumer consent. A two year research and development project is underway, and trials have commenced in Tasmania and NT.

MediConnect, formerly the Better Medication Management System, is a *voluntary* national system to draw together personal medicines information held by different doctors, pharmacies and hospitals. Strict privacy framework will support Medi*Connect*, and field tests are being undertaken this year in Launceston and Ballarat.

HealthInsite was launched in 2000, to provide a single entry point to access quality health information and links to authoritative sources. It currently covers over 100 major health topics, and links to more than 8000 resources from 57 respected health organisations.

In terms of **Electronic Decision Support**, the National Electronic Decision Support Taskforce reported to Health Ministers in November 2002, noting that electronic decision support systems can provide timely access to information to support clinical decision making. The report sets out a National Action Plan for electronic decision support development and recommends how a national approach to the development of systems can be achieved.

Ms Krauss concluded by noting that privacy of personal health information, national standards, telecommunications infrastructure and workforce capacity are other key issues.

Ms Martine Magers – New privacy provisions – enabler or barrier?

Ms Magers is a lawyer with extensive policy experience in the Office of the Federal Privacy Commissioner. Last year she managed the successful development and implementation of the Privacy Commissioner's first public interest determination for the private sector – the collection of social, medical and family history information by health service providers. She focused on:

- privacy and consumer expectations;
- privacy legislation and health; and
- the national privacy principles and health.

Privacy and consumer expectations

Ms Magers noted that consumers have expectations about how their health information will be handled.[23] She drew attention to:

- a *Flinders University Study* which concluded that almost one in ten (9.6 per cent) of South Australians are not confident that healthcare providers keep and use their information responsibly; [24]
- a *California HealthCare Foundation* study, which concluded that one in six Californians have taken special steps (incl. risking their health) to ensure their privacy, which illustrates that failing to address privacy can pose a serious risk to the continuity of care; and

23 Links to full research is available from www.privacy.gov.au

24 www.mja.com.au/public/issues/174_12_180601/mulligan/mulligan.html

- *OFPC Community Research*, where 61 per cent of participants thought their permission should be sought before using de-identified health information for research.[25]

Health privacy is real for people, and Australians take their health privacy seriously. Since 21 December 2001 the following were health related:

- of total complaints – 103 (9.4 %), of which 68 per cent concerned access to health records;
- of total telephone enquires, 4,046 (14.8 per cent); and
- of written enquiries – 179 (9%).

Ms Magers noted that good privacy enhances good clinical care, and that the *Privacy Act* is not intended to cut across clinical care pathways, but enhance consumer control and decision-making over the collection, use and disclosure of personal information. While the health sector has a long tradition of respecting patient confidentiality, the Act provides legislated legal protection and support for much of this traditional framework.

However, privacy is more than confidentiality, and indeed, the latter is a subset of privacy. Privacy also includes choice and consumer control, obligations in relation to data security and data integrity, access rights, obligations when sending personal information overseas and obligations to develop privacy policies.

Health professionals need to work to align expectations with consumers and be open about information-handling practices.

If individuals understand what information is held, why, and how it will be used and disclosed there is less likelihood of a complaint. Good privacy is about seeking clearer mutual understanding of how people's information is handled.

Privacy legislation and health

The *Privacy Act* 1988 protects personal information held by the federal public sector and tax file numbers wherever held, and regulates the collection, use and disclosure of consumer credit information by private sector organisations. The *Privacy Act* protects information about an individual – ie, any information recorded about a person. The *Privacy Act* does not cover statistical de-identified data where someone's identity could not be reasonably ascertained. Information covered includes:

- personal information – this is information (or an opinion whether true or not) about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion. (see s.6 of the Act);
- sensitive information – this is information (or an opinion) about an individual's racial or ethnic origin, political opinion, membership of a political association or their religious beliefs, affiliations or philosophical beliefs, membership of a professional or trade association or their membership of a trade union, sexual preferences or practices, criminal record and health. [26]

The *Privacy Amendment (Private Sector) Act (PAPS)* commenced on 21 December 2001 and applies to the acts and practices of private sector organisations, which can be individuals, companies, unincorporated associations,

25 See also 'Attitudes of the Japanese public & doctors towards use of archived information & samples without informed consent: preliminary findings based on focus group interviews' (Asai, A., et al., BioMed Central Medical Ethics, 09/01/03), 'Patient consent preferences for research uses of information in electronic medical records: interview and survey data' (Willison, DJ., et al., BMJ Vol. 326, 15/02/03)

26 See S.6 of the Act.

partnerships, or trusts. Some organisations are exempt, including small business with annual turnover less then $3m, Commonwealth and State/Territory authorities (unless they opt in), political parties, media organisations, employee records of organisations. Nevertheless, all health service providers that hold health information are covered under the Act, whether or not they are a small business.

Health issues were given particular attention in the course of the development of *PAPS Act*. A number of factors lie behind the approach to protecting health information, including:

- that health information is increasingly being stored and communicated electronically;
- the growing demand for increased capacity to link health information to better inform policy making and evaluation;
- more parties seeking to make use of health information for secondary purposes, such as improving the quality and consistency of care, or to verify payments; and
- the fact that many people other than doctors hold health information, such as gymnasiums, alternative therapists and insurers, and these are not necessarily bound by professional codes of ethics or common law duties of confidentiality. [27]

There is also clear evidence that people are not confident that the privacy of their health information will not be respected. The traditional understanding in Australia is that medical professionals own the medical records about their patients. This was confirmed in the High Court judgement Breen v Williams, which also made it clear that without action by the legislature, private patients will not be able to enjoy a general right of access to their health information.

The National Privacy Principles and health

There are ten National Privacy Principles (NPPs), which are the core of the private sector provisions of the *Privacy Act*. These principles set the minimum standards for privacy that organisations must meet.

1. Collection
2. Use and disclosure
3. Data Quality
4. Data Security
5. Openness
6. Access (and correction)
7. Identifiers
8. Anonymity
9. Transborder Data-flowsCollection of Sensitive InformationHealth information [28] gets extra protection through the NPPs.

Under NPPs 1 and 10 consent is required for collection (with limited exceptions). This includes collection of only what is necessary, and taking reasonable steps to advise consumers of:

- the organisation's identity and how to contact it;
- their right of access;
- why their information is collected, and the usual disclosures;
- laws requiring collection; and

27 Under section 6 of the Act a health service provider includes any activity that involves either/or assessing, recording, monitoring or improving a person's health or diagnosing or treating a person or dispensing a drug. As a result, the Privacy Act applies to all private sector organisations that deliver a health service, including all small health services that hold health information.

28 Health information includes information about a person's health, disability, expressed wishes about the provision of healthcare or other PI collected when providing health service. When a health service provider delivers health services, health information may include:

- medical information, including notes and clinical opinions;personal details, such as an individual's name, address, admission and discharge information, billing information and their Medicare number;
- information about physical or biological samples, where this can be linked to an individual (such as, where a name or identifier is attached); and
- genetic information, if collected or otherwise handled when delivering a health service, or when this is predictive of the individual's health.

- main consequences of not providing full information; andthird party collection.

Under NPP 2 health information cannot be used for direct marketing as a secondary purpose. This information is about how organisations and health service providers can use and disclose information, including health information. Use relates to the handling of information within an organisation and disclosure refers to when information is transferred out of the possession and control of the organisation to a third party.

A number of other NPPs are relevant to health information and privacy, and readers are strongly advised to refer to the Information sheets on the website of the Federal Privacy Commissioner at (www.privacy.gov.au)

In conclusion, Ms Magers noted the upcoming 25th International Conference of Data Protection & Privacy Commissioners, to be held 10-12 September 2003. Details of this are available at www.privacyconference2003.org

Discussion

This section summarises the discussions and observations of Symposium participants during both plenary and concurrent sessions. The sessions on 'Information' were facilitated by Mr Steven Tipper. [29]

Participants noted that information needs are extremely broad, but that a national vision is already forming. Nevertheless, there are still a large number of small and quite complex programs. It was acknowledged that 'its all too hard' was not an option, local solutions were required and that information management and technology was an enabler to be deployed when, and only when useful. It was suggested that government should prescribe in terms of the use of particular systems, or the development of standards rather than imposing a single approach.

There was also discussion around both the issues of information exchange and change management, and the possibility of 'virtual amalgamation' based around sharing of patient records and assisting the consumer in navigating through the health system.

The role of health call centres was also discussed in detail, and how these might meet after hours primary medical care needs. Participants also questioned the ability of the system to pay for new clinical and/or record keeping and audit systems. In summary, there was a general consensus that there was no immediate need for everyone to invoke or move to systems or solutions requiring higher technology solely because such technology was available, and that information technology decisions must always derive from patient and community need.

29 Mr Steven Tipper is the Business Manager of the Centre for Health Informatics. He holds an adjunct lecturer appointment in the Faculty of Medicine at the University of NSW, and is a board member of the Health Informatics Society of Australia.

Abstracts

Secure electronic messaging system improves practice efficiency

Canning Division of General Practice

Aims

- To implement a secure electronic messaging system for the transfer of patient notes to their usual GP.
- To comply with privacy guidelines in the handling of patient information.
- To improve the efficiency of handling patient data at the after hours clinic and the GPs' surgery.
- To increase the uptake of electronic patient record usage in the after hours clinic and by GPs in Canning Division of General Practice.

Background

- GP After Hours Armadale is operated by a cooperative of local GPs and provides an acute primary care service when the patient's usual GP is closed. This is a complementary service to local general practices with patients referred back to their usual GP for ongoing management where necessary. This requires the transfer of the patient notes from the After Hours clinic to their usual GP within 24 hours. Faxing this information is time-consuming for staff at both the after hours clinic and the GP practices and is not secure.
- An electronic messaging system was developed using Health Insurance Commission (HIC) public key infrastructure (PKI). The Division has used this as an example to demonstrate to GPs the benefits of secure electronic transfer of patient information using PKI and electronic record keeping.

Key lessons

The project is entering the implementation phase. Key lessons to date in the use of the system include:

- Development of the software using a commercial contractor was straightforward.
- Installation of the software at each site is quick and easy.
- Users of the software find it simple to operate.

Obstacles

- Lack of interest from GPs at the after hours clinic to use computers for recording clinical information.
- Difficulty in convincing GPs of the benefits of PKI.
- Many GPs find the application process to obtain the PKI too onerous.
- Lack of support from medical software vendors.

Successes

- Replacement of faxed consultation notices with PKI secured electronic data to comply with privacy guidelines.
- More efficient work practices in the handling of patient information.
- Data transfer is faster and requires less handling by staff along the way.
- Data is secure during transit.
- This system is transferable to other settings requiring the transfer of patient information.

Family Care After Hours GP Service

Sunshine Coast DGP [30]

Aims

For Family Care Medical Services (the Brisbane after hours service) to work in conjunction with other consortium partners (Sunshine Coast Private Hospital and Sunshine Coast GPs) to establish a new AGPAL accredited and commercially sustainable after hours service for the Sunshine Coast region (Maroochydore, Caloundra and Buderim).

To improve after hours primary medical care service provision at the Sunshine Coast by establishing an AGPAL accredited after hours clinic (operating during part of the after hours period) together with an AGPAL accredited home visiting service that operates continuously during the whole of the defined after hours period.

To support the after hours services via an accredited after hours call centre.

Successes

- The Family Care After Hours GP Service commenced ahead of schedule on 26 November 2001 with a service development grant of $270,000 which amounts to a cost of $1.69 per head of population. The grant was awarded for 18 months with the aim of the service being self-funding at the end of the grant period.
- It was originally expected that 60 per cent of GPs would subscribe to the service. Actual GP subscribers as at the end of March 2003 is 98 per cent.
- The service area has been extended (at no cost to the Commonwealth) to include Nambour.
- The after hours services owner and operator has written to the Commonwealth advising that the service is financially sustainable and will be maintained after conclusion of the grant period.
- Both GP and patient satisfaction levels have been surveyed and found to be very high (data is provided in paper). GPs accept that the mixed and balanced service delivery model (Clinic, Home Visiting and Call Centre priority triage with ambulance support) is well regarded by patients.
- Establishment of Information Pathways – the flow of information from the GP to the service, from the service (following patient encounter) back to the GP, between the clinic, private hospital and family care and from the community (patient and GP satisfaction surveys/complaint processes) through Family Care Medical Service and fed back into the service.

Key Lessons Learnt

The service has been a collaborative arrangement between Family Care Medical Service, the Sunshine Coast Private Hospital and the Sunshine Coast General Practitioners. Each player has wanted different things from the service and developing appropriate mechanisms to ensure the service covered these requirements and effective communication between each group took significant time and resources to establish. This included:

- Arrangement of special training for the doctors to cover additional hospital requirements;
- Employing a locally respected Medical Director to provide ongoing up-skilling and support where required to ensure

30 stuartt@familycare.com.au lynelle@hpandp.com.au

Consistency in Care and High Quality Care;

- Establishment of information pathways to ensure the doctor has information about patients from GP and ensure the GP gets information about the patient within 24 hours; and
- Establishment of a Management Committee to ensure communication between players and work through issues as they arise.

Vital Factors for Success

Support of General Practitioners:

- Experience and established infrastructure of FCMS operating a Medical Deputising Service, including established systems in recruitment, telephone triage and operational/financial management.
- Promotion to GPs and to patients.
- Effective communication pathways.

Ongoing Challenges

- Further refinement of information pathways – looking at how can translate manual system into exchange of information between the clinic and FCMS via computer.
- Better community awareness of AHPMC services offered.
- Best location for clinic in regional and management context.
- Recruitment of workforce.

Hospital After Hours Triage Education and Training in Rural SA

Rural Doctors Workforce Agency [31]

The single most important factor that determines whether rural General Practitioners (GPs) and their families leave country SA and move back to the metropolitan area, is the excessive workload and commitment to after hours.[32]

After hours is a recruitment and retention issue for both the rural medical and nursing workforce, and it is essential to address for the long-term future of the rural and remote workforce in Australia. Many rural GPs in South Australia utilise the local hospital nurse triage system for after hours service provision, however many nurses have reported that they don't have appropriate training and often lack confidence in after hours triage. In addition to this, there is currently no specific rural nurse triage-training program in South Australia.

As a result, the Rural Doctors Workforce Agency (RDWA) SA has been funded through the Commonwealth Department of Health and Ageing to conduct an innovative Program, After Hours Triage Training and Education Program, in rural South Australia. This Program will enhance after hours primary care service provision through:

- improving better communication links between rural GPs and local hospital/ practice based triage nurses;
- providing triage training for rural nurses in SA rural hospitals and GP practices;
- developing a transferable and sustainable training and collaboration model that can be applied to other areas of rural SA and Australia; and

31 Kiara Pulford, Program Coordinator, Rural Doctors Workforce Agency, and Jenny Fleming, Manager, Planning and Development, Rural Doctors Workforce Agency, 57 Greenhill Road, Wayville SA 5034

32 Rural GP Survey (1998) South Australian Rural and Remote Medical Support Agency

- developing strong partnerships with the State Department of Human Services

The Program was developed in collaboration with rural GPs, including rural Divisions of General Practice, rural nurses/rural hospitals and the State Department of Human Services (DHS). Over 80 per cent of rural SA will be involved including 7 Divisions of General Practice, 21 hospitals, over 160 nurses and 111 GPs.

A number of outcomes are expected from this Program at both the micro and macro levels. Not only will a triage training program be implemented in rural SA, and communication links between rural GPs and rural nurses improved, but the Program will develop a 'blueprint' – a transferable and sustainable Training and Collaboration Model, enabling the Program to be practically applied and replicated in other communities in rural Australia. The Program will be conducted over 2 years, to be completed by December 2004.

COMMON ISSUES FOR 24/7 INDUSTRIES

Presentations

Assistant Commissioner Andy Hughes – the Australian Federal Police

Assistant Commissioner Hughes is presently the Australian Federal Police (AFP) Deputy Chief Police Officer for ACT Policing, with over 25 years experience in law enforcement at community, regional, national and international levels. He was elected to Interpol's 13 member Executive Committee in 2000, and was awarded the National Medal and clasp.

He discussed managing a 24/7 service during the January 2003 ACT bushfire emergency from a policing perspective. He focused on:

- ACT policing in general; and
- lessons from the ACT bushfire emergency relevant to the provision of 24/7 services.

ACT policing

AC Hughes noted that the ACT police are an arm of the AFP, under a contractual relationship with the ACT government, and that Canberra was quite a unique environment due to a predominantly middle class demographic, the presence of the Federal government and international embassies. The police role was to protect people and property, maintain order via law enforcement, support the judicial system and undertake crime prevention and investigations. ACT police were committed to consulting with the community and at the forefront of community policing.

He noted that police working environments varied throughout the week, during the day, and across different locations, with officers covering the 24 hour period over three shifts. He also noted that each shift had a different culture, and that officers on night shifts had to exercise greater autonomy and make decisions in a context where other services were unavailable.

He suggested that the challenge of delivering a 24/7 service involved:

- providing consistent and continuous quality of service;
- the delivery of differentiated services;
- responding to crimes and needs that varied according to the time of day; and
- acknowledging and maximising differing shift work cultures and tasks.

Lessons from the ACT bushfire emergency for 24/7 services

AC Hughes observed that the ACT bushfire emergency had raised a number of emergency management issues. These included:

- obtaining sufficient staff resources;
- ensuring continuity in service in demanding conditions;
- managing additional resources;
- managing officer tiredness, exhaustion, safety and stress; and
- providing un-related normal and emergency policing services.

He stressed that communication issues were critical, both internally within the organisation and with other relevant agencies, many of which did not have a culture of 24/7 service provision or understanding or experience in providing after hours services or the management of shift work and rostering.

He also stressed the need to manage the workforce carefully, with regard to occupational health and safety issues and staff tiredness as the AFP moved from a 3x6 to 2x12 roster during the emergency period. Stress was also a significant factor, given that in the fire period officers were dealing with people in a state of heightened tension, fear and traumatisation.

AC Hughes concluded by noting that all these issues could be effectively managed where organisations were aware of, experienced in, and planned for the demands of providing a 24/7 service.

Superintendent Peter Payne – the Ambulance Service of NSW

Superintendent Payne is a career ambulance officer. Since 1976 he has worked in a number of areas, specialising in communications. While his current substantive position is Operations Centre Manager for the Sydney Ambulance Centre he has been seconded to State Headquarters to establish and manage the Performance Management Unit, which reports on key activity and performance indicators relating to ambulance operations and has input into the development of service delivery strategic programs. He focused on the challenges of providing 24/7 cover for ambulance services in terms of issues for:

- the organisation;
- staffing; and
- patients.

Organisation

Superintendent Payne began by noting that the NSW Ambulance is a large organisation, with over 230 services. Under the Ambulance Act 1900 it has a legal obligation to respond to emergency calls for assistance and needs to match resources to demand, meet response time performance targets, and be on duty or on call. To operate effectively it needs to be flexible, and distinguish between the needs of urban, rural and remote patients. It also needs to work within its budget, and operate a service consistent with occupational health and safety principles.

The organisation receives around 860,000 calls a year, of which over 500,000 are for emergency assistance. This equates to about one call per minute.

Staffing

Superintendent Payne noted that the service has around 3,300 staff, of which 90 per cent are uniformed and 70 per cent of the budget is on staffing. The service staff is highly unionised, and attention needs to be given to issues such as:

- award conditions or requirements;
- staff safety;
- travel and transport issues;
- shift lengths and patterns;
- start and finish times; and
- staff lifestyles.

Patients

In regard to patients Superintendent Payne observed that:

- access to the '000' number was unimpeded, and that in the after hours environment the provision of an ambulance service was probably the most critical, given that it was a last line of defence and dealt with life-threatening instances;
- there was an increasing demand for ambulance and emergency services, which is common across Australia and internationally, but ambulance services need to ensure equity of access regardless of location or the time of day;
- access to after hours health services is diminishing; and
- there is a high community expectation of the availability of ambulance services, but that there are also unpredictable patterns in demand.

In conclusion, Superintendent Payne suggested that ambulance services are increasingly required to supplement after hours health care demand, but this occurs at considerable cost and having complementary or alternative after hours options that minimise excessive response delays to life threatening incidents will result in better health outcomes, improved quality of life and improved customer satisfaction.

Dr Mark Robinson – Rural General Practitioners

Dr Mark Robinson (MBBS, FACRRM, FRACGP,DRANZCOG) has worked as a rural GP in Mount Beauty, Victoria, since 1978. He was a past secretary of the Rural Doctors Association of Australia (RDAA), past president of the Rural Doctors Association of Victoria (RDAV), and is currently censor for the Australian College of Rural and Remote Medicine (ACRRM). He addressed the issue of the provision of 24/7 services in rural general practice. He focused on:

- the nature of rural after hours general practice; and
- the role of the RDAA.

The nature of rural after hours general practice

Dr Robinson outlined his experience of rural after hours GP care. He noted that many GPs by necessity must be available for after hours work, and that this was a major factor in the sustainability of rural practice, along with the lack of specialist services. He noted that his own practice provided 24/7 care in two towns, with the population rising considerably in winter in the Falls Creek ski resort. This required a 1 in 3 roster and a 1 in 2 roster during winter months, with the weekend 'on' involving most of Saturday and Sunday morning. He noted that rostering is a major factor in the sustainability of rural practices, and that GP turnover increases once the roster gets below 1 in 3.

Rural after hours issues cited include:

- patterns of rural morbidity and mortality;
- community expectations, and the old model of the 'super doctor';
- towns without hospitals;
- recruitment, an ageing workforce and feminisation of the workforce;
- security, safety and morale, and skills;
- financial and financing issues;
- GP quality of life;
- the existence or otherwise of other specialist or community based services; and
- communication issues.

Dr Robinson observed that the relationship between rural GPs and hospitals is very important – each is dependent on the other. GPs also depend on other rural services for after hours medical care services, including other GPs, provincial or base hospitals, ambulance, State Emergency Services, and others such as the Red Cross, St John's Ambulance. Major medical problems for rural after hours and emergency services include major head and chest injury, abdominal trauma, fractures, and cardiac and psychiatric illness.

He noted that there were a number of considerations for a rural GP providing 24 hour accident and emergency services, including:

- costs and equipment, where a rural GP may be faced with meeting costs that are normally met by other parties in urban settings;
- the availability and ease of access to hospital based services, equipment and specialist skills such as obstetrics and anaesthetics;
- transport arrangements and travel time and distance to major centres;
- communication; and
- workforce skills.

Dr Robinson acknowledged that there were many innovations in rural after hours care, including nurse-led telephone triage, workforce support through locums and CME, Divisional programs, and the development of GP after hours clinics in bigger centres. He also drew attention to development programs and grants provided through the AHPMC program and work undertaken by the Australian College of Rural and Remote Medicine (ACCRM).

The Rural Doctors Association of Australia (RDAA)

Dr Robinson noted that the RDAA has identified specific problems with rural after hours issues, including the lack of after hours rates for long or prolonged consultations, the inability for two doctors to bill for the same patient (as in multiple trauma situations), confusion over the use of MBS item 24 in unfunded casualty departments, and the inability of the HIC to supply Medicare numbers for claims in hours. The RDAA has argued that:

- appropriate remuneration for rural after hours, with an additional $25m to adequately fund MBS item numbers to ensure provision of after hours emergency care in rural areas;

- the sustainable after hours roster is the single most important issue in retaining a rural medical practitioner workforce, and that adequate remuneration is at the core of this; and
- many rural practices in towns without hospitals have to purchase extra equipment to ensure comprehensive care, and infrastructure grants need to be developed to address this issue.[33]

Dr Robinson concluded by suggesting the following ideas for improvement:

- better funding of rural GP infrastructure;
- better funding of rural hospitals;
- better use of information technology;
- better education of nurses in triage;
- better integration, feedback, cooperation; and
- better coordination of services.

33 For further information, see www.rdaa.com.au