



# After Hours Primary Health Care Review

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**Australian Primary Health Care Nurses Association (APNA)  
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## The key principles for after hours primary health care services

- APNA supports the provision of after hours primary health care to existing patients of primary care services where that is safe and reasonable to do – continuity of care is important.
- Primary health care nurses play a key role, and can play an enhanced role in after hours primary health care – primary health care is more than general practitioners.
- Security for patients and for health professionals is critically important. Primary health care services need to have the same level of security as non-primary care after hours services. This has workforce and funding implications because it means more than one person needs to be involved in the service on many occasions.
- A locally effective model is important.
- The overall use of the workforce (in rural areas especially, this needs to account for hospital-based and state-funded after hours duties) needs to be considered when looking at workforce adequacy.
- Effective team members are needed (including administrative staff where appropriate).
- Residential aged care needs effective nursing cover after hours to prevent unnecessary primary health care in-reach.
- After hours services need to tie in to broader initiatives to enhance continuity of care, especially the personally controlled electronic health record, and to exploring voluntary patient enrolment.

## The role of general practitioners and general practice in delivering after hours services

- There is a critical role for general practice to perform some telephone-based and some face-to-face care. The better use of long-acting pain relief and assertive in-hours chronic disease management (including self-management) means that the acuity of many after hours calls is higher, and there seems to be an increase in calls from patients outside the practice.
- This means that the patient subsidy through Medicare needs to account for both the higher acuity and the need for good infrastructure (e.g. security).

## Delivery challenges of after hours primary health care services in rural and remote regions

- The challenges are significant; GPs work long hours rurally plus offer service provision to their own clients after hours and also to local residential aged care facilities and local hospitals. This is a major obstacle for new GPs contemplating moving to rural or remote regions; any variation in the expectation of doctors-in-training between urban and rural locations (e.g. not being on after hours rosters) is an impediment to recruitment to rural locations.
- Triage is an issue, especially where the nurses in small hospitals are discouraged from undertaking telephone triage.
- Access to pharmaceuticals can be an issue.
- The nurse role is yet to be recognised and rewarded with appropriate incentives to work to the full scope of practice.

## Views on the Practice Incentive Program (PIP) after hours incentive

- The PIP After Hours incentive was a good idea, poorly designed.
- The PIP After Hours incentive acknowledged the social and physical imposition on GPs providing after hours services.
- The PIP After Hours incentive was insufficient in quantum to be a real incentive, as is shown in the number of GPs ceasing to do after hours care.
- The PIP After Hours incentive needs to acknowledge all activity undertaken, including the work of primary health care nurses and nurse practitioners who could undertake a number of roles safely within their scope of practice.
- The PIP After Hours incentive does not recognise the role of assertive chronic disease management and palliative care in-hours, which prevents after hours costs.

## Views on Medicare Locals being responsible for funding and incentivising after hours primary health care services

- Medicare Local involvement and success has been very mixed. It ranges from successful models to situations where local organisations, like residential aged care facilities have no understanding of the role of the Medicare Local.
- Medicare Locals are seen to have taken a disproportionately high amount of the already scarce funds to administer the after hours program, and to have substantially increased the reporting burden and uncertainty of funding (especially the level of funding over time), in a number of cases.
- Because of the change management needed, if a locality-based model is needed, significant setup costs need to be considered, separate to the recurrent costs of running the model.

## Potential future arrangements for funding and incentivising after hours primary health care services, including advantages and disadvantages of potential options and their relevance to rural and remote regions

- The incentives need to be better designed. Preferably, there would be an incentive for the site to bear infrastructure costs, and an incentive to the practitioners who participate, differentiated by whether that participation is in face-to-face care or telephone-based models (the immunisation model of mixed incentives made a difference).
- APNA members want incentives to GPs and practices that transfer responsibility for after hours care to other services to be lower than the incentives to GPs and practices that do their own after hours care.
- There are no incentives for structured, anticipatory care. Where primary care services know that an early evening home visit could support self-care or carers, and prevent calls in the unsociable hours, there is no incentive for a nurse-based assertive outreach, or one by GPs. This assertive model has worked in some locations to reduce calls in unsociable hours.

## Views on after hours GP helpline

- The experience has been mixed.
- The after hours GP helpline has its place.
- It is seen as having a high rate of referral to emergency departments, which can sometimes mean seeing the same general practitioner as would have been available through primary health care arrangements – perhaps a direct link between the helpline and regional hubs would be useful.

## Views on using video conferencing for after hours primary health care services

- APNA supports video-conferencing for after hours primary health care within sound professional standards.
- Nurses could play an effective role in many cases, as is shown by the routine use of domiciliary and community health nurses in many fields.
- Consideration should be given to funding video-conferencing with sufficiently skilled carers, especially in cases of known chronic illness and palliative care – where this is professionally appropriate. Residential aged care facilities are an example of where this would be useful; but consideration should be given to home-based carers who often develop excellent skills.

\*Further to the two-page submission, the following experiences of our members may prove valuable.

## Illustrations in the local context

We are one of three GP practices in a rural setting with a population of 9000. The closest hospital is 30 minutes away and there are two nursing homes in the area. In the past 35 years our principle GP has provided after hours care to the population and only in the last 10 years has she had help from other doctors in this practice, and with a shared agreement with the other two practices in the area. This practice has been open on a Saturday morning for four hours and Sunday for one hour, while the other practices have opened for one hour both days when they have been on call. We were receiving funding through Medicare Local until four months ago. Our practice decided to go it alone and now we are open for four hours on a Saturday and close on Sunday, with the doctor being on call for the rest of the weekend and weeknights. This program rotates weekly through six doctors in the practice. Medicare Local has now announced a new round of funding; the chopping and changing through that organisation makes it difficult to keep up with what is going on. Our patients receive some triage through the local hospital and some patients use the GP helpline.

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Our practice of two GPs provides after hours care for some of our elderly patients at home and a lot of residential aged care residents. Previously with the PIP we did not have to worry about calculating the number of visits or how much we were entitled to. Under the Medicare Local administration it has been a constant emailing and time wasting exercise. They never seem to get the faxed documents so they have to be sent again and further emails to follow up, etc. We have to justify payment each quarter, prove SWPE, provide tax invoice; none on this was required for PIP as the information is already held by the Department of Human Services. The new way has provided very poor performance and too much red tape in our opinion. Now as of 1 July 2014 we are being asked to calculate, use PEN data extraction tool and submit our invoice for payment each financial quarter. It is our belief that the Government has provided the Medicare Locals with ample funding so they should be responsible for the complete administration. Hopefully with the review it will go back to being part of the PIP, as previously it ran smoothly without any extra effort on our part. This is yet another cost in time and effort that general practice should not have to bear. We use an after hours deputising service for all other after hours visits and do not actively promote the use of GP helpline. The information is available in the practice but most patients do not use it as they prefer to either speak with us or get the after hours doctor to come. For after hours services in rural and remote areas there needs to be a whole lot of other guidelines specific to the regions. What is good in metropolitan areas would not work in these areas. Consultation with stakeholders (i.e. general practice) is paramount.

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Our clinic looked at being a provider for after hours care. We were already open seven days a week, and nights until 8pm during the week. The contract was not suitable to the GPs, it was not possible to fulfil the obligations if people were on leave or sick, plus complete all of the reports. So our clinic is no longer open seven days a week. We now close on a Sunday and some nights due to GP shortage or annual leave. We try to stay open most weeknights until 8pm, but sometimes it is not possible.

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As a registered nurse working in a large general practice, providing after hours care is an integral part of our commitment to our patients. We are able to do this by using the Medicare Local GP Access. Our GPs work as part of a team to provide coverage from 6-11pm on weeknights and over the weekend. There are five clinics within the local area and four are co-located within the major local hospitals. This gives our patients access to x-ray, pathology, and if the need arises, to be transferred to the emergency department. There is a local call centre staffed by RNs and receptionists who triage the patient and direct them to the appropriate clinic with a specified appointment time, taking the load off the local emergency departments. The emergency department can also triage the patients that present and if suitable may send them to the clinics in appointments specifically reserved for them. The GP helpline is also used and if a patient is deemed to need an appointment they are transferred back to the local system where this can be arranged. Calls from residential care, palliative care and patients requiring home visits are referred to an on-call GP and assessed for the appropriate level of care needed. This system meets all the criteria for our surgery accreditation, and also allows our GPs to contribute to after hours care within the local area.



## **About APNA**

The vision of the Australian Primary Health Care Nurses Association (APNA) is for a healthy Australia through best practice primary health care nursing.

APNA is the peak professional body for nurses working in primary health care including general practice. With 4000 members, APNA provides primary health care nurses with a voice, access to quality continuing professional development, educational resources, support and networking opportunities.

APNA continually strives to increase awareness of the role of the primary health care nurse, and to be a dynamic and vibrant organisation for its members.

Primary health care nursing is wide ranging and covers many specialist areas including general practice, Aboriginal health, aged care, occupational health and safety, telephone triage, palliative care, sexual health, drug and alcohol issues, women's health, men's health, infection control, chronic disease management, cardiovascular care, immunisation, cancer, asthma, COPD, mental health, maternal and child health, health promotion, care plans, population health, diabetes, wound management and much more.

APNA aims to:

1. Support the professional interests of primary health care nurses
2. Promote recognition of primary health care nursing as a specialised area
3. Provide professional development for primary health care nurses
4. Represent and advocate for the profession
5. Collaborate with other stakeholders to advance our mission
6. Ensure a sustainable and growing professional association, by and for primary health care nurses.