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Review of Primary Care After Hours Programs and Policy

Submitted to:

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For:

The Department of Health and Aged Care in response to the recommendations of the Strengthening Medicare Taskforce Report (2022)

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 9000 people with lived experience of mental health concerns, including suicide and suicidality, across Australia.

All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both. This includes lived experiences with all parts of the mental health care system, including primary care and the after hours options described in this consultation, public and private service options, and service provision in rural, regional and remote Australia.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care, services and support across the whole Australian health and social care system, including within State and Territory jurisdictions.

We welcome the opportunity to provide our feedback to this crucially important issue for people with mental health challenges, and their families/carers/kin-supporters in the Australian community.

Purpose of this Consultation

Australia's after hours service system is complex and evolving. Services are delivered by a multidisciplinary workforce in multiple physical and virtual health system settings. These settings include private general practice (GP) clinics funded by Medicare Benefits Schedule (MBS) and patient contributions, primary care clinics and hospital services, Medicare Urgent Care Clinics and state urgent care services, Healthdirect, aged care facilities, Aboriginal Community Controlled Health Services (ACCHSs) and Medical Deputising Services (MDS).

Funding for after hours services is also fragmented, and includes Medicare and patient contributions, After Hours Practice Incentive Payments (After Hours PIP) for GP clinics, and Commonwealth and state government funding administered through Primary Health Networks (PHNs). The Australian Government has primary responsibility for funding primary care through the administration of Medicare, PIP, and oversight of PHNs. State and territory governments are responsible for planning and funding the emergency system (including hospital emergency departments) and provide funding for a variety of hospital-aligned urgent care clinics and other initiatives.

The accessibility of after hours care varies considerably across the country, and across different population groups, as do needs and expectations of services. In 2022, the Strengthening Medicare Taskforce Report recommended improving access to primary care in the after hours period and reducing pressure on emergency departments by increasing the availability of primary care services.

Figure 1: Key Review Questions

	**What is the need for primary care after hours services?**
	**What is the current state of after hours service provision?**
	**What are successful models of primary care after hours service provision?**

Our response to the Review

In order to respond to this consultation, we reached out to our representative panel of LEA friends who have expressed particular commitment to being more actively involved in advocacy. Over a 2-week period, 8 individuals provided verbal and written feedback on the review questions. We gratefully acknowledge these contributions by Louise Coulter, Lee-anne Finter, and the other 6 LEA friends who preferred to remain anonymous. Their direct feedback on the consultation questions are provided below.

Dimension 1: The extent to which the current after hours primary care service and funding system supports the provision of the right services, at the right time, in the right places, by the right providers.

- ***How effective are the current financial arrangements, including relevant MBS items and the After Hours Practice Incentive Payment, in supporting the provision of after hours primary care services? What changes to the current financial arrangements would better support practitioners to provide after hours services?***

The current arrangements have the potential to penalize people who otherwise rely on after hours primary care service, especially if their employment and ability to take leave from work makes it difficult for them to attend during regular times. Public holidays, in particular, are times that attract significantly higher out of pocket costs. Providing a way for bulk billing regular clients on a Saturday was proposed as one potential way to improve this situation.

Making payment rates for those on call commensurate with those employed in other private allied health fields was also suggested. Placing more resources where they are needed as opposed to the top-heavy current structure of the health system, and higher Medicare rates to enable bulk billing of patients for those with comorbidities and complex health, were also suggested.

The current health system which allows a GP care plan with 5 visits to allied health falls far short of what is required, especially for people with mental health challenges and multiple physical health conditions, creating little impact on the compounding impacts of multi-morbidity and earlier mortaility, a greater burden on the long wait lists for therapies and surgery across all age groups. If the amount of visits was increased, it would assist individuals in accessing more affordable physiotherapy, dieticians, occupational therapy, etc. These services are particularly important for people with psychosocial disability to build and mainting capacity, independent living skills, community tenure and mobility. Many people with psychosocial disability are not eligible for NDIS, and the nexus between mental health and physical health is poorly understood within the NDIS system. For many with limited financial means, the GP care plan is one of their few means of accessing these important allied health services.

There is also increasing concern that allied health private practitioners are charging far more than before the NDIS came in. Paying penalty rates consistent with other health professions could be considered.

Greater incentives, payments and staff is required. Bring back free telehealth sessions; increase Medicare funding and subsidies.

- ***How effective is the current after hours system in supporting the provision of multidisciplinary team-based care to consumers in the after hours period? How could the system better support practitioners other than medical practitioners (e.g., nurses and nurse practitioners, allied health practitioners and Aboriginal and Torres Strait Islander health workers) to provide after hours services?***

A multidisciplinary team takes a holistic picture of the patient and is this is more likely to promote a positive outcome. Currently in Albany MHit health goes through ED after hours and the younger community members are sent to Bentley in Perth.

There is an overall shortage of allied health professionals willing to work within the government system unfortunately with the creation of NDIS fee schedule and many are choosing private practice. This is impacting on accessibility, availability and quality of these services. Incentives such as quality supervision and other supports, discounted or free training and professional development, waivers of discipline-specific set up costs, or other incentives to entice this workforce to after hours services may be options.

Access to after hours multi-D allied health services is very poor, especially in rural and regional areas. Increased staffing and incentives, being more flexible with roles (e.g. not being fixed within one service) and more sharing of resources and collaboration are needed.

- ***How does demand for services change across the after hours period, and how can the system support alignment between service availability and need?***

Like most service providers, they have an indication of what nights are likely to be busier and to staff the services accordingly, recognizing that no system is fool proof at predicting demand and need. The information provided by Health-Direct provides an indication of the growing need for further services. There are no options in Albany which is considered the central hospital for the region for doctors or nurse practitioners to see those requiring assistance after 6pm weekdays and midday on a Saturday; none do home visits.

To provide increased availability of nurse practitioners or paramedics would be a starting point.

Dimension 2: The extent to which the after hour primary care system – and different models of after hours service delivery – meet the needs of consumers and the community.

- ***To what extent, and in what ways, is the need for after hours primary care in the community being met? What gaps exist in service provision?***

There are many gaps in after hours service provision. Early support options for mental health support line Sane is not available on the weekend, and frequently it has too high demand to answer all calls.

Other services after hours like The Mental Health Line and Lifeline don't provide counselling support for distress that has not reached suicidal crisis, or it is limited to a fifteen minutes intervention.

Bulk billing often not available for Saturday general practitioner appointments.

24-hour pharmacies are limited or non-existent in many areas.

I have found that some Locums won't visit for mental health issues.

The biggest gap is being able to speak with a doctor or nurse practitioner

It is being met in emergency cases through emergency health care. However, in emergency mental health crisis I noticed the response is haphazard where the mentally ill person would be grateful to have someone to assist them in a gentler way as opposed to police, paramedics, sirens and busy emergency departments. I am a carer and my adult child who is often so traumatised by those factors they withdraw which is interpreted as crisis stabilised and my child has been through this cycle so many times they know the 3 things to say to get out. "I am no longer suicidal I have no plans. I will get a mental health plan via my GP, and I have a supportive home to go home to." Crisis is never dealt with, and I return with a still mentally ill child but traumatised by the experience.

Also working full time after hours is the only real time my adult child can access care.

In the Great Southern region of Western Australia, the only way to access after hours primary care is through the hospital emergency. We have a GP after hours which is limited and is at the hospital or calling Health-Direct which is hit and miss dependent on who you get and their clarity of English. Many elderly people are unaware of Health-Direct and some also struggle with hearing issues.

Living in regional western Australia, there a huge gap in both after hours and business hours in primary health care.

Most services including cardiology are offered via tele-health and are not available after hours.

There are no doctors that provide out of business hours service or home visits leaving the only alternative attendance to the emergency department.

Many aged individuals do not like driving at night and are reluctant to "i*nconvenie*nce" friends or family as its "*probably nothing*".

Another factor is many aged Australians may not want to go to hospital for fear of catching Covid or other airborne viruses or the long wait to be seen. Often sitting in uncomfortable chairs that are not conducive to those with varying forms of arthritis.

It's hard to get in, they are not open late enough, they are too far away and many people are unaware of the options available to them.

- ***What are the main factors driving demand for services in the after hours period?***

Sickness, increase in infections in the community since covid, eg UTIs, colds, stomach bugs.

Not able to get timely appointments with my doctor at the usual General Practice.

Mental health crisis.

We are hard wired to get anxious at night to some extent. Socio economic factors, substance use, and relationship issues can often become more evident after hours.

The inferred pressure to conform to a 8am to 6 pm schedule is a big factor. Psychiatric private hospitals try to get you in this routine during admissions. Even being up at night may be considered unsocial. I am a night person at times. It just suits me, and someone has to do graveyard shifts. Many people only want to work 8 to 6 including Doctors.

Private emergency departments have been great for me twice. Although you pay $400, this counts towards your Medicare safety net. I consider this like an excess and once you reach the safety net you get very generous returns from Medicare. Epworth was great but Knox wouldn't see me in ED for a psych issue!!!

I can afford to be out of sync because I am not employed. Many people need to be encouraged to have normal hours for their job prospects.

I think the main factors in my experience are returning home from work and school etc, they have time to think they may take something to help them sleep weed or drink because sleeping when your mind is racing is impossible. So, I would say insomnia. drugs, drinking and the social isolation, and especially public holidays, lead to increased demand for after hours services.

The ageing population have more complex underlying health issues than many younger Australians. The fact that the Albany Health Campus frequently has high numbers of avoidable deaths speaks for itself.

The lack of services to support the aged is a significant issue. Most services that offer home package type products are not available to assist their clients if they have a fall or health episode during the night.

The demand for doctors on call that can visit the aged at home if they are taken ill of evening is overwhelming as many aged Australians prefer not to go to hospital as its probably nothing or it will be alright in a bit. Most rural and regional areas have limited resources when ambulances are required.

It is difficult in regional and remote areas to access internet even phone coverage. Often people are required to be flown to Perth by the RFDS to undergo tests and surgery. This often further traumatizes the patient as they are removed or isolated from family and their social network making recovery slower.

Work and caring responsibilities during the day, long wait lists to see GPs, especially in rural areas, and many illnesses and injuries occur after hours and can't wait till the next day.

- ***What are the specific needs of people living in rural and remote Australia, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, residents of aged care facilities and people receiving palliative care, people with disability and/or chronic illness, older people, children, and people in precarious or less flexible employment? How can these needs best be met?***

I think there is a need with climate change for "heat teams" to care for the elderly in heatwaves, providing a home visitation service, transport to designated cool places when required, and monitoring and triage for heat exhaustion. After hours options are vital for such services.

Providing a wider range of services in the country areas – having health care workers that speak languages of our indigenous Australians.

There are virtually no OT's and Physio's available in care homes in my rural region.

Cultural training and interpreters, conscious of social and cultural norms and diversity of cultures in any community is a clear gap that needs to be filled.

Aged care residents should be provided with more supports by people with knowledge who can support residents and their families holistically.

Chronic comorbidities require practitioners with a higher level of skills. Government should incentivise to attract more highly skilled nurse practitioners.

All health services should offer free options in the regions. This is not available and there are very few services such as MRI's which are not free in regional areas, yet they are free in the metro for low income and concession card holders.

Ambulance cover should be free for all. This would go a long way to providing an equitable service and free medical health care.

At a recent meeting of GSHPN, I mentioned to allied health providers about providing services for those who are unable to afford health services which are expensive. The comment was: "Why should we prop up a broken health system?" I pointed out if the health system was not broken, they would not be working in private practice! Many have forgotten the ethical role of health providers.

Continuity of care, person-centred and trauma-informed models are necessary. Increase telehealth options, low and no-cost options, especially in rural and regional areas, and increase home visiting options.

- ***How can after hours services be made more accessible and easier for consumers to navigate? Would a 'single front door' or access point improve Australia's after hours system?***

Transport is a major issue when sick. This will need consideration when we ask folk in the cities to give up their cars for public transport. It is not easy to attend a clinic when suffering from bodily ailments like pain, vomiting, diarrhea, or confusion from mental health when you don't have a friend or family member available with a car. This applies when the clinic says the patient needs to go hospital more than a suburb away too when they attend in person.

In one instance, the triage line for ambulance didn't seem to understand the slurring of voice and confusion and inability to answer questions was due to severe infection rather than alcohol. Hence, those staffing a single front door would need to have significant training and understanding to meet the needs and cover information relevant across a very broad and diverse set of needs, circumstances and groups.

Telehealth Telehealth Telehealth. I believe and renumerate well. With home visits for exceptional circumstances.
Single front door? I don't think so. I believe it will exacerbate and grow the amount of people out of sync with normal daylight hours. Telehealth delivered kindly helps people at home. The person deliveries Telehealth needs to be an expert and well-trained in delivering services virtually.

Yes, as long as once that door is opened, it is clear to the people accessing after hours care how to seek out exactly what they need.

More nurse practitioners been employed to visit the aged at home if they required assistance as opposed to someone diagnosing on the phone and suggesting going to the emergency department where there are already large numbers waiting to be seen.

A single front door model would be easy to navigate for those that are confident with technology the offer of a doctor/ nurse practitioner on call with transportation available independent of family or friends in regional and rural areas would be more beneficial for the aged population as long as there was no cost attached to the service.

An additional support would be to provide unpaid carers with BP monitors and oxygen saturation/ pulse monitors to assist them when speaking with nurse practitioners in providing readings and symptoms – the government relies so heavily on family carers and pays them so little; often they are the ones transporting their elderly family member to the hospital.

The system is very complex and fractured; don't know which services is best or available. More education is needed. One number to call and be directed to appropriate services would be useful if it was responsive and matched to what people actually need.

Dimension 3: The experiences of primary care providers, and barriers and enablers to afterhours service provision.

- ***What is the proper role within the system of different models of care, including telehealth and home visits? How can consumers be matched to the most appropriate services?***

Telehealth is good for triage.

Telehealth is not suitable for cardiologists and other specialists if they choose to deliver their service via telehealth it should be at a significantly lower cost.

Consumers should have choice and control over their health options not simply given what's on offer. Home visits should be offered or free transportation to remove the onus of people requesting assistance for others.

Older Australians prefer face to face consultations. In the country, many are disadvantaged by restrictions of distance and cost.

Similarly to schemes that have been rolled out across other large countries where one person perhaps a nurse practitioner could upskill those in allied health professionals such as social workers to provide basic assistance to others – it seems social workers are employed in government roles and not for profits and I have found are more holistic in their approach enabling them to work within health to support patients with

treatments and access to services – often asking questions and advocating for those needing to access services.

In aged care, some people with mental health challenges cannot attend their community hub @fellowship house once their fuel subsidy card has been used or if they cannot drive because of underlying health issues.

A standardized central intake / triage system which will allow efficient and appropriate access to after hours services is needed. Person-centred care approaches are required (especially for CALD, aged, mental health, complex needs, carers, children and LGBTQIA) so that the right approach, service and referrals can be made. When calling '000' or going to ED, consumers should be redirected to other services that are available and better matched to the person's needs (to take the burden off that system and avoid unnecessary delays too).

Contact

We thank the Department of Health and Ageing and Allen and Clarke Consulting for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our lived experience perspectives to any future discussions about this important topic.

Your sincerely

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