



‘It’s Easier to see a Vet’

ACT health care consumers’ experiences and needs for after-hours medical services

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for the
ACT Division of General Practice.**



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This report should be read in conjunction with *‘I wouldn’t be here if I could see a GP’*
Consumer Use of Emergency Departments, Needs Analysis, After hours Primary
Medical Care in the ACT.

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Executive Summary

‘It’s Easier to see a Vet!’

ACT health care consumers’ experiences and needs for after-hours medical services

A report by the Health Care Consumers’ Association of the ACT
for the ACT Division of General Practice

Introduction

This report documents a study undertaken by the Health Care Consumers’ Association of the ACT (HCCA) for the ACT Division of General Practice (ACTDGP). It is part of a larger study conducted by the ACTDGP which aims to examine options and to develop a preferred model for delivering an enhanced, sustainable and affordable after-hours primary medical care service for the ACT community generally, and for low income earners in particular.

Project Overview

This study aimed to explore ACT residents’ responses and needs with regard to after-hours medical services. By utilising a qualitative approach through focus groups, the study has illuminated health care consumers’ experiences of the current system, their perceptions of strengths and weakness of the system and of the elements that they see as essential in an improved after-hours medical service.

Six focus groups were held in March 2002, and involved diverse groups of consumers: older women (14); mental health consumers (13); Southside residents (nine); men (eight); Northside residents (seven) and mothers (five). Although the gender and regional spread of participants was adequate, no consumers from culturally and linguistically diverse backgrounds or people under 23 years of age attended the focus groups.

At the time of the study, the ACT and region population exceeded 420,000 people. General after-hours medical services were available from:

- Two Accident and Emergency Departments (ED)
- Canberra After Hours Locum Medical Service (CALMS)
- Health First Call Centre
- A small number of extended hours GP surgeries
- Some GPs provided limited after-hours service for specific patients.

Specific after-hours medical services referred to by participants in this study included:

- Chemists
- Some medical specialists
- Some mental health professionals
- Mental Health Crisis team
- Ambulance

Report Overview

This report is divided into seven sections. Section one introduces the project, its context and the research team. The section two provides a short background to the role of consumers in enhancing health care service improvement and highlights the diversity of the client groups. Section Three outlines the focus group methodology. Section Four presents detailed reports on each of the six focus groups. Section Five draws out the issues raised by consumers. Section Six concludes the report with consideration of the implications of this study for improving after-hours medical service delivery in the ACT.

MAJOR THEMES

Accessibility — Transport to medical services was an issue for a number of population groups such as mothers and the elderly. The easy phone access of Health First was appreciated, although the majority of people attending the focus groups had not heard of this service. CALMS home visiting service was highly valued and ambulance care was used strategically by a number of consumers.

Affordability — Cost of services, especially the need to pay up-front, was an overarching concern. The elderly, mental health consumers, many of whom were on low incomes, and young people were noted as groups who could not pay up-front. Some groups, such as the mothers and the men's group, were willing to pay for the after-hours care of sick children or spouses but would wait until the next day for their own care. Bulk-billing was highlighted by most participants as an important component of after-hours services.

Continuity of care — Most of the groups stressed the need for a well-designed flow of information between the regular GP and all after-hours services. Although there was some concern about privacy, especially for groups such as young men and marginalised youth, most people believed that central records would enhance their confidence in after-hours services. Many consumers had developed their own hierarchy of care services, from first-aid, to chemist, to Health First, CALMS or ambulance to ED.

Quality of care — The experiences across the system were diverse. Mental health care consumers and young people appear to be the least satisfied. The lack of services in Gungahlin and the Tuggeranong Valley were noted by more than one group. Consumers were clear that quality of care was a high priority and they would make health care decisions based on their prior experiences with each part of the system.

SPECIFIC ISSUES

The role of the GP in relation to after-hours care — The group of consumers who highly valued their own GP were aware that their own doctor could not, and should not, be available around the clock. What they did expect was a system that would prioritise the timely transfer of information across sections and where the GP was key to their health service provision. Some consumers did not see the GP as the pivotal role but chose different practitioners for different roles; whilst at the other end of the spectrum, it was reported that some young people specifically seek out GPs who don't know them, in order to preserve their anonymity.

The GP and information flow — A good flow of information between after-hours care and one's own GP was frequently raised as enhancing an after-hours service. Problems with a full information cycle, from the past history to after-hours actions, were evident. Electronic record keeping was seen as a way of potentially improving information flow. Although for some people the issue of privacy was very important, for others, the information flow took precedence.

Extended hours and extended services — A number of consumers believed that the health care system could be greatly improved through simple structural changes. This included extending the hours of normal GP services, especially where the client has difficulty accessing doctors during working hours, and extending local services for conditions which can't wait but don't need ED specialist care or equipment, such as stitching, pain relief and monitoring of chronic conditions.

Self triage — Seeking medical help after-hours was a significant decision for most people, and involved weighing up the cost of seeking help both to themselves and to the health system. All participants were clear about their own hierarchy of care options and conditions. There was general consensus that ED was necessary for possible heart conditions, bleeding, broken bones and accidents requiring surgery or x-rays. However, in other situations, consumers went to ED because they couldn't access appropriate level help locally. Other sources of triage advice identified were the local chemist and the ambulance.

It is significant that most participants were unaware of Health First but almost all were responsive to the concept. The issue of anonymous advice was important for men and young people and may make the difference between timely medical treatment rather than no treatment at all.

Knowledge of the system — The only health service that was universally known to exist and to be available after-hours was the Emergency Department at The Canberra Hospital. Although Calvary Hospital was noted, some consumers were not sure that it was open 24 hours (Calvary ED did originally open for limited hours). Knowledge about extended hours clinics was confused with a number of consumers reporting that they previously had used extended hours clinics, but the hours had changed, or were no longer offering extended hours, or they didn't know what hours were currently being offered.

Very few people's GP had advised them of his/her preferred after-hours services. Only a few people knew if their doctor was a member of CALMS and what that meant hence consumers were forced on to their own resources. Consumers who valued their doctor's management of their on-going health issues were keen to know what s/he would recommend for after-hours service use. Other consumers assumed that the locum service could be used on a needs basis as assessed by them.

Waiting times — All participants understood the reality of a triage system that affected waiting times at ED. However as there were so few other after-hours medical options, consumers had strong opinions about improved services choices as a way to decrease waiting times. Regional medical centres with multiple treatment services such as stitching and medication purchases were raised as one option.

A place for service options — The pattern of some young people's use of health services suggests that there may be a place for after-hours medical services that are more informal and not emergency-based. The fact that the current infrastructure does not acknowledge or meet these specific needs is an indication of a 'one-size fits all system' that may appear efficient at one level, but that creates another level of service inefficiency and consequent increased morbidity.

STUDY IMPLICATIONS

Based on the consultations, a tailored and integrated model of after-hours medical services would have the following multiple features.

Levels of care — GPs who are able to provide diagnostic and treatment advice are central to the service. To ease the load on GPs, face-to-face consultations could be complemented by an extended phone advice system. In the present system, an enhanced information flow between Health First, CALMS and the ED would be an important starting point and would begin to address the concern for continuity of care. It is important for the community to have confidence that after-hours services will be available in set patterns over time.

Home visits are key as, by definition, illness after-hours is a serious concern. This study and other studies continue show that most consumers will 'wait it out' wherever possible. Many consumers see home visits as the ideal model as after-hours are the times that they are most vulnerable, find travel difficult or have other care responsibilities with little available support. Although many consumers had not needed to use CALMS home visits, most had assumed that their doctor was a member of CALMS and that this service was an ACT-wide inclusive option.

Consumers did note that access to an appointment with a GP was not the only need they had from such a service. Good practice services would be able to provide a number of types of care on the one premises and to assist with the accessibility of medicines with,

for example, small amounts available for the doctor to give or with arrangements with an ACT-wide service for delivery from a chemist.

Telephone triage was seen as a service gap.

Transport — Ambulance care and service needs to be a central facet but it is important to ensure other services take up the load wherever possible to ensure that emergency treatment and transport is retained as their primary role. EDs provide the specialist level of care where technical services, a full diagnostic team and admissions are facilitated.

Regional centres — The stress of travel and the cost of or lack of transport options coupled with many consumers' family care responsibilities suggest that regional services are a preferred option. Given that CALMS already operates from the Canberra Hospital, Calvary Hospital and Erindale, a further centre in Gungahlin is crucial.

Extended practice hours — Both GP practices and regional centres would be more effective for consumers if their hours were adjusted to serve the needs for routine medical services outside the 9 to 5 period. Consumers expressed a keen interest in clinics open to mid-evening. It would be valuable to undertake a mapping exercise with GPs and consumers to determine suitable hours by region.

Affordable at the time — Bulk-billing, at the least for priority groups, is essential. Gap payment only or accounts through a central system should be possible. It must be stressed that up-front cash payments are often not accessible for even the well-off who are sick at the time of the medical visit.

Integrated information flow — There is a need to consider a full cycle information flow, from the GP to the after-hours service and back to the GP after an after-hours attendance. Although most consumers saw information flow as a primary need, the issue of privacy was a concern for others. As this is a current focus of many health service redevelopments across Australia, it is anticipated that good practice models will be available in the near future to address this complex concern.

In order to facilitate the most effective use of after-hours medical services, it will be crucial that a number of information pathways are developed and/or enhanced.

Health service knowledge — most consumers did not know what services were available, or when and how to access after-hours medical care. Both web-based and print based up-to-date information must be available. A community education campaign to support consumers' willingness to self-triage would be an important beginning, followed up with leaflets delivered to all ACT residents on an annual basis. This information should also be available at all residential tourist locations for the use of interstate visitors.

It is important to note that it is not just education of the consumers that is required for an effective system. It will be the responsibility of each level of after-hours service to

ensure that their staff are trained to facilitate effective triage. Consumers highly valued the skilled receptionist, the nurses and the GPs who had the knowledge and commitment to support effective access and triage.

Health service literacy — The design of a wider health education campaign “what to use when” could cover the continuum from first-aid to full emergencies, linking signs and symptoms to service choices and could utilise the multi-media strategies that are currently under development. Given the development of ACT specific health service information, GPs will be able to advise their own client groups on the appropriate after-hours services for their condition and situation.

WHERE TO FROM HERE

This study has given a number of ACT health care consumers the opportunity to share their experiences of the current after-hours medical services available to them. Each and every person who attended the focus groups believed that an effective and accessible after-hours service is central to quality health care.

This study has illuminated system problems that are not unique to the ACT. These include medical workforce issues, professional boundaries and limited and limiting funding models to name but a few.

Although the ACT health service system has many challenges to face, it is unique in Australia as a bounded region in which system-wide innovations can be trialed. In the first instance it is hoped that this study will feed into further improvements to GP practice, CALMS and the EDs in our town. But it is also hoped that some of the more far-reaching visions of the participants will be carried forward towards wider system change. Some of the ideas of these participants challenge those of us interested in deep quality health care to look forward to far-off future possibilities. They invite all system advocates to join together to make collaborative fully integrated after-hours medical services a reality.

Further information about this study is available from:
Health Care Consumers' Association
GPO Box 1659
ACT 2601
02 6290 1660 ph

GLOSSARY OF TERMS AND ABBREVIATIONS

A&E – Accident and Emergency Department

ACTDGP – ACT Division of General Practice

ACTDHCC – ACT Department of Health and Community Care

After-hours – the time between usual GP practice closure and re-opening, typically is between 6pm and 8am weekdays, 12md to 12mn Saturdays and 24 hours Sundays.

AHPMC – After Hours Primary Medical Care

CALMS – Canberra After Hours Locum Medical Service

DoHA – Department of Health and Aging (Commonwealth)

ED – Emergency Department

GP – General Practitioner

HCCA – Health Care Consumers' Association of the ACT Inc.

Health Care Consumer – Anyone who uses, has used or may use any health service, whether public or private, institutional or individual, mainstream or complementary.

Health First: ACT Consumer Access Call Centre (Health) (introduced February 2001)

1. Introduction

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1.1 Project Overview

This study explored ACT residents' responses and needs with regard to after-hours medical services. By utilising a qualitative approach through focus groups, the study has illuminated health care consumers' experiences of the current system, their perceptions of strengths and weakness of the system and of the elements that they see as essential in an improved after-hours medical service.

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1.2 Report Overview

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1.3 The Project Team

The Health Care Consumers' Association of the ACT, with Dr Barbara Pamphilon, Head of the School of Professional and Community Education at the University of Canberra, conducted this study. The HCCA Project Officer was Helen Skeat, and Emma Hawke and Kirily Philip undertook focus group scribing. Barbara Chevalier of the University of Canberra provided the first level analysis of the focus group data. The co-authors of the report are Barbara Pamphilon and Helen Skeat.

1.3.1 Health Care Consumers' Association of the ACT

HCCA was formed in 1978 by concerned ACT health care consumers to provide a voice for consumers on local health issues. HCCA aims to be a means for health care

consumers to participate in policy, planning and service decisions that affect their health by:

- Working with health services to achieve services that are responsive, respectful, accessible and affordable to all;
- Encouraging direct consumer involvement in health decision making; and
- Lobbying and advocating on behalf of ACT health care consumers.

HCCA has a broad interest in consumer access to equitable, effective and appropriate health services. They encourage consumers to be involved in all aspects and all levels of health service planning and decision making.

HCCA works to improve the quality and availability of health services by involving consumers through:

- Regular meetings;
- Newsletters to members;
- Providing training and support to consumer representatives on government and non-government planning committees, councils, advisory groups and reviews; and
- Providing speakers for information about HCCA's work.

As consumers they share their understanding, experience and views, identify shared priorities and goals and represent and raise the awareness of these views to the ACT government.

1.4 Project Context

1.4.1 National Context

This study has been funded as part of the After Hours Primary Medical Care (AHPMC) project — a Commonwealth Government initiative funded by the Commonwealth Department of Health and Aging (DoHA). \$43.4 million dollars has been made available over four years to establish new, and improve existing, after-hour primary medical care services across Australia. In 2002, a proportion of these funds was made available to state and territory Divisions of General Practice to employ an AHPMC Policy Officer to work with General Practitioners and other key stakeholders to develop and implement policies around GP AHPMC.

1.4.2 ACT context

This study was part of a wider study undertaken by the ACTDGP and was funded through the After Hours Primary Medical Care (AHPMC) Development Grants Program. The overall aim of the full study was to undertake a needs analysis, and examine options for delivering an enhanced, sustainable and affordable after-hours primary medical care service for the ACT community generally and for low income earners in particular.

Components of the needs analysis included a literature review, situation analysis, Emergency Department (ED) research, GP consultations and focus groups, stakeholder consultations and this study.

At the time of the study, the ACT and region population exceeded 420,000 people. General after-hours medical services were available from:

- Two Accident and Emergency Departments (ED) – The Canberra Hospital and Calvary Hospital
- Canberra After Hours Locum Medical Service (CALMS)
- Health First Call Centre
- A small number of extended-hours GP surgeries
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Specific after-hours medical services referred to by participants in this study included:

- Chemists
- Some medical specialists
- Some mental health professionals
- Mental Health Crisis team
- Ambulance

As was highlighted in the AHPMC Development Grant Application (p. 2)

“the provision of after-hours health care has long been recognised as a problem by consumers, GPs, hospital emergency departments and governments at all levels. The current system of after-hours health care has essentially evolved in the absence of any predefined organisational plan or model. As a consequence there are concerns that consumers are not accessing health care from the most appropriate providers after-hours, thus impacting on quality, access and cost of health services.”

Given this perception by service providers, it is crucial to document health care consumers’ voices and views in order to understand their experiences and needs.

2. Consumer Perspectives and Their Role in Improving Service Delivery

The principle of consumer participation in the planning and implementation of health care is increasingly being recognised as critical to the development of health systems which promote the health and well-being of communities.¹

This is part of a global trend in which, for example, World Health Organisation conventions such as the Alma-Ata Declaration (1978), the Ottawa Charter (1986) and the Jakarta Declaration (1997) have identified the critical role of consumer participation in the planning and implementation of effective health services.

¹ National Resource Centre for Consumer Participation in Health (2000) *Feedback, Participation and Consumer Diversity: A Literature Review*, Consumer Focus Collaboration, Canberra

The Commonwealth Government has established or supported a number of initiatives in recent years, to enhance the effectiveness of consumer participation in health care. Principal among these have been the National Resource Centre for Consumer Participation in Health, and the Consumer Focus Collaboration (CFC), established in 1997 to further the goal of enhancing quality and safety through increasing the consumer focus of the health system. In turn, these two bodies have supported a range of initiatives to improve understanding and develop models for consumer participation.

At a local level, the recently developed framework for the improvement of quality and safety in ACT health care recognises the central role of consumers in both their own health care, and in the planning of health services. “The consumer should be at the centre of all the system does, they should be the active participants, well informed and empowered in decision making”.² Collaboration with consumers means “involving consumers in health service planning, policy development, setting priorities and addressing quality issues in the delivery of health services ... consumer participation is an important component of improving the quality, safety and appropriateness of health care”.

Beyond government, many health care providers are seeking to enhance the role of consumers in the planning and delivery of health services. For example, the WA Divisions of General Practice recently collaborated with the WA Health Consumers’ Council Inc to develop a *Statewide Action Plan for Consumer Involvement with Divisions of General Practice*.

The participation of consumers in health care can range from participation in their individual care, through to participation in health services, and on to the health system. Active consumer participation in individual health care has become a recognised part of health care and has been demonstrated to improve health outcomes. For example, “acting on the conclusions from a Cochrane systematic review, Lahdensour found strong evidence that when adults with asthma are active participants in their care, undergo self-management education and are supported by written action plans” their need for a range of health services is reduced.³

At a health service level, Draper’s work⁴ has supported hospitals to move beyond the simplistic “happy sheet” patient satisfaction surveys which maintain the consumer in a passive role. Similarly Australia has been a world leader in mental health service consumers’ participation in service design and evaluation⁵.

² ACT Department of Health, Housing and Community Care (2001) *Quality First*, ACT Department of Health, Housing and Community Care, Canberra

³ Consumer Focus Collaboration (2001) *The evidence supporting consumer participation in health*, Department of Health and Aging, Canberra

⁴ Draper, M. (1997) *Involving consumers in improving hospital care: Lessons from Australian hospitals*, Commonwealth Department of Health and Family Services, Canberra

⁵ Victorian Mental Illness Awareness Council (1997) *Developing effective consumer participation in mental health services: the report of the lemon tree learning project*, Victorian Mental Illness

At a health system level, consumer participation has been notably successful in at least two national strategies. For example, the National Mental Health Strategy has been underpinned by consumer input. Consumers have been involved at all planning stages, and have led many of the associated reforms. Partnership approaches to policy development have been identified as critical to the National AIDS strategy, recognised internationally for its success in controlling the spread of HIV⁶.

What are consumers able to contribute? Following consultation with consumers and consumer organisations, the Consumers' Health Forum concluded that: "consumers can contribute to the quality of research by providing a different perspective to health professionals, based on their own experiences of what are the important questions and outcomes that would make a difference, for example with a particular illness".⁷ Indeed Draper argues that consumers have a democratic right to voice their views on treatment and service delivery and she notes that "many informants noted that consumer involvement in their hospital has brought about a more accepting culture in their hospitals. This had been good for staff morale, as well as creating a more accepting environment for consumers".⁸

The *Consumer Focus Collaboration Strategic Plan* encapsulates the goal for consumer involvement in health service design and delivery as it stresses that an effective health care system:

"would also provide frameworks and opportunities for consumers of health care to participate collaboratively with health organisations and service providers in planning, delivery, monitoring and evaluation at all levels, in a dynamic and responsive way."

Awareness Council, Melbourne; Wadsworth, Y & Epstein, M, (1996) *Understanding and involvement: consumer evaluation of acute psychiatric hospital practice*, Victorian Mental Illness Awareness Council, Melbourne

⁶ Consumer Focus Collaboration (2001) *The evidence supporting consumer participation in health*, Department of Health and Aging, Canberra

⁷ Consumers' Health Forum (September 2000) 'Developing a statement for consumers and community participation in health and medical research', *A consultation paper*, Canberra

⁸ Draper, M. (1997) *Involving consumers in improving hospital care: Lessons from Australian hospitals*, Commonwealth Department of Health and Family Services, Canberra

3. Study Methodology

Focus group methodology was selected as it enables the researcher to hear participants' experiences and understandings expressed in their own words. Unlike the group interview in which participants respond to a structured set of questions, focus groups encourage interaction across the group and allow the group to draw in issues that are related for them. As such focus groups are an exploratory methodology and have been of particular value in health areas to elicit a deeper understanding of the perceptions and values of both consumers and service providers'⁹.

Although focus groups can be conducted with groups who do not know each other, recent research indicates that deeper data is gained when existing groups are utilised.¹⁰ The benefit of this naturalistic approach is that groups who have an existing trust will be able to share more personal responses, and shared knowledges may trigger cross-group interaction and probes. Regional groups, on the other hand, can elicit the issues associated with a particular region from a range of participants, for example, the availability of health care.

3.1 Focus Group Design

Six focus groups were held over a three-week period. Four naturalistic groups were used complemented by two regional groups — one Northside and one Southside. The naturalistic groups were:

- A mental health consumers group who do not meet regularly but are familiar with each other via regular use of the Mental Health Consumer Facility;
- A mothers' playgroup who meet weekly;
- An older women's discussion group who meet fortnightly; and
- A men's discussion group who have been meeting fortnightly for three years.

Participants for the regional groups were recruited via mix of direct and indirect approaches:

- An article regarding the project and focus groups appeared in all regional editions of the *Chronicle*
- Meetings were held with key community bodies such as Tuggeranong Link
- A broad range of community organisations such as the Carers Association, Asthma Community Education, and Parents and Citizens Council were contacted

⁹ see Morgan, DL (1997) *Focus groups as qualitative research* (second edition), Sage, London; Kitzinger, J (1995) Introducing focus groups, *British Medical Journal* no. 311, pp 299-301; Powell R and Single H (1996) 'Focus Groups' *International Journal of Quality in Health Care*, vol. 8, no. 5 pp 499-504

¹⁰ Mackay, H (2001) Keynote address, Association of Qualitative Research Conference Melbourne

- Direct contact was made with community workers in Tuggeranong, Belconnen, Dickson, Gunghalin and Woden
- Leaflets were posted in community spaces such as neighbourhood houses, public libraries, and community centres.

The focus groups ran for 90 minutes and were facilitated by Barbara Pamphilon, with two scribes used for four groups, and one scribe for two groups. A short anonymous demographics form was handed out at the end of each group to collect information on gender, age, postcode, language spoken at home and average weekly income. Focus group participants were provided with appropriately healthy refreshments, during or at the conclusion of the group.

As well as discussing their experiences and needs for after-hours medical services, participants were invited to brainstorm a list of the essential elements for good practice after-hours GP services. Each person was then given five stars to place beside their most valued components (a person could put all five of their stars on one issue or spread them according to their values). All essential elements have been recorded in rank order in the Focus Group Reports, with a summary table of the consolidated votes across all groups presented in the concluding sub-section of Section 5. This exercise was used to enable group members to draw together some of the issues that had arisen across the wider discussion. It must be stressed that this should not be read as the participants' *consensus* for good practice. The lists were not discussed across the group and so remain collections of individual qualitative responses. They must be considered in concert with other data on good practice service design.

Data from each focus group was transcribed, compiled and sorted into themes. Summary tables by themes are to be found in the appendix. Cross themes were determined, however, as this is an in depth exploratory methodology, single responses were equally valued.

3.2 Reporting the Findings

In the Section Four, “The Focus Groups”, the participants' words and concepts have been highlighted in order to most adequately represent the diverse consumer perspectives. Editing has been used minimally in order to ensure that clarity of meaning is retained. The subsequent sections, ‘Themes’ and ‘Implications’ draw out the issues across the groups whilst continuing to use the words of the participants in order to illuminate their perceptions, needs and vision for after-hours medical care. The final section presents possible service responses and system improvements to enhance after-hours health care in the ACT.

This report includes an extensive appendix . The inclusion of much of the focus group data acknowledges that qualitative research aims make available the breadth and depth of individual views, experiences and needs. It is hope that this appendix will enable the reader to peruse this wide resource in order to further understand the complex challenge of inclusive and appropriate service design and delivery.

3.3 Study Limitations

Although the gender and regional spread of participants were adequate, no consumers from culturally and linguistically diverse backgrounds or people under 23 years of age attended the focus groups. Further qualitative research with youth, indigenous people and other specific cultural groups may reveal other facets of after-hours service needs of these population groups.

4. The Focus Groups: Themes and Issues

The following section presents the data from each of the focus groups, outlining the participant demographics, the key themes under the headings accessibility, affordability, quality of care and continuity of care, and concludes with the rank order elements regarded as essential for an after-hours medical care service. (for expanded data sets, see the appendix).

4.1 ‘Doctors are like hairdressers – when you find a good one you stick to them’: The Mothers Group

4.1.1 Participants

Table 1 : Mothers’ Group profile

Mothers of young children 6th March 2002 9:30am - 11:30am Calwell Neighbourhood Centre Attendees: 5	Age: 20-24: 1 25-29: 1 30-34: 1 35-39: 2	Gender: All female
Postcode: 2905: 4 2906: 1	Language spoken at home: All English	Weekly household income: \$400-499 x 2 \$1000-1499 x 2 \$1500 or more x 1

4.1.2 Key themes

Accessibility themes

Of all of the focus group participants, this group of mothers had used after-hours services the most, particularly for their children. All participants valued a long-term relationship with their GP.

- *I once waited two weeks to see my own doctor*
- *You just have to get sick between 9am and 6pm*
- *You have to plan to get sick ... you get a rapport with your GP. You have to book in a couple of days ahead ... my GP doesn't take walk ins ... my GP tells his receptionist to fit us in no matter what*

When asked what they would do if their own GP was not available, the mothers used a form of self-triage.

- *Depends on the level of emergency. If it were bad I'd go off to the hospital*
- *If it weren't a big emergency, I'd put it off*
- *I'd use Health First, then go to my GP the next day*

Although the women had varied but limited experience with *Health First*, most agreed that it was a service they may use in the future.

- *They said to go to Emergency*
- *I found it very rigid, like a textbook. I think the end result from most of them is to go to Emergency. That's what they always say*
- *I had also just seen an ad on telly for it*

With one exception, the women did not have a clear understanding of CALMS.

- *I've needed it, but have never heard of it*
- *GP gave information about CALM ... gave pamphlet and phone number*

There was general agreement that using ED was to be avoided as far as possible, with the exception of accidents that required stitches or X-rays, and again the need for immediate care for children was apparent.

- *Decisions are different for adults, [adults] are more likely to wait an extra day to see their GP, but kids have a more immediate need*
- *I try to avoid the ED if possible if it's not necessary, the long wait*

Affordability themes

The women in this group clearly linked affordability to the need, that is to how sick the child was.

- *If they were really, really sick I'd pay for it*
- *It didn't enter my head (the cost), just put it on visa*

However there was concern about payment modes.

- *CALMS costs money and you have to pay up front*
- *Children and the elderly should be bulk-billed*

Continuity of care themes

The mothers' choice to wait until their own GP was available was linked to their need for continuity of care.

- *Doctors have your records*
- *It depends on whether it is a real emergency or not. I like to stick to my own doctor rather than having to explain ... I like my file being there even if I have to see another doctor*

Quality of care themes

The mothers commented on a number of after-hours services including the local chemist who was used to give advice on pharmaceutical care and other treatment options.

There was a range of experiences with ED. One woman had needed to use ED for her partner because no other appropriate service was available.

- *My partner was going through withdrawals from smoking heroin. He needed specialist care and it was 12 at night. We found that the staff were judgmental. We would have used a different service if one was available.*

Waiting times was a quality of care issue

- *I had to wait about two hours and I was getting pretty stressed.*
- *They seem to leave adults to suffer, but kids seem to be faster. My partner went to ED with a head injury and he had to wait four hours. We would have preferred to go somewhere local.*

Health First, CALMS and chemists all received positive comments for quality of care.

4.1.3 Essential elements of good practice after-hours GP service

For this group, the essential elements of good after-hours service involved full overnight coverage, access within their region, and the ability to have prescriptions filled in the same medical centre.

Table 2 : Mothers' group: Essential elements of an after-hours medical service (rank order of stars)

5	Overnight service (take pressure off EDs)
5	Pharmacy attached
3	Centre in each region
2	Open till 9pm
2	File link-up (both ways)
2	GPs with experience
2	Follow up call/contact
2	Bulk-billing - children and elderly
1	GP who is happy to be there
1	GP who can work well at night
	GP who you can understand (language)
	No great waiting time
	Bulk-billing all people

Note - some issues were suggested by the group, but received no votes

4.2 'I would much rather ring a nurse to make a fool of myself than see a doctor': The Men's Group

Unlike the other five groups, the men's group had had little direct experience with after-hours medical care and, consistent with the literature, reported that until their fifties they did not use a GP on a regular basis. Their main experiences with health care were through their wife and/or for their grandchildren. However, as this was a regular men's discussion group, the men did provide substantial information relating to the range of men's responses to health care.

4.2.1 Participants

Table 3: Men’s group profile

Men’s group Tuesday 5th March 11.00 am – 12.30pm Attendees: 8 7 surveys received	Age: 60-64: 4 65-69: 2 70-74: 1	Gender: all male
Postcode: 2607: 2 2611: 1 2614: 2 2612: 1 2903: 1	Language spoken at home: All English	Weekly household income: \$120-159: 1 \$160-199: 1 \$500-599: 1 \$600-699: 1 \$700-799: 2 \$800-999: 1

4.2.2 Key themes

Accessibility themes

Most of the men in this group preferred to access medical centres, ED and chemists, rather than having a particular GP. The use of health services was pragmatic with location and after-hours service important. The group noted the importance of drop-in after-hours medical centres for young men who they believed need very accessible services when they do decide to take the initiative to seek medical advice.

- *Philip [Clinic] was accessible because you could phone in to see how long a wait there was. It is less accessible now they have moved and reduced their hours*
- *Sports injuries on weekends ... no doctors available*
- *Phone booking to put yourself in the queue and check waiting time*

Although only one person indicated he had used Health First (for his grandchildren), the rest of the group saw that this was an ideal service for certain health concerns because it was safe and anonymous.

- *I would much rather ring a nurse to make a fool of myself than see a doctor and make a fool of myself because she is a woman and because she is a nurse*
- *Certainly I would use it for my wife*

Because of this interest in Health First, they discussed how important it was to ‘niche market’ the service.

- *There are lots of ads for male erectile issues – could insert an ad about after-hours services with these ads*
- *Most guys I know read the sports pages*

The group had used after-hour's group practices but in later life some of the men had developed a longer-term relationship with a GP who was therefore their preferred service provider.

- *The client has faith, belief and trust in a person and you still go to that doctor even if he is far away*
- *We have been going to the same Doctor for years I asked him if we were dying what would we do? He said in that case we [the surgery] would organise something and come up to the house – they don't do it normally*

In considering the use of ED for themselves, the men thought about emergencies in terms of heart attacks or life threatening events, however for a grandchild with a broken arm or a wife a cut finger for example, ED would be the choice.

- *If I feel my life is threatened*
- *Yes, if it was a cut or sprain, I would go to a locum or Health First*

The locations of ED were not an issue for this group but the wait was a concern.

- *The critical issue in making the decision is how many people are in A&E and how long you would have to wait*

One man raised the lack of after-hours services for mental health issues.

These men suggested that accessibility issues for men revolve around men's orientation to health issues in general. Although some of the group believed this to be due to the stereotypes of masculinity, others argued that it was due to concern about 'bothering' a professional.

- *Bothering people after-hours becomes an extra problem ... is it really necessary ... for me it was a problem, I was even resistant on my wife's behalf ... it has to do with self value*
- *There is a niggling thing that says that it is not available unless it is an emergency ... is this an emergency – do I have the right to this?*
- *The reason why [young] men don't go to specialists etc is because they have something to show, [that] they are macho*

The men noted the differences between men and women in relationship to their patterns of use of health care services.

- *Women have to see doctors in the normal ... of their lives*
- *Because I am pretty healthy I can only think of three times in 30 years when I have needed care after-hours*
- *I would guess that the connection with children and grandchildren might mean [a woman would] know more about CALMS and Health First*
- *Women are allowed to show emotion and ask for help but boys don't cry*

However they also noted that many of the health care messages are not gender inclusive.

- *We have a poster that we use that shows a man sitting in a clinic and behind him is all the information about breast cancer, have you had your pap smear, are you getting enough calcium? Six issues on the wall and none relate to men.*

Affordability themes

Following the concern to remove barriers to health care, especially for younger men, the group saw bulk-billing as helpful for pensioners and young people. They were concerned about CALMS being expensive and requiring cash up front, and believed that ED and medical centres were cheaper.

Continuity of care themes

The men noted the levels of care, from emergency to medical care to first-aid, commenting how they would use each differently.

- *CALMS – they do treat you, but then they say that you should see your GP tomorrow*
- *GPs are more critical for some matters eg. managing compensation claim matters*
- *Ambulance have certain knowledge ... no degree ... but know how to deal with patient before emergency ward*

Although a number of men said they would use CALMS, their concerns revolved around the continuity of care.

- *CALMS know nothing about medical history whereas A&E does*
- *It is an issue that the CALMS don't have my medical history*

The group stressed the need for central medical records.

- *It would be nice for A&E to have access to my medical records*
- *CALMS know nothing about your medical history, I would rather go to A&E, they can look up your records*
- *Need doctor to access allergies, blood tests etc*

They noted the privacy issues highlighting that central records might be a disincentive for some men.

- *System[with] important information on computer[should be] available widely, but not all health information [should be held centrally]*
- *Concerns about privacy, putting young men off going to the doctor re STDs, drugs etc.*
- *Big brother*
- *[need to have a] choice about what went onto records*

Quality of care themes

As this group of men had not used after-hours services to any degree, their discussion focussed on improving health information delivery to men.

- *Needs to be in front of you all the time*
- *Fridge magnets*
- *Phone book –[essential phone numbers should go] inside the front cover*
- *White pages should be better organised*
- *We can't find ads in the white pages – what about NESB, or when you are in a panic*

- *Government departments send out info about community services [health should be the same]*
- *Niche – eg. next to impotence ads*
- *Local medical line with phone number H-E-L-P easy to remember*
- *000 [for all emergency calls] - if you use a mobile the number is not 000*
- *An e-mail number you could type in symptoms and ask for instant diagnosis available to patients*
- *A men’s health centre when we have defined our health issues more clearly*

4.2.3 Essential elements of good practice after-hours GP service

The men had a wide range of ideas on how GP after-hours service could be more effective for men. They stressed the issues of community education, effective record sharing and bulk-billing.

Table 4: Men’s group: Essential elements of an after-hours medical service (rank order of stars)

7	Regular community wide advertising, phone book
6	Central medical records – levels, secure, choices of register, key data
6	Computer based GP files for search[ing easily]
5	Bulk-billing
4	In-house minor procedures clinic
4	Regional medical centre approach, not individual practices
2	Connected to chemist
2	Available six to midnight but flexible
1	Phone booking
1	Queue advice
1	A&E after midnight

4.3 ‘After-hours is our crisis time’: The Mental Health Consumers’ Group

The mental health consumers reported longstanding difficulties in accessing after-hours medical care. They stressed that although they sometimes required the care of a mental health professional, many other times their needs were no different to those of the general population. Due to the interaction of physical illness with mental illness, this group highlighted the need for an intergrated health care system.

4.3.1 Participants

Table 5: Mental health consumers' profile

<p>Mental health consumers group</p> <p>Wed 27th February 2002 11 – 12.30</p> <p>Attendees: 13 Survey results: 12 returned</p>	<p>Age: 35-49: 7 50-54: 3 55-59: 2</p>	<p>Gender: 6 male 7 female</p>
<p>Postcode: 2602: 2 2604: 2 2618: 1 2615: 1 2614: 1 2612: 3 2617: 1 2903: 1</p>	<p>Language spoken at home: All English</p>	<p>Weekly household income: Full Pension: 1 \$40-70: 1 \$120-159: 2 \$160-190: 5 \$200-299: 2 \$300-399: 1 \$400-499: 1 (NB one participant circled both 120-159 and 160-190 and has been counted twice)</p>

4.3.2 Key themes

Accessibility themes

- The mental health consumers commented that after-hours access to medical care was a key concern *“it’s easier to get a vet after-hours”*. They reported needing to use a wide range of care services, for example four people had heard of CALMS; Health First had been used by two people, ambulance used by one and drug and alcohol detox. was used by three people. Comments on other services included:
- Lifeline — *for crisis counselling they [Lifeline] have been invaluable for me*
- Police — *we need more education for police ... If the police take someone to hospital they want someone to stay with you while you wait, but the hospital won’t provide someone so the police have to stay*
- Erindale Centre — *gives you no help at night time*
- Psychologists — *they are not on the agenda for after-hours*
- Other professionals — *all sorts of on-line things*

The Mental Health Crisis team – the experiences with this care team was mixed

- *They came out three times a day for three weeks*
- *They’re pretty good*
- *Seem to be able to get them usually*
- *People often have to wait two to three hours*
- *They don’t always answer*

- *I have been refused help three times*
- *The crisis team only have two people for the whole of Canberra*
- *They don't have enough funding*

Most of the group preferred to go to their own doctor and one person did know of their GP locum service.

- *I've got my own[GP] and he has my medical record and history*
- *I find it impossible to see a GP after-hours, after four p.m.*
- *GP locum on weekend I have his number in my wallet*

This group found transport to after-hours care a major issue when they were unwell.

- *Not having a car is a big problem*
- *If you are very ill you can't drive*

They noted the difficulty for people living with mental health issues accessing doctors after-hours when they travel interstate travel.

- *What do we do when we travel?*
- *I got quite insane – the only people I could get hold of was Lifeline*

Affordability themes

This group of consumers reported major difficulties with the cost of after-hours health care.

CALMS

- *Even if I was dying I would go to the hospital, not to CALMS – they don't pass on information, they are hard to get to and they cost a lot of money. I would ring an ambulance*
- *the Doctor said that it was going to be \$100, I said 'I don't have it' and they ended up bulk-billing me, but they weren't too pleased*

GPs – there was much debate in the group about doctors not bulk-billing

- *At my practice – no new bulk-billing patients and they only bulk-bill between 10 and four*
- *most of us are on pensions*
- *one person reported being threatened with legal action because they couldn't pay*
- *Florey used to but they are cutting back and back and they don't bulk-bill, even pensioners*

ED

- *Money is not an issue but the wait*

Continuity of care themes

This group of consumers stressed the importance of an integrated health system. They need their health information shared in a timely way. Some consumers were pleased with

the ED passing on information whereas CALMS was reported as having problems with passing on information.

- *We [my doctor and I] had to really push to get information from CALMS*
- *Even if I was dying I would go to the hospital, not to CALMS – they don't pass on information, they are hard to get to and they cost a lot of money*

Respondents commented positively that the Crisis Team maintained appropriate records.

- *All records are put on MAGIC (a recently introduced information system)*

Quality of care themes

There was a diverse range of experiences of medical services within this group with mixed reports on the quality of care from the Crisis Team, CALMS, ED and the few GPs who would see a mentally ill patient out-of-hours. Health First received positive comments with the note that they had limitations regarding medication advice.

GPs

- *With us there is always the mental side of things – we are going with double trouble*
- *Sometimes they won't take you seriously enough if you do have mental problems*

ED

- *The mental health issue has a lot to do with it – we are treated a lot differently*
- *Main problem is waiting time – for people with psychiatric problems – with crisis team you get seen quicker*
- *I have taken someone to A&E I have sat there for five hours*
- *Some felt it was terrible – like jail, others found it 'very good or great.*
- *I needed to build up a history – they wouldn't admit me until over the years they would. They would ask me the date and if I could tell them they would send me home even though I needed to be in hospital. These days they know me and will admit me*

Crisis teams

- *A few years ago it was shocking – much more professional now, they don't say negative things to you any more*
- *I was sick once and they called each day on Saturday and Sunday*
- *I got told to 'calm down, and lie down'*
- *I got told to 'go and have a bath and watch a video' I made a complaint*

The group commented that they also needed to have ways to support each other and not always rely on medical services.

4.3.3 Essential elements of good practice after-hours GP service

This group reflected the needs of people living with a long-term medical condition and the concomitant financial disadvantages. They stressed the need for a system, which was affordable, flexible and responsive to their specialised needs.

Table 6: Mental health consumer group: Essential elements of an after-hours medical service (rank order of stars)

9	Bulk-billing
5	Home visits if necessary
5	More training for GPs in psychiatric area
4	Ability to get us into the asylums – have us admitted to hospital
2	Able to get in quickly
2	Know people’s medical history
2	Better communication between GPs specialists and EDs
2	Open evenings, weekends and holidays
1	Easy to remember phone number
1	Education of community and GPs
	Easy to get to
	Stock of common medicines so don’t have to go to chemist after-hours
	Electronic diagnosis
	IT system – including the ability to read interstate

4.4 ‘You can't just jump in a car’: The Older Women’s Group

The older women’s group focused on issues related to continuity of care, accessibility and affordability. As many of them no longer drove and also lived alone, after-hours care was an issue of ongoing concern. This group remembered the days when home visits were the norm and the contrast with current service delivery is great.

4.4.1 Participants

Table 7: Older women’s profile

Older Women’s Group 14th March 2002 10am to 12pm Attendees: 14 Survey Results: 10 received	Age: 65-69: 2 70-74: 3 75-79: 2 80-84: 3	Gender: All female
Postcode: 2604: 1 2605: 2 2606: 4 2607: 2 2612: 1	Language spoken at home: All English	Weekly Household Income: Full Pension: 2 \$200-299: 3 \$300-399: 1 \$400-499: 3 \$500-599: 1

4.4.2 Key themes

Accessibility themes

The women believed that GP surgeries should open routinely from 9am to 10pm, citing the services they knew.

- *There's one in Garran near the hospital and the Bloodbank*
- *There's one in Erindale open until 9pm*

There were six people who had utilised ED, but transport there was a major issue for all participants:

- *To go by ambulance to the ED is the only way to get in there*
- *I don't drive any more*
- *Taxi*
- *Or friend*
- *You can't just jump in a car. Especially if you are feeling sick*
- *A good neighbour*
- *We don't all have a good neighbour*

Although four people had utilised an ambulance, there was confusion regarding who could use this service.

- *My brother is a paramedic. He said it [ambulance] is the best way to go to ED. It's a wonderful service*

Four women had used CALMS, however only three women's GPs had explained what to do after-hours and how to access the service.

Health First: No-one had used this service to date and only one woman had heard of it but did not know how to contact them. The entire group thought that this was a wonderful addition and, as all had access to a phone, participants thought they would use the service if needed.

- *That sounds good*
- *Is it a real person that answers the phone?*
- *I like nurses – I feel comfortable ringing nurses*

The local chemist was again noted as an easily accessible source of weekend health advice.

Affordability themes

Many of the group were concerned about bulk-billing, but there was not agreement about different charges for after-hours.

- *Most GPs want up front payment, very little bulk-bill these days*
- *I've heard of people leaving GPs to go to one that bulk-bills*
- *You have to expect to pay more at night*
- *If it is bulk-billed, it should be the same as normal hours*

When considering ambulance costs, comments included:

- *They do send an account, you don't have to pay up front*
- *They never sent me a bill*

Although most of the group did not have experience with CALMS, they were concerned about the requirement to pay up-front.

- *I don't keep cash in my home for safety reasons*
- *I don't have any cards*
- *Does that mean they won't come if you can't pay?*
- *They assume you are an old-age pensioner and just bill you*
- *The account could go to your normal GP and then you could pay it there*

Continuity of care themes

This group saw the ambulance team as an essential part of continuity of care.

- *It's the assessment thing, the ambulance can assess whether you need to go to hospital or not ... they might not know exactly what's wrong. They sent me the intensive care ambulance*
- *If an ambulance had seen her, they wouldn't have sent her home*

They stressed the need for an after-hours service link to the local GP.

- *They have my record*
- *You don't have to tell them your whole life history if they have your record*

Quality of care themes

This group of women had had many experiences with ED. They generally believed they would do what they could to avoid going there but were clear about the conditions that would lead them to use the ED as their first option.

- *In my experience, I wouldn't go there, I'd try to wait it out*
- *It would depend upon the pain*
- *If the pain was so severe and I was on my own, I'd go to the hospital*
- *I wouldn't go to ED late at night*
- *I was told that if you come here you'll be here all night*
- *–I went [to hospital] and as soon as they heard that they put me straight in a wheelchair and did the tests I was there all night. They did every test under the sun [Chest pains]*
- *Marvellous, they did scans and everything possible, straight away*

Negative experiences with EDs were recalled as reasons to seek other care options first if possible.

- *My brother who was dying was brought over from Calvary to Woden. He waited for hours to get a bed and he only just got a bed minutes before he died*
- *I went to the hospital once with a sore leg and they said 'Your leg is fine, you can go' They were quite rude. I went by ambulance*
- *We saw two young doctors that sent her home. She was in a lot of pain. [Ectopic pregnancy] I wonder about their level of expertise. The ED was the only option we*

had. I wonder about their level of competency ... They were so young — what experience they had behind them I don't know

- *[The doctor] said to take [my frail aged mother] home – ‘she’ll be right. He said you’ve got to weigh up putting her in hospital at the expense of other people. I said ‘it’s the middle of the night in June, I’m not going to take her home,’ I was really angry, I blew his socks off. The next day she couldn’t walk*

For real emergencies, ambulances were seen as most trustworthy, especially for people living on their own and the elderly.

- *If an ambulance had seen her, they wouldn’t have sent her home*
- *For people on their own, it's a security thing ... especially aged people*

All participants who had used it valued the CALMS service, with one woman noting that she would use CALMS as a triage option.

- *I'd ring CALMS first before going to the ED*
- *I couldn't have had better treatment from the locum*
- *My brother’s daughter overdosed on herbal medicine stuff. I rang CALMS and the doctor came around and said I think I will put her in hospital*
- *I've called once. It was for my husband who had actually died. It was excellent, really, really good. I rang my GP and he told me to ring CALMS. I rang and told them my GP was away. The locum rang the specialist and even rang the funeral parlour. She couldn't have done anything better*

4.4.3 Essential elements of good practice after-hours GP service

The older women highly value the personal service of a GP system in which they and their situation is known. The need for home visits was stressed. This was the only group who raised the issue of a highly skilled receptionist as a key factor in quality GP service.

Table 8: Older women’s group: Essential elements of an after-hours medical service (rank order of stars)

9	Knowing you is very important and knowing your history
7	They come to you
6	A highly skilled receptionist
5	They are prepared to talk to you and give you advice over the phone
4	Full time practitioners
4	Relationship and trust - must be able to trust your doctor
3	Have a group practice that has a roster to cater for after hour’s service. Still have your record
2	Central locations
2	Same cost as normal hours
2	Other related services eg. dental
1	Shorter waiting than ED
	A team of doctors, not co-located, but do after-hours together

4.5 ‘But someone else is not as good as your own doctor’: The Northside Group

4.5.1 Participants

Table 9 : Northside group profile

Northside Wednesday 13th March 6.30-8.00pm Attendees: 7 Survey results: 7 received)	Age: 25-29: 1 40-44: 1 45-49: 1 55-59: 3 70-74: 1	Gender: 3 male 4 female
Postcode: 2602: 4 2906: 1 2913: 2	Language spoken at home: All English	Weekly Household Income: \$80-119: 1 \$160-199: 2 \$200-299: 1 \$700-799: 1 \$1500 or more: 2

4.5.2 Key themes

Accessibility themes

The Northside residents had used the standard medical services of ED; CALMS and one had used Health First. They had also used 000 (three), specialist after-hours teams (two), Lifeline (one), and police (one). Most people had used the chemist but noted that their opening hours were not ideal.

For some members of this group, the distance to the hospital was not as much of an issue as the waiting time; for others, accessibility was considered more important than continuity of care.

- *I have been prejudiced against Calvary because of waiting times so I go to Woden*
- *Even though I live in Ainslie I go to Woden*

The issue of transport was raised with the group options being *get a taxi; call an ambulance; go to the CAT [mental health crisis] team*. There were different views regarding the use of ambulances, most related to perceptions of the presenting medical condition.

- *I would prefer to go to the hospital because I feel like I am making a fuss [to call an ambulance]*
- *I can't lift him — I need a strong man around — because I have done first-aid I am confident to know when we need hospital [husband with stroke effects]*
- *With ambulance and paramedics they can do most things*
- *To get oxygen saturation done by the ambulance, of course they then stayed — they always need to transport children to hospital*

- *And you're talking about how far you are from the nearest [ambulance] station, it can take time [for the ambulance to arrive]*
- *The ambulance came out and looked and they said 'we can't take you, why didn't you ring [the hospital] — they have a station wagon'. I'd never heard it, they said 'this is not an emergency'*

For people with ongoing conditions (asthma, mental illness, stroke effect), some had developed specific self-triage routes whilst others reported continuing problems.

- *Call 000 or go to A&E because of my special circumstances [child with asthma]*
- *For someone with a mental illness they have a crisis team. Its confusing: there is a triage team and the CAT team at Woden casualty ... [for mental health] the latest thing is that they call Health First*
- (stroke effect see above)

The small number of people who had used CALMS were positive and one person had had a GP who was willing to visit him at home.

- *I had an arrangement – the GP is no longer there — but if I really needed him he would come – I never needed to*
- *It's common practice if you need a doctor after-hours you call CALMS*

One single mother noted the need for basic extended GP practice hours for full time workers (and their children)

- *I am a single parent my work has only half-hour lunch. I work two jobs — one at Fyshwick and one at Spence — and I can't get to Ainslie [where I live] during lunch hour. After-hours medical care for basic care is not enough. Doctors I have tried open after-hours but I don't like the way they work ...I need to be seen after] 5pm or [so I can leave] before 9am so I would only miss half an hour or an hour of work ... I ask friends to take my kids to the doctor, or I send my 17 year old by herself, I ask 'what happened?' she says 'I went in and didn't say anything much' – it's not OK*

Affordability themes

There was general agreement that cost was an issue

- *CALMS - I had a friend – she was charged \$70 and wasn't impressed, but the treatment was good*

GPs - bulk-billing

- *It is going to be an issue from May 1st – [my GP is] not going to bulk-bill. 5-7pm pay \$60 a visit and Sat and Sunday morning have to pay up front, which means the need to go to Medicare to get reimbursed. Don't always have the spare money to be able to do that*
- *Bulk-billing is really important – most doctors in Canberra don't, it's almost a conspiracy there is pressure on doctors not to bulk-bill*
- *Doctors who did [bulk-bill] now don't – I changed doctor each time*

Continuity of care themes

As this group had a number of people with chronic health conditions, the issue of continuity of care was paramount.

- *My daughter was admitted during the day I wondered if what was put on the file was information relayed there [to GP etc] for [their] file – I don't remember what they [A&E] said*
- *If you go to A&E they send you home with a discharge note sometimes to show to your GP*
- *Mostly that [discharge note] happens — they wanted to change [husband's] medication last time I said no, and they tried to contact my GP but couldn't because it was after-hours. They made the decision [about changing his medication]. As soon as he was available I called our GP*

Health First was seen as a good model for continuity of care.

- *Very useful because it is computerised – just say your name and address and your history is there. Once they suggested going to the hospital 'say you got sent from Health First and skip the waiting list' I got seen nearly straight away.*

Similarly the ambulance service provided first step care that was highly valued

- *000 with ambulance and paramedics they can do most things — each time they come they put a cannula in so when he gets to hospital there is no delay*
- *To get oxygen saturation done by the ambulance, of course they then stayed – they always need to transport children to hospital*

Quality of care themes

For a number of participants, a trip to ED was their only option for the medical treatment of their family member.

- *We don't have anyone who will come to the house. The last time at four to five p.m. he stayed in a bed in A&E all night*
- *I can't lift him. The 000 here sent out firemen*
- *We can only get his saturation done in hospital or in an ambulance.*

However, the ED situation was not always perceived as quality care.

- *The last time [husband] went to hospital I followed in my car (I always do that). When I got to A&E I had to sit and wait and not know if he was alive or dead because they wouldn't let me in. They said to sit and take my turn*
- *Once they gave my daughter some sleeping tablets and said to take her home. I said 'no, I'm not taking her home'. They have a special flat but its not always easy to get in to*

Most participants would have preferred GPs or medical centres.

- *I took her to Dickson and she got seen quickly — I would go there then again, [but] they don't do the afternoons. It's hard to know these things without doing the research*
- *I automatically think [ED] — especially some trauma, I think hospital, but in retrospect you think a GP could have done*
- *Local GP ... would be a lot easier and quicker. We've all sat in the queues*

- *Wound-stitching - if you can find a GP to do it, I would go there*
- *but someone else is not as good as your own doctor*

Although most people were pleased with the treatment given by CALMS, the group believed that nurses could be used more as in the model used in some GP practices

- *they also have a couple of sisters who will do injections*

4.5.3 Essential elements of good practice after-hours GP service

The cost of after-hours medical care was a paramount issue for this group. They saw moderate cost as a reasonable option but also argued for the need for one-stop-shop practices in after-hours centres.

Table 10: Northside group: Essential elements of an after-hours medical service (rank order of stars)

6	Moderate cost
6	Full service practice (tests, drugs, x ray)
5	Bulk-billing
5	Electronic records
2	Regional locations
2	Home visit by GP
2	Till 11 am from a central group
1	Visiting nurse assessment
1	24 hours from a central group
1	Ability to phone own doctor
1	Some transport available

4.6 ‘It’s a big problem to end up in A&E but there is nowhere else in Tuggeranong’: The Southside Group

4.6.1 Participants

Table 11: Southside group profile

Southside Chisholm Community House 14th March 2002 2pm to 3:30pm Attendees: 9 Survey results: 9 received	Age 25-29: 1 40-44: 2 45-49: 1 60-64: 2 65-69: 1 70-74: 2	Gender Female: 7 Male: 2
Postcode 2902: 1 2904: 3 2905: 3 2612: 1 2620: 1	Language All English	Weekly Household Income Pension: 1 \$160-199: 1 \$200-299: 1 \$300-399: 1 \$400-499: 1 \$500-599: 1 \$800-899: 3

4.6.2 Key Themes

Accessibility themes

This group had utilised a number of after-hours services. Three people had used Health First, three people had heard about it, three people didn’t know about it. Some people hoped to find a GP who would do home visits, whilst one had a GP who did home visits, and one GP stayed at the surgery when needed. Two people had used CALMS and two people’s GPs had told them about CALMS.

A number of people had utilised the ambulance system for ‘life threatening’ ‘emergency’ situations.

- *If I can’t get there myself*
- *If I think they can get there quicker than I can*

One person commented that ambulance transport was a strategic choice.

- *I have a friend who says you use an ambulance to get into the ED at the top of the list — I think that is only a perception*

Most of the group had used ED because of the lack of other local options.

- *My main reason for going there is that is no medical centre around this area who do stitches and that sort of thing. Every time I have been to the ED, the problem could*

have been sorted out by a GP. I now go to Monash, who do stitches, but a lot of doctors don't do stitches. A lot of people go to ED because there is a lack of doctors in the Tuggeranong area. You also have to pay.

- *It's a big problem to end up in A&E but there is nowhere else in Tuggeranong that you don't have to pay. There are a few places that you can go during the week on a low income*
- *The majority of people in A&E could be easily seen by a GP or a nurse*
- *I've gone simply because my GP is not open at that time. It was easy because I know where the ED is. It is easier than finding an after-hours GP*

Two people stressed the issue of transport to ED.

- *An average stay is about four hours and, you know, I've got transport but a lot of my friends don't have transport, so you can imagine how hard it would be. I have gone about six times in the last 12 months, one or two times for my own children and the rest transporting friends' children*
- *A single parent or even a family with three kids and one is sick, how does the mother get the sick child to hospital while the others are asleep?*

There was concern about the access of youth to medical services (see also affordability).

- *Actually, I have heard that young people don't want to go to their local doctor in case they run into their parents' friends. Are there any places after-hours for young people?*
- *If they don't have a Medicare card, their options are narrow. To get a Medicare card is very hard. [Our youth service] tend to see the same group of young people all the time, they get well known, and the hospital is colder to them each time they go.*
- *Maybe we should be opening clinics with nurses to distribute such things as the morning after pill*
- *One p.m. of a Monday the [youth clinic] is chokkas with young women coming for the morning after pill [The service] doesn't open till 1pm Monday ... if the young woman has unprotected sex on Friday night, Monday afternoon is getting close to the deadline for treatment*
- *[The youth service] is a long way from Tuggeranong. We could [run some of our services] from clinics here*

Chemists were also cited as accessible after-hours services.

- *If I can't find a doctor I go to the chemist. They are always willing to help and advise you. The chemist at Lanyon can't cope with the amount of people that use it. And he's not getting paid anymore for having to deal with the extra people. They are thinking about putting a nurse on. I have always found them to be very helpful. The only thing is they can't do is diagnose*
- *I go there for the kids when they have asthma*
- *They give me advice on which tablets I can and can't have*
- *I would go to the chemist rather than the doctor [because with her autistic child the chemist is more accessible]*

Affordability themes

There was considerable concern regarding the cost of services outside that of the ED.

- *A lot of people go to ED because there is a lack of doctors in the Tuggeranong area. You also have to pay*
- *It's a big problem to end up in A&E but there is nowhere else in Tuggeranong that you don't have to pay. There are a few places that you can go during the week on a low income*
- *Payment is also a huge issue for youth, as a lot don't have Medicare cards. They might be on their Mum and Dad's card but if they don't want their Mum and Dad to know about their problem, then they are cactus. They are often blatantly refused services because they don't have a Medicare card. Lots of youth from Queanbeyan, Tuggeranong and Gungahlin come to the [youth centre] to get medical help because they don't need a Medicare card*
- *Cost is also an issue for young people. [Services] may have the young person's Medicare number on file from previous incidents but if not they are usually turned away*

The cost of CALMS was raised by a number of people.

- *Even a single parent with a health care card has to pay*
- *So what do they do if they don't have any money?*
- *I guess it depends on whether the doctor has a heart or not*

Similar concern was noted regarding GPs and medical centres.

- *We used to not have to pay up front for a doctor, but now it is all the money up front*
- *Some medical centres will charge the difference between bulk-billing and the amount they charge*

Continuity of care themes

For two of the group ED offered the best option for continuity of care after-hours.

- *The next time I went to ED they looked up his records and saw how berserk he went last time and they gave us a room by ourselves. The doctors look at me and think 'she must be a bad mother - because he doesn't have ADD stamped across his forehead. You need a GP you can go to no matter what ... he is a very mixed little bag ... and he is very violent [mother of an autistic child]*
- *When I go to ED I just ring up and say I am coming, or my cardiologist says I am coming. All emergency admissions have to go via A&E. I may have to wait for a bed, but who cares if you know that you are being looked after, you are near help and at least you know you're not going to die. [And was it your cardiologist that said you should ring or was it you that said I am going to ring if I have a problem?] A bit of both really. I know if I go into rapid AF I need help. I phone or turn up at the desk [Do they have your records?] Yes. I also like to carry my own records. I've never had any complaints with the ED [woman with cardiac condition]*

One person noted that when she moved to a group practice the continuity of care that improved.

- *I was with a GP for 14 years - I changed to a medical centre I find I am getting much better service, they are interested in me they know me, I see one person all the time ... I find it an advantage to go to someone in the clinic who knows about me*

Another person who highly valued continuity of care mirrored this.

- *The closer relationship the better between my GP and an after-hours clinic*

Quality of care themes

The role of Health First for some consumers with special needs was highlighted.

- *[The youth service] has used it on a couple of occasions when the GPs are running late and the youth doesn't want us to call an ambulance. They are a good mediator for us. It's hard [the young person] may be adamant about not going to hospital but we have a duty of care. [Does it help that it is anonymous?] Yes definitely. They don't judge. It's just a voice to them. I might have heaps of earrings and body piercing and tattoos, but they don't know that.*
- *[Other group member] It wasn't anonymous though, I had to tell them my name, not that I cared*
- *I phoned for my baby once and once for my own needs. It was helpful but off-putting that they had to phone back [How long was it before they phoned back?] Good question. It seems like a long time when you have a baby you are trying to settle. 30-45 minutes later. They were quite helpful particularly in relation to my baby. We discussed options – 'if x develops, check out who my GP refers me to after-hours'*

However for the mother of a child with autism, Health First was not a choice.

- *I wouldn't use them. With autism, you can't just talk to anyone. And I have never noticed anything saying that they have experience with autism or that kind of thing*

There was differing satisfaction with CALMS.

- *I used it once. I thought I was dying. I had pneumonia. They were very good; they came to my home. It didn't take them long to get there.*
- *I rang CALMS once and the doctor took that long in coming I phoned to say don't bother coming.*
- *I have used CALMS. The guy came to see me, he was very very good, an excellent service from him.*

In contrast, most people who had used the ambulance were highly satisfied.

- *My child broke their leg and the ambulance was brilliant. I couldn't fault them and we did go to the head of the queue!*
- *I rang an ambulance for my next door neighbour, he had kidney stones. It was a 45-minute wait. We rang three times, every 15 minutes.*
- *I rang an ambulance once from home and they were there in a short space of time. The other time was from my GP's. I'm a great admirer of the ambulance boys*
- *I used one once from home, I had chest pains – they lectured me all the way there, but after all I had chest pains. Another time I got one from a day surgery, he said I was going to have the roughest ride of my life ... 'because they all know you there'.*

Responses to the quality of care in ED varied.

- *I got treated well. It was wonderful ... Calvary is apparently the best place to go, but I have never been. I have been to Woden twice and both times were good*
- *I went with a broken bone and it was brilliant. I couldn't fault them. But with an autistic child, four hours is four hours too long and seven to eight hours is way too long. Once I had to calm him down after being sedated and all the doctors and nurses were just watching on as I tried to calm him down*

For some consumers the need to use ED arose from the type of condition and the lack of other local options.

- *I gashed my arm and went to the ED. The local organisation [doctor] didn't want to know about it. They said go home and ring ED. I waited for hours — would have been happy enough to have a nurse stitch that ... if it is holding everyone up, then a nurse could do it*
- *The second time was when I had a bone in my throat and I didn't want to spend the night with it in there as I live alone. I didn't want to be stuck in the middle of the night. I had an Asian doctor who didn't know what I was saying and I didn't know what he saying.*

There was some concern expressed about the quality of health care for young people which was seen as a disincentive for continuing use of medical care.

- *I would like to bring up the youth issues. Two of the major issues are drug related issues and sexual health. Drug related issues are often seen by doctors as self inflicted and sexual health issues are often seen as 'Well, they're only 14 so they shouldn't be having sex anyway'*

4.6.3 Essential elements of good practice after-hours GP service

This group emphasised the need for a 24-hour medical centre with associated services in the Tuggeranong Valley. The need for an adequate flow of information between the GP and all after-hours services was stressed.

Table 12: Southside group: Essential elements of an after-hours medical service (Rank order of stars)

8	24 hour medical centre
7	Formal relationship through histories with own GP
5	Late night chemist attached
4	Home visits
4	Bulk-billing (unclear whether votes for everyone or low income earners)
3	Nurse on duty to deal with lesser cases
3	Own GP to do home visits
2	Central location
2	GP practice attached to the ED
1	Fees not greater than normal hours
0	Transport to made available
0	Pay the gap from Medicare
0	Interested in my case- continuity

4.7 Focus Group Summary

4.7.1 Participants

In total 37 women and 18 men contributed to the focus groups. Ages ranged from 20 to 84 years, and participants came from all areas of Canberra. Participants included people living on pensions, supporting parents, low income families and more economically secure people. It should be noted that all participants spoke English at home, therefore the needs of people from culturally and linguistically diverse groups are not represented in this study.

4.7.2 Overall themes

From the focus groups it is apparent that there are a number of common issues across the ACT and specific issues for certain population groups.

Accessibility — Consumers were clear in discriminating when to go to ED (for serious accidents, heart attack etc) and although many people would prefer to use a local service, the hospital ED was often the only after-hours option. Transport to medical services was an issue for a number of population groups such as mothers and the elderly. The easy phone access of Health First was appreciated although the majority of people attending the focus groups had not heard of this service. CALMS home visiting service was highly valued and ambulance care was used strategically by a number of consumers.

Affordability — Cost of services, especially the need to pay up-front, was an overarching concern. The elderly and young people were noted as groups who could not pay up-front. Some groups, such as the mothers and the men's group, were willing to pay for the after-hours care of sick children or spouses but would wait until the next day for their own care. Bulk-billing was highlighted by most participants as an important component of after-hours services.

Continuity of care — Most of the groups stressed the need for a well-designed flow of information between the regular GP and all after-hours services. Although there was some concern about privacy, especially for groups such as young men and marginalised youth, most people believed that central records would enhance their confidence in after-hours services. Many consumers had developed their own hierarchy of care services, from first-aid, to chemist, to Health First, CALMS or ambulance to ED.

Quality of care — The experiences across the system were diverse. Mental health care consumers and young people appear to be the least satisfied. The lack of services in Gungahlin and the Tuggeranong Valley were noted by more than one group. Consumers were clear that quality of care was a high priority and they would make health care decisions based on their prior experiences with each part of the system.

4.7.3 Summary elements of good practice after-hours GP service

The participants generated an extensive list of what makes good practice after-hours GP services. This brainstorm enabled participants to draw together the implications of their discussions across many issues concerning after-hours services. However it is important to note that the following tables should not be read as group consensus but rather an indicative list of issues that should be considered in the further development of after-hours medical services.

The first table lists the top priority elements from each group. This is followed by a combined table consolidating the priority elements across all groups

Table 13: Top ranking ideas from each group

Mother's Group

5(MO)	Overnight Service (take pressure off EDs)
5(MO)	Pharmacy attached
3(MO)	Centre in each region

Men's Group

7 (M)	Regular community wide advertising, phone book
6 (M)	Central medical records – levels secure, choices of register, key data
6 (M)	Computer based GP files for search[ing easily]
5 (M)	Bulk-billing
4 (M)	In-house minor procedures clinic
4 (M)	Regional medical centre approach, not individual practices

Mental Health Consumers

9(MH)	Bulk-billing
5(MH)	Home visits if necessary
5(MH)	More training for GPs in psychiatric area
4(MH)	Ability to get us into the asylums – have us admitted to hospital

Older women

9 (OW)	Knowing you is very important and knowing your history
7 (OW)	They come to you
6 (OW)	A highly skilled receptionist
5 (OW)	They are prepared to talk to you and give advice over phone
4 (OW)	Full time practitioners
4 (OW)	Relationship and trust - must be able to trust your doctor

Northside

6 (NS)	Moderate cost
6 (NS)	Full service practice (tests, drugs, x ray)
5 (NS)	Bulk-billing
5 (NS)	Electronic records

Southside

8(S)	24 hour medical centre
7(S)	Formal relationship through histories with own GP
5(S)	Late night chemist attached
4(S)	Home visits
4(S)	Bulk-billing (unclear whether votes for everyone or low income earners)

Table 14: All groups' essential elements top rankings combined

23 (MH, M, NS)	Bulk-billing	AF
16 (S, OW, MH)	Home visits	AC
16 (OW, S)	Knowing your history	CC
11 (M,NS)	Central secure electronic medical records	CC
10 (NS, M)	Full service practice (tests, drugs, x ray, minor procedures)	QC
10 (S,M0)	Late night chemist attached	QC
8 (S)	24 hour medical centre	AC
7 (M)	Regular community wide advertising	O
6 (M)	Computer based GP files for search[ing easily]	QC
6 (OW)	A highly skilled receptionist	QC
6 (NS)	Moderate cost	AF
5 (OW)	Prepared to talk to you and give you advice over the phone	AC
5 (MH)	More training for GPs in psychiatric area	QC
5 (M0)	Overnight Service	AC
4 (M)	Regional medical centre approach, not individual practices	AC
4 (OW)	Full time practitioners	QC
4 (OW)	Relationship and trust with doctor	QC
4 (MH)	Ability to have us admitted to hospital/ asylums	QC

Key: (MH – mental health, OW – older women, MO – mothers, M – men, NS – northside, S – southside), with each classified by theme (AC – accessibility, AF – affordability, CC – continuity of care, QC – quality of care, O – other)

5. After-hours Issues

This section presents a synthesis of the issues across the groups. The first sub-section focuses on the issues related to the GP and is followed by an analysis of consumers' approaches to self-triage. The section concludes with an examination of how individual and system barriers interact.

5.1 My GP is great but...

5.1.1: *The role of the GP in relation to after-hours care*

One group of consumers highly valued their own GP and for them quality of care and trust emerged from a long-term relationship. These consumers were equally aware that their own doctor could not and should not be available around the clock. What they did expect was a system that would prioritise the timely transfer of information across sections and where the GP was key to their health service provision. In some cases, consumers also required the integration of a specialist medical practitioner, such as a psychiatrist or cardiologist.

The relationship with a specific GP was repeatedly emphasized as being critical with some people willing to wait well beyond 'after-hours' to seek the advice of a good GP - *I once waited two weeks to see my own doctor*. A part of this relationship was the building up of rapport, not just with the GP but with associated staff. *The receptionist knows me now. She says how are the kids?* Further, this long-term relationship gave confidence in the quality of care; *At least you know the quality of your own doctor. That they are good*. As one woman summarised - *Doctors are like hairdressers, once you find a good one you stick to them*.

Many consumers had invested time looking for a doctor and 'educating them' about any special needs or in general.

- *It's very hard to find a good [doctor] – I had a bad experience with one and I ended up drifting in the clinic. I found a really good one in the end [mental health consumer]*
- *It's taken me six years to train my doctor [mother with child with autism]*
- *I needed to build up a history – they wouldn't admit me [to the psychiatric unit] until over the years they would. ... These days they know me and will admit me [mental health consumer]*

It was this group of consumers who stressed the need for a system that pivoted around their own GP with a proviso in some cases that *your own GP can get a bit blasé at times, it's not always the answer*. For some of these consumers, the fact that their GP could not admit them to a hospital directly was a notable flaw in the system.

However some consumers did not see the GP as the pivotal role but chose different practitioners for different roles. *Continuity of care is more critical for some parts of my*

health than others. My doctor has managed compensation claims matters; I stay with him for that, and go to another doctor for other things. At the other end of the spectrum, it was reported that some young people specifically seek out GPs who don't know them, in order to preserve their anonymity. *Actually, I have heard that young people don't want to go to their local doctor in case they run into their parent's friends*

5.1.2 The GP and information flow

A good flow of information between after-hours care and your own GP was frequently raised as enhancing health care of an after-hours service, with comments including:

- *the closer the relationship the better between my GP and an after-hours clinic*
- *[Health First is] very useful because it is computerized – just say your name and address and your history is there*
- *It's an issue that CALMS don't have my medical history*

Problems with a full information cycle, from the past history to after-hours actions were evident. The relief of not having to go through your medical history several times was important to many. *I like to stick to my own doctor rather than having to explain. I like my file being there even if I have to see another doctor.* Whilst several people reported that it had been difficult to get information passed on:

- *We [doctor and I] had to really push to get information from CALMS*
- *Even if I was dying I would go to the hospital, not to CALMS – they don't pass on information, they are hard to get to and they cost a lot of money*

Some consumers were proactive in managing their own records to ensure greater quality care and so carried their own records *Yes I also like to carry my own [cardiac] records'* or distributed their own records, *I was administered the very drugs I was allergic to [after-hours]. I made a living will and sent it out, with my allergies, medications etc to doctors.*

Electronic record keeping was seen as potentially improving the possibilities of information flow, and although for some people the issue of privacy was very important, for others, the information flow took precedence. Many thought that privacy issues had technical solutions.

5.1.3 Extended hours and extended services

A number of consumers believed that the health care system could be greatly improved through simple structural changes. This included extending the hours of normal GP services where the client has difficulty accessing doctors during working hours or extending local services for conditions which can't wait but don't need specialist care or equipment, such as stitching, pain relief, monitoring of chronic conditions. This would enable specialist extended services to be focused at the hospital level, for example services which require immediate specialist care or equipment such as heart conditions, haemorrhage or broken limbs.

People who cannot take time off work or cannot afford to forgo the income were typical of those who needed simple extended hours. *I am a single parent; my work has only half-hour lunch. I work two jobs - one at Fyshwick and one at Spence and I can't get to Ainslie [where I live] during lunch hour. After-hours medical care for basic care ... After 5pm and before 9am so I would only miss half an hour or an hour of work. I ask friends to take my kids to the doctor, or I send my 17 year old by herself I ask 'what happened?' she says 'I went in and didn't say anything much' its not OK.*

The lack of extended service options was relevant to families with children, especially where an adult decides they can't or shouldn't wait until the next day. *Decisions are different for adults, they are more likely to wait an extra day to see their GP, but kids have a more immediate need.* There was a reluctance to use full emergency services but extended-hours services just do not exist. *My main reason for going [to ED] is that there is no medical centre around this area who do stitches and that sort of thing*

Consumers who manage long-term chronic conditions often prefer a local extended service for conditions such as asthma or mental illness for example. Current service structures do not give a choice of local care. *All they [Health First] can do is give you some counselling, but they can't adjust your medication; we see a specialist for [asthma] a paediatrician is on the team. We would start with them, we would call and see who is on call and call the ambulance if necessary*

5.2 “Bothering people after-hours” – self triage

Seeking medical help after-hours was a significant decision for most people, and involved weighing up the cost of seeking help both to themselves and to the health system. There was a range of decision paths followed by consumers with no evidence that consumers turned to any one service such as ED without careful thought.

Not wishing to put pressure on the system

Most of the consumer groups were aware of the demand placed on after-hours services, and if their own personal resources permitted they would use other options. This was reflected strongly in the men's group and in the mother's group in regards to their own health. *“Bothering people after-hours becomes an extra problem ... is it really necessary ... for me it was a problem ... I was even resistant on my wife's behalf ... it has to do with self-value.”* It should be noted that all groups were aware of the need to go to hospital for possible heart conditions; a sign of a successful health education campaign.

Not wishing to increase the stress on themselves

The waiting times at ED were cited as a major reason to look for other after-hours options, although people in the newer suburbs noted that there were not adequate options during the day. Many people had issues with transport at night to the services, even locally to a GP practice *[I would go somewhere other than A&E] if it wasn't too extreme, because of the wait at A&E and someone having to drive you and stay with you.*

Personal resources — I was alone, and I thought – what do I do?

The resources available to particular consumers after-hours had a bearing on whether and when they sought medical care. If you live alone with no car, and no-one to provide advice or reassurance it is reasonable to seek medical help earlier — *the second time [to ED] was when I had a bone in my throat and I didn't want to spend the night with it in there as I live alone. I didn't want to be stuck in the middle of the night*

5.2.1 Consumers' hierarchies of options

All participants were clear about their own hierarchy of care options and conditions. There was general consensus that ED was necessary for possible heart conditions, bleeding, broken bones and accidents requiring surgery or x-rays. For some consumers ED was the only option for their condition: eg for asthma flow tests or admission to the psychiatric unit which, according to the participants, is only possible through ED after-hours.

However, in other situations, consumers went to ED because they couldn't access appropriate level help locally. ED was used in situations where the consumer assessed that a GP or nurse would have been more appropriate - *my main reason for going there [ED] is that there is no medical centre around this area who do stitches and that sort of thing. Every time I go to ED the problem could have been sorted out by a GP.*

When a consumer could not make the decision about triage, some went to ED as a default *I just thought 'gotta go'* or because it was quicker than trying to find an after-hours GP service that was open. Other sources of triage advice identified were the local chemist and the ambulance service *it's the assessment thing, the ambulance can assess whether you need to go to hospital or not.*

It is significant that most participants were unaware of Health First but all were responsive to the concept, for example no-one in the older women's group had used this service but most said they would. The issue of anonymous advice was important for men and young people and may make the difference of timely medical treatment rather than no treatment at all. *I would much rather ring a nurse to make a fool of myself than see a doctor and make a fool of myself, because she is a woman and because she is a nurse.*

5.3 'That's closed isn't it?' 'No, it's open again'? Individual And System Barriers Interacting

The interaction of fragmented service options and diverse and complex individual circumstances compound the effective and efficient use of after-hours medical services. Not only do consumers not always know what services are available and how to access them; most had not had any professional advice on appropriate options.

5.3.1 Knowledge of the system

The only health service that was universally known to exist and to be available after-hours was the Emergency Department at The Canberra Hospital. Although Calvary Hospital was noted, some consumers were not sure that it was open 24 hours (Calvary ED did originally open for limited hours). Knowledge about extended hours clinics was confused. A number of consumers reported that they previously had used extended hours clinics, but the hours had changed, or were no longer offering extended hours, or they didn't know what hours were currently being offered. Some consumers had been advised by health professionals to go to ED as they had arrived at a service close to closing time.

Very few people reported that their own GP had advised them of his/her preferred after-hours services. Only a few people knew if their doctor was a member of CALMS and what that meant hence the consumers were forced on to their own resources. Consumers who valued their doctor's management of their on-going health issues were keen to know what s/he would recommend for after-hours service use. Other consumers assumed that the locum service could be used on a needs basis as assessed by them.

The potential role of Health First as a first port of call was highlighted by a number of consumers, many of whom felt that a service provided by nurses would be a welcome model.

5.3.2 Coming to us or us getting to them

For a number of population groups, the issue of access to any after-hours service is paramount. People who did not have a car, those who felt too unwell to travel, parents with a number of children and those who live without family or friendship networks identified transport to health facilities as a very significant issue. Most people used neighbours, family friends and taxis as sources of transport. One consumer reported having used a bus on the weekend to access a doctor. Home visits , especially late at night, were the preferred option — this was especially important to those whose condition may need hospitalisation, but needed the first opinion. Ambulances were the only other option for many.

A number of consumers noted that once you get to the doctor, you may have to go further to a chemist, an ATM machine, or ED — all of which were barriers for those with limited resources, physically, mentally and/or financially. The few external resources that exist to enable people to access health care after-hours (eg the mental health crisis team), often required personal knowledge and contacts to gain access.

5.3.3 'I used to go when I was working and could afford to' — the issue of cost

Although some participants such as the mothers' group reported that they were prepared to pay higher costs if they considered that the child really needed medical attention. *I assess the child on a need to use basis*; most groups were concerned about the apparent lack of bulk-billing for after-hours services.

Most people had not used CALMS or an after-hours GP and so had not experienced the cost of this service, however a number of people reported that the cost of CALMS would be prohibitive – especially the older women and the mental health consumers (10 out of 12 of whom earned less than \$300 per week) who mentioned cost frequently, mainly in the context of negotiating bulk-billing. This group also identified bulk-billing as the most important feature of an ideal after-hours service. The need for up front payment was also a concern to this group. *The doctor said it was going to be \$100, I said 'I don't have it' and they ended up bulk-billing me, but they weren't too pleased.* Most of the older women noted that they chose not to use credit cards or to hold cash in the house and could not understand why they would not be billed through the GP practice where they were well-known.

5.3.4 Waiting times

All participants understood the reality of a triage system that affected waiting times at ED. However as there were so few other after-hours medical options, consumers had strong opinions about improved services choices as a way to decrease waiting times. Regional medical centres with multiple treatment options such as Xrays, stitching and medication purchases were raised as one option. Ideas from the previous 24 hours medical centres, such as phoning ahead to see where you were on the waiting list were proposed as improvements that could ease the stress of waiting. Many consumers knew what they needed; eg peak flow testing or simple stitches and did not believe that they always needed a GP to undertake this procedure. They were aware of the shortage of GPs and some recommended that the use of nurses to undertake processes such as simple stitching would be an improvement to the system options and an important efficiency to ease waiting times.

5.3.5 Differing needs — a place for service options

The pattern of some young people's use of health services suggests that there may be a place for after-hours medical services that are more informal and not emergency –based. The older men believed that more male youth would access an anonymous service, especially outside of usual hours – this could be seen as a 'brief intervention' with a group that are notoriously difficult to engage in pro-active health care. Similarly, those people living with mental health challenges expressed the need to access a service that could respond quickly to their specific state and avoid triage through the stressful environment of ED. Others saw the need for their GP to be able to admit. The fact that the current infrastructure does not acknowledge or meet these specific needs is an indication of a 'one-size fits all system' that may appear efficient at one level but that creates another level of service inefficiency and consequent increased morbidity.

6. Implications: Towards Improved Systems and Services

This section presents the implications of the consumers' focus groups. It is hoped that this section can be triangulated with data from other ACT studies to contribute to an extended 'good practice' model for after-hours medical care. The section begins with the concept of integrated multi-level pathways and is followed by a discussion of the processes needed to support a successful pathway system. It concludes with suggestions for further investigation into this important primary medical care issue.

6.1 Tailored And Integrated Pathways

The current model of after-hours medical care in the ACT could be described as a 'one-size fits all' service. Following the clothing metaphor, the services are available at 'one-stop shop' which was once a specialist shop that has been forced to adjust to meet the demand for different products. For those able to pay for home fittings, there is a service that comes to you but most people cannot afford their services. It is timely to consider how to move beyond this 'one-size fits all' model.

From the data from the consumer groups, a tailored and integrated after-hours medical service model would have the following features.

6.1.1 Levels of care

When consumers are informed about the levels of care within a service and provided with understanding of the service parameters, they will access the service more effectively. However before this is possible, the service must be designed to clarify and streamline the levels of care.

GPs who are able to provide diagnostic and treatment advice are central to the service, however, in order to use GPS skills effectively after-hours, there is a need for practice nurses who can handle particular services instead of the GP or to implement recommended treatment after the initial consultation. Suggestions made by consumers included simple stitching, respiratory testing and blood pressure checks.

To further ease the load on GPs, face-to-face consultations could be complemented by an extended phone advice system. In the present system, an enhanced information flow between Health First, CALMS and the ED would be an important starting point and would begin to address the concern for continuity of care. However in the longer-term many consumers believed that they would be more confident 'waiting for their GP the next day' if they were assured that they could gain phone advice throughout the night, for example a consumer who lived alone could arrange to phone or be phoned at set times to assess their condition and gain advice on options. Telephone triage was seen as a service gap.

Home visits are also key as, by definition, illness after-hours is a serious concern. This study and other studies continue show that most consumers will ‘wait it out’ wherever possible. Many consumers see home visits as the ideal model as after-hours are the times that they are most vulnerable, find travel difficult or have other care responsibilities with little available support. Although many consumers had not needed to use CALMS home visits, most had assumed that their doctor was a member of CALMS and that this service was an ACT-wide inclusive option.

Ambulance care and service needs to be a central facet but it is important to ensure other services take up the load wherever possible to ensure that emergency treatment and transport is retained as their primary role.

Emergency Departments provide the specialist level of care where technical services, a full diagnostic team and admissions are facilitated .

6.1.2 Regional centres

The stress of travel and the cost of or lack of transport options coupled with many consumers’ family care responsibilities suggest that regional services are a preferred option. Given that CALMS already operates from the Canberra Hospital, Calvary Hospital and Erindale, a further centre in Gungahlin is crucial. The lack of fully developed GP services in the new Tuggeranong and Gungahlin suburbs compounds their need for regional after-hours centres.

However consumers did note that access to an appointment with a GP was not the only need they had from such a service. Good practice services would be able to provide a number of levels of care on the one premises and to assist with the accessibility of medicines with either small amounts available for the doctor to give or with arrangements with an ACT-wide service for delivery from a chemist.

6.1.3 Extended practice hours

Both GP practices and regional centres would be more effective for consumers if their hours were adjusted to serve the needs for routine medical services outside the 9 to 5 period. It would seem that evening clinics could provide options for some GPs who are choosing to balance family/work responsibilities through shared parenting for example. Consumers expressed a keen interest in evening clinics open to mid-evening. It would be valuable to undertake a mapping exercise with GPs and consumers to determine suitable hours by region.

It is important for the community to have confidence that after-hours services will be available in set patterns over time. The current situation whereby individual practices adjust their service hours as a business decision, according to economic considerations rather than as a response to need, leaves consumers confused and concerned — the back-up of an after-hours regional centre would alleviate the worry of knowing what the individual practice hours are this month and enable timely attention.

6.1.4 Affordable at the time

Once again as most use of after-hours medical services are unexpected and serious for the consumer, it is essential that a range of payment modes are possible. Bulk-billing at the least for priority groups is essential. Gap payment only or accounts through a central system should be possible. It must be stressed that up-front cash payments are often not accessible for even the well-off who are sick at the time of the medical visit.

6.1.5 Integrated information flow

As a pivotal part of an integrated service there is a need to consider a full cycle information flow, from the GP to the after-hours service and back to the GP after an after-hours attendance. Consumers often assumed that this system was already in train and appreciated the discharge notes used by Calvary Hospital for example. Most consumers in this study saw information flow as a primary need, however the issue of privacy was a concern for some consumers. As this is a current focus of many health service redevelopments across Australia, it is anticipated that good practice models will be available in the near future to address this complex concern.

6.1.6 Parallel service options

The specific needs of certain population groups must be considered in the design of a fully integrated after-hours service. For groups such a young people, the elderly, frail people living alone and people living with long-term mental illness, service delivery may be much more effective if it is designed to meet their particular barriers and challenges. For example, the informal non-appointment drop-in clinic approach used by the Junction and some Family Planning clinics appear more effective for many groups of young people. Similarly, the holistic and flexible service approach taken by Winnunga Nimmityjah is a model that is congruent with the health needs of Indigenous people. It will be important to ensure that parallel models of after-hours medical care are continued to be trialed and developed. For example, in this study, the older women's group suggested that a phone service for would be welcomed as an innovation by the elderly or frail.

6.2 Processes Behind Successful Pathways

It has been well demonstrated that consumers will be more pro-active in managing their health if up-to-date information is available¹¹. In order to facilitate the most effective use of after-hours medical services, it will be crucial that a number of information pathways are developed and/or enhanced.

6.2.1 Finding out about the ACT after-hours medical services

Both web-based and print based up-to-date information must be available – in plain English and in other community languages. A community education campaign to support consumers' willingness to self-triage would be an important beginning, followed up with

¹¹ Shepperd, S, Charneck, G, Gann, B (1999) Helping patients access high quality health information, *British Medical Journal*, no. 381, pp1280–3

leaflets delivered to all ACT residents on an annual basis. Further information should be available at all residential tourist locations for the use of inter-state visitors.

Such health system information needs to cover the type of service, its location, cost and treatment types. This information needs to be practical and specific, listing the types of conditions able to be treated at each service. It will be essential to ensure that any printed material is supported by a phone service through agencies such as Health First, the regional centres and CALMS. Written service information should be available at each of the service levels.

It is important to note that it is not just education of the consumers that is required for an effective system. It will be the responsibility of each level of after-hours services to ensure that their staff are trained to facilitate effective triage. Consumers highly valued the skilled receptionist, the nurses and the GPs who had the knowledge and commitment to support effective access and triage.

6.2.2 Health literacy

It is apparent that the ‘heart health’ messages have had some impact on health care consumers’ behaviour in that all of the participants were clear that the ED and/or ambulance were the key service providers in this situation. The design of further condition specific and longer-term generic health education campaign for the ACT would have the potential to enable residents to be more confident and appropriate in their after-hours, and indeed normal hours, self management. This wider health education campaign “what to use when” could cover the continuum from first-aid to full emergencies, linking signs and symptoms to service choices and could utilise the many multi-media strategies that are currently under development.

Given the provision of ACT specific health service information, GPs will be well positioned to advise their own client groups on the appropriate after-hours services for their particular condition and situation. This has the potential to enhance the long-term medical relationship so valued by many consumers. Equally such information will be available for those client groups who prefer to access GP care irregularly but who will be better informed in their choice of occasional services.

6.3 Where To From Here

This study has given a number of ACT health care consumers the opportunity to share their experiences of the current after-hours medical services available to them. Each and every person who attended the focus groups believed that an effective and accessible after-hours service is central to quality of health care. However this study has not been able to access the full range of consumer voices, in particular those people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islanders and young people under the age of 25 years in all their diversity. Second-stage research with these groups may reveal very different orientations to service delivery and would be worthy of a subsequent study. Barriers to participation in consumer feedback projects are

often structural as well as individual and as such demand specifically focused research strategies¹².

The study has illuminated system problems that are not unique to the ACT. These include medical workforce issues, professional boundaries and limited and limiting funding models to name but a few. Although the ACT as a health service system has many challenges to face, it is unique in Australia as a bounded region in which system-wide innovations can be trialed. In the first instance it is hoped that this study will feed into further improvements to GP practice, CALMS and the EDs in our town. But it is also hoped that some of the more far-reaching visions of the participants will be carried forward towards wider system change. There comes a point where piece-meal or random evolution is no longer tenable. Some of the ideas of these participants challenge those of us interested in deep quality health care to look forward to far-off future possibilities. They invite all system advocates to join together to make collaborative fully integrated after-hours medical services a reality.

¹² Consumer Focus Collaboration (2000) *Feedback, participation and consumer diversity*, National Resource Centre for Consumer Participation in Health, Commonwealth Department of Health and Aging, Canberra.

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