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***AFTER HOURS
PRIMARY MEDICAL
CARE DARWIN
URBAN***

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Commonwealth Department of Health and Ageing*

*and conducted through the
General Practice Divisions Northern Territory*



*The Centre for Quality and Productivity.
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GENERAL PRACTICE DIVISION NORTHERN TERRITORY
DARWIN URBAN AFTER HOURS PRIMARY MEDICAL CARE STUDY.–
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1 EXECUTIVE SUMMARY

1.1 Introduction

General Practice Division Northern Territory (GPDNT) contracted the services of TCQP to undertake a three-month study into the provision of after hours primary medical care within the Darwin Urban area. Funding for the study was provided by the Commonwealth Department of Health and Ageing. The study set out to ascertain whether current 'after hours' medical services met determined (validated) need. Having established a platform against which service delivery can be tested, a feasibility study then identified how 'after hours' primary medical care might progress within the greater Darwin area.

The greater Darwin area for the purposes of this study included the Darwin CBD and inner suburbs, Northern Suburbs, Palmerston and rural area extending to Humpty Doo. Humpty Doo is usually categorised as Darwin Rural, however for the purposes of this study that area of Darwin Rural has been included with Darwin Urban.

A range of stakeholders including General Practitioners (GPs), associated organisations and consumers were surveyed. The operating environment in the greater Darwin area is dynamic with a high proportion of transient population, therefore this study provides a snap shot in time. Statistics that relate to the number of GP clinical hours are likely to vary from week to week and month to month. For the purposes of this study the After Hours Study Steering Committee has defined 'after hours' as: after 6pm and before 8am Monday to Friday, after 12noon Saturday to 8am Monday and all public holiday hours.

1.2 Aim

1. To identify the current after hours primary medical care services;
2. To identify the level of satisfaction with the current level of after hours primary medical care;
3. To identify the obstacles to the provision and acceptance of after hours care;
4. Identify the impact of inappropriate access to Royal Darwin Hospital (RDH) for primary medical care; and
5. To identify areas for improvement / enhancement of current services; and
6. Identify and undertake a feasibility study of possible alternative modes of delivery of after hours care, including possibility of establishing an after hours-primary care service within RDH.

1.3 Consultation Method

Direct contact interviews were conducted with:

1. GPs representing all but one of the six 'after hours' primary medical care clinics;
2. A selection of GPs from single GP and larger practices;
3. Other stakeholders including direct primary and tertiary medical care providers (Attach.2); and
4. Randomly selected consumers of after hours primary medical care.

The interviews were semi-structured utilising a consistent set of questions across all four groups.

1.4 Summary of Findings

- There are currently six 'After hours' primary medical care clinics in the study area. They provide approximately 116 clinic operating hours per week, out of a total of 1540 GP clinic operating hours per week. Most GPs provide a level of after hours service (usually home/residential care visits) to a selection of their patients. Other than these situations, RDH is the only provider of medical care between 10pm and 8am. The number of patients who present in these hours and would be suited to Primary Medical Care is approximately 6% of all presentations (an average of 49 presentations per week).
- A significant proportion of GPs are part time (>50%) and female (>35%), with many of these involved in multiple practices and/or other areas of work involving General Practice.
- All GPs interviewed indicated they have withdrawn or decided not to attend house calls for other than patients they have chosen to make prior arrangements with. This choice is based on several factors 1) concerns about safety and security, 2) difficulty in providing the care required with the minimal resources at hand, 3) remuneration does not reflect the time required to provide home visits 4) high costs associated with employing security services.
- Current after hours-primary medical care services, report concerns related to maintaining security of themselves, staff and patients. Security issues are often associated with intoxicated or drug seeking behaviors of the public. Additional costs of security reduce the financial feasibility of after hours services.
- Infrastructure cost of operating an 'after hours' clinic is higher than 'in hours' and remuneration under the bulk billing system requires a high throughput of patients to achieve financial viability.

- The study identified the majority of respondent's consider the current services are generally of a satisfactory level, although some service gaps and areas for improvement were identified.
- The gaps identified in the study include the provision of after hours primary medical services to people in residential care and after hours home visits to aged and/or people with disabilities. This would provide people with primary medical care in the most appropriate place (their usual place of residence).
- An emerging need is for more GP involvement in Department of Health and Community Services (DHCS) program areas in both 'in' and 'after hours'. Program examples provided include mental health and alcohol and other drugs.
- A range of areas for overall after hours services performance enhancement has been identified. These include:
 - increasing and retaining the number of GP clinical hours;
 - marketing of the range of 'after hours' primary medical services available;
 - streamlining access to after hours primary medical care;
 - improving links between the range of after hours health and community services.
- Disincentives for GPs to be involved in after hours include:
 - current levels of remuneration in relation to the Medicare rebate system;
 - concerns about security of themselves, staff and other patients waiting for consults;
 - lifestyle limitations through working during the day and in the after hours period; and
 - inadequate numbers of GPs involved in 'after hours' work.

1.5 Recommendations

The study did not identify a need for a new after hours primary health care service in the greater Darwin area. However, it did identify a need to enhance the capacity of the current after-hours services to address service gaps and ensure sustainability of existing services. Collaboration at all levels, but primarily between existing GPs is essential to the design and implementation of an operational and financially sustainable service model.

The study identified the achievement of any level of success will be dependent on all proposals for improvement/additions to 'after hours' primary medical care services to be based on the following five principles:

- Existing after hours services are enhanced;
- Opportunities for stakeholder collaboration are maximised;
- Security of providers and consumers is maximised;

- Quality and cost-effectiveness of services is at least maintained; and
- Ease of access to 'after hours' primary medical service is improved.

1.6 After Hours Service Enhancements

1.6.1 Collaborative System Model

A General Practice Collaborative System be developed to provide increased GP Clinical Hours. The Collaborative System to operate through the Top End Division of General Practice (TEDGP). On behalf of all GPs, the TEDGP would operate as an information clearing house and support GP workforce recruitment and retention.

Current 'after hours' clinics encouraged to adopt operational methods of meeting the gaps (identified above) e.g. home/residential care visits.

1.6.2 Call Centres

Respondents expressed a moderate level of interest in a centralised 'Call Centre' as a means of enhancing current 'after hours' services. The study did not clarify the operational model of 'Call Centre' that would meet the specific requirements of the greater Darwin area. However, suggestions include the need for it to be able to:

- Provide phone advice to the public and health professionals on the range of after hours services available;
- Provide a level of triage or health care need assessment over the phone;
- Provide a link between 'after hours' services and 'in hours' services;
- Provide evidence on usage rate and range of services;
- Be available to the public at least in the total after hours period and potentially a 24 hour service;
- Ensure provision for expansion of the service outside the greater Darwin area;
- Be a model of excellence; and
- Demonstrate the clear understanding of the caller's environment and access to resources.

It is important that any Call Centre enhance the operations of the existing after-hours clinics and proposed Collaborative System.

1.6.3 General

Between 10pm and 8am medical care continue to be centralised through RDH. RDH indicates that within existing resources it has the capacity to continue providing the majority of primary medical care during this period. This cooperation with GPs minimises the requirement for GPs to provide services overnight.

Recognition that the majority of GP's provide a level of after hours service to selected patients by prior arrangement.

Exploration of the available information and resources (eg: Police Departments, Crime Prevention Unit) to assist after hours services to maximise their security measures within the workplace, without necessary accessing costly Security Services.

1.7.4 Structural and Operational Issues in Service Delivery

GPDNT to lobby the Commonwealth government to re-examine rebates for after hours so they reflect the: actual time taken to provide the service; additional cost of providing an after hours service and lifestyle restriction compensation for working after hours. The Health and Aged Care, After hours Primary Health Care Services in Australia, 'An Analysis Of Research, Current Data And Activity November 2000' report, identifies, increases in funding needs to be a mix of infrastructure payments and rebate adjustments.

GPs and the TEDGP adopt a consistent message informing the public of the current after hours services available in the area in addition to the ambulance service number.

Many of the suggested enhancements have also been identified in a range of other national studies including: The Bartlett Report 2000; Hunter Urban Division of General Practice 1996 'After Hours Care Project'; Seru in Access- 1999, 'After Hours General Practice Services; 'A guide for Divisions of General Practice'; and The Health and Aged Care, After hours Primary Health Care Services in Australia, 'An Analysis Of Research, Current Data And Activity November 2000' report.

1.7 Acknowledgments

- The Commonwealth Department of Health and Ageing for funding the study through GPDNT
- The study's Steering Committee. For their direction, guidance and input to the study to ensure its validity and significance to improving after hours primary medical care in the greater Darwin area.
- The Department of Health and Community Services. For the provision of relevant statistical data that underpin the relevance of the study to the demographics on the study area.

- The Northern Territory Remote Health Workforce Agency. For the provision of data relating to General Practitioner numbers and clinical hours.
- The respondents for their valuable contributions.

2 METHODOLOGY

The methods used to achieve the study's aims are summarised below. The project plan was divided in to two stages. All stages of the study were conducted in collaboration with and under the guidance and direction of the Steering Committee (Attachment 5), which was representative of the stakeholders, With the Terms of Reference (Attachment 6) providing the framework for the study. An independent evaluation of the process and outcomes was conducted in parallel with the study and consistent consultation between the Evaluator, the consultants and the project manager and the project management group (Attachment 5) enhanced the study.

2.1 Needs Analysis

The needs analysis undertaken addressed the four dimensions to the "concept of need" identified by the GPDNT. Normative need (a desirable standard of care using best practice and evidence based medicine), felt need (felt need), expressed need (the services people actually use) and comparative need (a comparison of demographic profile and services provided).

2.1.1 Needs Analysis Planning

- a) Steering group members were identified to include the range of stakeholders. This group provided guidance, direction and specific detail to inform the study and monitored progress.
- b) A review of reports, published papers and direct contact with providers of different service delivery models both nationally and internationally was undertaken to identify current trends in after hours service delivery as well as issues impacting on after hours services both nationally and internationally.
- c) Survey tools for the study groups were developed under the guidance and approval of the Steering Group and the Evaluator.

2.1.2 Consultation

The majority of surveys were done face to face with several phone interviews taking place due to the interviewee's time limitations. Several GPs not selected for interview provided written comments. Face to face interviews were based on the survey tool, which was modified to the 4 groups of interviewees. The groups consulted included:

- a) GPs involved in after hours primary medical care clinics;
- b) GPs;

- c) Key non GP Stakeholder (Attachment 2); and
- d) Consumers who have accessed after hours medical care.

Over 40 General Practitioners were approached with a total of 26 interviewed. All but one 'After Hours' practices agreed to be interviewed. General Practitioners not currently providing 'after hours' clinic based services were selected to take part in the needs analysis. The selection was cognisant of the need to include General Practitioners in small (one or two doctor) practices as well as larger practices (four or more doctors). The selection also ensured the sample group included General Practitioners across the study area (greater Darwin).

The key non GP stakeholder group (Attachment 2) was nominated by the Steering Group as being representative of each major stakeholder of 'after hours' primary medical care.

In achieving a random sample of the community, approximately 100 potential consumers were approached resulting in 24 interviews. Interviews were undertaken at the two major shopping centres and in the cafeteria of the Royal Darwin Hospital. Attempts to access consumers outside a child care centre and pre-school were unsuccessful due to the consumers time limitations. The random selection included a range of ages, families and socio-economic groups across the study's geographical area.

The findings from the GP, Stakeholder and Consumer surveys were presented to two fora. The first was to GPs and the second to Stakeholders. The fora also offered an opportunity for feedback to inform the study and to include a presentation on a 'Call Centre' model. This presentation was designed to promote a broader understanding of the 'Call Centre' concept and its potential role in health services in the greater Darwin area.

2.2 Feasibility study

Utilising the information gained through the needs analysis process and further exploration of demographic data it became clear that despite the service gaps identified (listed above), generally, the current 'after hours' primary medical care services adequately meet the expressed need of providers and the community.

Within the terms of reference the study was asked to explore the number and appropriateness of consumers requiring primary medical care attending the Royal Darwin Hospital – Emergency Department. Evidence identified early in the study indicated there was not a high percentage of inappropriate presentation to RDH. This led the feasibility study to be focussed on enhancing current after hours service.

The needs analysis identified that not one model of service delivery is preferred and that a combination of models should be considered. The feasibility study explored the models presented to respondents for their ability to enhance current after hours primary medical

services. Each model and combinations of models were tested against the 5 principles identified within the study and ratified at the stakeholder feedback fora. The Principles are:

1. Existing after hours services are enhanced;
2. Opportunities for stakeholder collaboration are maximised;
3. Security of providers and consumers is maximised;
4. Quality and cost-effectiveness of services is at least maintained; and
5. Ease of access to 'after hours' primary medical service is improved.

3 CURRENT AFTER HOURS PRIMARY MEDICAL CARE SERVICE DELIVERY

3.1 Current After-Hours Primary Medical Care Clinics

There are six ‘after hours’ primary medical clinics in the greater Darwin area. These are located in Stuart Park, Northern Suburbs (3), Tiwi, Palmerston and Humpty Doo. Approximately twenty-seven General Practitioners are involved in these ‘after hours’ primary medical care clinics. These GPs are all part-time and provide a level of service within the 116 hours in which the population of approximately one hundred and ten thousand can access the after hours primary medical services. The number of clients is increased by up to 23% during the dry season (tourists and visitors). The approximate number of patients seen in the existing ‘after hours’ clinics in the dry season is 580 whilst the wet season the number reduces to approximately 480. 41% of these patients seek services in the CBD after-hours clinic. The increase in the dry season appears to affect most practices (‘in and after hours’).

Session times for after hours of consultation varies due to availability of GP workforce, number of people waiting for consultation at the usual closing time and seasonal demands. The clinic’s usual hours of operation are listed in the schedule below, in italics are the daily gaps in service availability from existing after hours primary medical care clinics.

Table 1: Schedule of ‘after hours’ services available:

CLINIC	MONDAY-FRIDAY		SATURDAY		SUNDAY		PUBLIC HOLIDAY	
	Open	Close	Open	Close	Open	Close	Open	Close
Humpty Doo	6pm	9pm	<i>No pm service</i>		9am	12md <i>No pm service</i>	9am	12md <i>No pm service</i>
Farrar Medical Centre	6pm	10pm	<i>No service 12md to 6pm</i>	10pm	6pm <i>No service prior to 6pm</i>	10pm	6pm <i>No service to 6pm</i>	10pm
Darwin Private Hospital	6pm	10pm-12mn	12md	10pm-12mn	9am	10pm-12mn	9am	10pm-12mn
Casuarina Night & Day	6pm	9pm	12md	9pm	9am	9pm	9am	9pm
Trower Road Medical Centre	6pm	8pm	<i>No pm service</i>		9am <i>No pm service</i>	12md	- <i>No service</i>	-
Stuart Park	6pm	10pm	12md	10pm	9am	10pm	9am	10pm

3 CURRENT AFTER HOURS PRIMARY MEDICAL CARE SERVICE DELIVERY 11

The number of Full Time Equivalent (FTE) GPs in the study area is 63.6 equating to a GP to population ratio of 1:1605. Approximately 20 GPs, all in a part time capacity, deliver some component of the after hours primary medical care in the greater Darwin area. The total of clinic operating hours in the greater Darwin area is 1540 hours, of which 116 hours are in the after hours period. All of the 26 GP respondents indicated they provided after hours service home visits to patients by prior arrangement who are generally elderly and frail patients and family friends. On average GPs provide this service between two and ten times per year.

Few GPs provide 'after hours' services to people in residential care. Stakeholders who provide residential care and home care support indicate this is a crucial gap in service. The problems associated with this gap in service, are the limited access to GP advice via the telephone and all residents who require direct medical attention are transferred to RDH via ambulance. Residential care services estimate 2 to 5 transfers via ambulance are required per week in the after hours period. Furthermore, Aged and Disability services stakeholders recount frequent incidences of elderly people waiting in the emergency department, often in uncomfortable circumstances, for long periods of time in the middle of the night. In many cases these patients have received additional investigations and care beyond the presenting problem which, suggests over servicing and lack of consideration to the frailness of these people. This sector also indicates inadequate numbers of GPs are available or are prepared to provide medical care to new residents.

RDH Emergency Department reports that over the last two years it has been promoting information to the public on how to access GP clinics in the 'after hours' and 'in hours' consultation periods. This has resulted in fewer people attending the department who could have been suitably cared for by a GP. The unit's Medical Director stated, "due to the relatively low numbers of people attending the RDH Emergency Department after twelve midnight the Department is happy to provide the medical care required to these people and that this is the best use of resources".

The Director also stated that due to the high level of co-morbidity associated with indigenous health, (which is well documented and is evidenced in Attachment 4), many people presenting to the department with seemingly minor illnesses are found to require more treatment than initially thought. On occasions this leads to hospitalisation (approximately 20% of emergency department triage category 4 & 5 presentations).

Table 2: Distribution of General Practitioners in the greater Darwin area.

	<i>GPs</i>	<i>Part Time GPs</i>	<i>Number of GP 'In Hours' clinic hours per week</i>	<i>Number of GP 'After Hours' clinic hours per week</i>	<i>Population</i>
Humpty Doo	7	2	140	18	Approximately 3,500
Palmerston	15	4	275.5	28	22,218
Northern Suburbs	43	15	658.5	95.5	Combined with the CBD & Inner Suburbs 85,000
CBD/Inner Suburbs	33	12	242.5	40	
Aboriginal Health Centres	15	11	40		
Total Greater Darwin Area	113	44	636		110,718

It should be noted, that the lowest numbers of presentations during the 'in hours' operations of Community Care Centres occurs where there are the greatest number of GPs per population (CBD). However, the highest number of Community Care Centre presentations occurs in the northern suburbs, which not only has a higher number of GPs per population than in Palmerston, but is also closest to both of the hospitals.

3.2 RDH Emergency Department Statistical Information

The number of patients presenting to RDH Emergency Department is approximately 8,500 per month with approximately 3,250 of these presentations occurring between 6pm and 7.59 am. Of the after hours presentations approximately 6% (approximately 49 presentations per week) of presentations are classified as suitable for Primary Care Clinic Management (PCCM). PCCM presentations are approximately 3% lower than the 'in hours' period. Seasonal trends indicate there is a slightly higher rate (400 to 600 per month) of overall RDH Emergency Department presentations from August to December. This is in conflict to the experiences of GP clinics both 'in hours' and 'after hours', who have provided information that indicates they experience up to a 20% increase in presentations during the dry season. GPs relate this increase to the influx of tourists and visitors during this period. This increase in numbers is supported by the tourist commission who estimate Darwin has between 191,000 and 359,000 tourists per year and that tourist numbers are higher in the dry season than the wet.

4 DEMOGRAPHICS

The study area originally included population of Darwin Urban, which covers the CBD & Inner Suburbs, Northern and Outer Suburbs and Palmerston. The first steering committee meeting recommended the extension of the study to include Humpty Doo, which is part of the Darwin Rural sector. Humpty Doo clinics service a large area, although not all the population from Darwin Rural would necessarily access service through the Humpty Doo or Palmerston clinic. Many of this population would access some level of services from within the study area. For this reason the total population of Darwin Urban and Darwin Rural has been considered in the study.

Population:

Darwin Urban	107,218
Darwin Rural	12,493 (of which approximately 5,000) of the Litchfield B population are included in this study)
Total of	119,710

The total population included in this study is approximately 112,218. This is increased in the dry season due to visitors and tourists, with some practices estimating up to 20% demand for services in this period.

4.1 Darwin Urban

4.1.1 CBD and Inner Suburbs

City, Fannie Bay, Larrakeyah, Ludmilla, Narrows, Parap, Parap, Stuart Park, Winnellie, Coonawarra East, Coonawarra West, HMAS Coonawarra, RAAF Base (Darwin), Berrimah.

4.1.2 Northern and Outer Suburbs

Alawa, Anula, Brinkin, Coconut Grove, Jingili, Karama, Leanyer, Lee Point – Leanyer Swamp, Malak, Marrara, Millner, Moil, Nakara, Nightcliff, Rapid Creek, Tiwi, Wagaman, Wanguri, Wulagi

4.1.3 Palmerston

Driver, Gray, Moulden, Palmerston town, Woodroffe

4.2 Darwin Rural

4.2.1 Litchfield B

Acacia Hills, Bees Creek, Berry Springs, Darwin River, Fly Creek, Herbert, Howard Springs, Howard Springs (16 mile), Humpty Doo, Lambells Lagoon, McMinns Lagoon, Middle Point, Noonamah, Southport, Virginia.

4.2.2 Litchfield A

Knuckeyes Lagoons,

4.2.3 Coomalie

Adelaide River (town), Batchelor, Lake Bennett, Manton Dam, Rum Jungle.

4.2.4 Cox-Finnis

Belyuen, Byunoe Harbour, Cox Peninsula, Delissaville, Dundee Beach, Dundee Downs, Mandoorah, Woolaning

5 SURVEY – FINDINGS

5.1 Location and Infrastructure

Current After Hours Services are located across the geographical area of the study. There is a greater ratio of GPs per population in the CBD area than in either the northern suburbs or the Palmerston area. While clinics are staffed by up to eight GPs, the clinics which provide after hours care, may have one to three GPs on duty at one time.

More than 50% of the 'in hours' clinics are operated by one or two GP. Approximately 34% of the GPs are female and approximately 40% of GPs work part time while most of the GPs who responded to the survey are between 41 and 50 years of age.

Table 1 (page 10) lists the hours of operation of current after hours clinics.

5.2 Financial Feasibility

After hours clinic operators indicate that it is not operationally or financially feasible to extend services past 10pm. Consequently the Farrar Medical Service found it necessary to reduce their 24 hours service to one which closed at midnight and then one which closed at 10pm. Such a reduction is based on non-financial viability due to low numbers of people seeking care overnight in the area. One Practice indicated that to cover operational costs, without allowing for a profit margin, a GP would be required to provide four consultations per hour. GPs identify that throughput of people accessing after hours medical care; remuneration and the availability of GPs as limiting factors in the decision to extend clinic hours.

GPs and stakeholders indicate current levels of remuneration for after hours work is one of the issues resulting in GPs not providing after hours services. Remuneration of between \$100 to \$120 per hour would be considered appropriate for working in the 'after hours' period. They also indicated that in the majority of consultations the patient should pay some level of charge. Suggestions ranged from \$5 to \$60 with the average being between \$20 and \$45, while current fees range from Bulk Billing to between \$24 and \$90 per consultation in the after hours period. Without exception, respondents indicated that a bulk billing service should be available to some patients.

GPs indicate that to achieve and maintain financial sustainability in a competitive arena of increasing costs, increased throughput of patients, enrolling more practices or increasing fees is required. This finding is reinforced in The Health and Aged Care, After hours Primary Health Care Services in Australia, 'An Analysis Of Research, Current Data And Activity November 2000' report.

There is only one after-hours service in the greater Darwin area that provides a bulk billing service. This service is subsidised by the Northern Territory government and therefore may or may not be sustainable. All other services provide bulk billing to specific clients only.

Dr Phelps, AMA president, statement in the NT News on the 21st May 2002 highlights the grave concern that financial compensation through bulk billing will not be able to sustain after hours primary medical services. The statement read “the higher costs of maintaining general practice means that GPs can no longer bulk bill all their patients, unless the government acts to address the inadequacy of the MBS, it won’t be long before bulk billing GPs in Australia are extinct”.

5.3 Disincentives

The study identified a range of other disincentives for GPs to be involved in providing after hours care. These concerns related to security of themselves, other staff and of people waiting for care as well as the historically low level of cooperation between GPs in addition to concerns about how after hours services have been operated and utilised in the past. Security issues were related to behaviours of intoxicated people and those with drug seeking behaviours. Both issues of behavioural concern also exist ‘in hours’, however, in the ‘after hours’ period access to back up within and external to the clinic are very limited. All GPs indicated that they would only provide home visits to well known and trusted patients because of concerns for their safety.

5.4 RDH Attendances

The study identified that the reduction in after hours services in Palmerston has not lead to a noticeable change in the average number of people attending RDH-Emergency Department. The Department’s Medical Director stated that due to the relatively low numbers of people attending the Emergency Department after midnight, the department has the capacity to provide the medical care required to all that attend between midnight and 8.00am. He also stated that the department must maintain a consistent staffing level after hours, therefore attending to people who would meet the criteria for attending a primary medical care service is an appropriate use of resources, which minimises the dependency on GPs to provide after hours care overnight. Of the 8,500 presentations per month to the unit > 38% occur between 6pm and 7.59 am. Of the after hours presentations approximately 6% (195 presentations) of presentations are classified as suitable for Primary Care Clinic Management. Presentations to RDH – Emergency Department that are within the primary medical management category is reduced by approximately 3% in the after hours period.

5.5 Satisfaction

Stakeholders, including GPs, indicate current after-hours primary medical care services in the greater Darwin area are satisfactory. A minority group of respondent's felt there is a need for increased hours of service to be available through GPs, although GPs indicated that patients rarely expressed that they expected their GP to provide extended after hours services.

The majority of consumers indicate a moderate to high level of satisfaction with the care they have received.

5.6 Identified Gaps

The respondents indicated a range of gaps in after-hours primary medical care services. The gaps are related to access to non-clinic services by/for the elderly and people with a disability in the community. The access required includes home visits and residential care visits.

Residential care providers indicate that it is an accreditation requirement for them to have a nominated GP for each of the residents and that achieving this requirement is not always readily achievable. They also indicated that all residents who require direct after-hours medical care are currently transferred via ambulance to the RDH Emergency Department. This has raised concerns about the suitability of that service provider for aged/frail people who require urgent medical attention that does not require an episode of hospitalisation. Care providers also indicated that much of the care/treatment provided to residents from the emergency department could have been provided in the person's residential care facility if a GP was available to assess the person and provide instructions on the person's continuing care.

The need for increased public awareness about the range and location of after-hours primary medical services, which are available, is also an identified gap. Respondents, including some GPs, demonstrated a level of confusion concerning the availability of services. This seems to be exacerbated with varied messages in relation to the availability of after hours. This is demonstrated through GP feedback where one GP indicated that all after hours care was available from RDH-Emergency Department, while another referred patients to only one of the three after hours services available in the Northern Suburbs, with no reference to the only service after 10pm.

6 DEFINING THE NEED

This study addressed 'need' according to the criteria specified by GPDNT and identified in the subsequent funded grant.

Felt Need – (Felt Need)

The major geographical area that felt a need for a 24-hour primary medical service is Palmerston. The felt need is based on the desire to have access to an after hours-medical service that is situated in that area. This group express concern that travelling 20 to 30 mins is inappropriate, in addition to concern that not all of the population in this area has access to a private vehicle. Some respondent's from, or representing people from Palmerston, indicate after hours access to RDH by bus is either difficult or not possible and other transport is too costly for the lower socio-economic group (one way taxi fee of approximately \$25-\$30).

Despite the stated 'felt need', over the past six months the Palmerston 'Farrar After Hours' GP clinic has reduced its after hours service from 6pm to 8am in the first instance to 6pm to 12 midnight with a further reduction to 10pm. The reduction in operational hours is based on inadequate numbers of patient presentations. This practice, which provides a bulk billing after hours service, is financially supported by the Northern Territory Government. Royal Darwin Hospital-Emergency Department has not experienced an increase, or decrease in the numbers of people presenting after hours prior to or during the period of changed operational hours of the Farrar Medical Centre.

Several stakeholders mentioned they felt there is a need for provision of culturally appropriate after-hours medical services for Aboriginal people. GP's providing care in existing after-hours services indicate they treat many Aboriginal people and the Emergency Department at RDH indicate no increase in numbers of Aboriginal patients after 6pm who require services that could be provided by General Practitioners. The Emergency Department at RDH also state that the majority of Aboriginal patients requiring services after hours require the access to the range of services provided through the emergency department and greater than 20% of the less urgent category of patient presentations require hospitalisation for further treatment or investigation. Existing after-hours clinics state that a percentage of their after-hours patients are Aboriginal.

Normative Need - (A desirable standard of care using best practices and evidence-based medicine).

Residential care providers state their accreditation standards require access to after-hours medical services for all residents. Currently only a few residents have a GP who is available for phone assessment and/a GP to visit residential care.

All resident's requiring direct medical care, are transferred to the RDH-Emergency Department via ambulance. Care providers also indicate there is a high level of over-servicing

of residents occurs when they attend RDH-Emergency Department and that a considerable proportion of these residents could well be managed in house (for the residents comfort and orientation), if there were available GPs to attend residential care visits.

The few people who felt a full after hours (all hours outside business hours) primary medical service was required in Palmerston offered concerns about the distance between them and the RDH Emergency Department. Travel time estimated for the largest proportion of the population estimated by the St John Ambulance is approximately 30minutes. To reduce the response time for emergency situations St John Ambulance services are increasing their presence in the outer Darwin area in the near future. The second reason for a full after hours service to be located in Palmerston related to cost of travel to RDH from Palmerston for people who do not have access to private transport. Respondents indicate taxi fares for this distance are estimated at \$20 to \$30 one way and bus travel if appropriate and available is limited and would require a change of buses at Casuarina.

Comparative Need - (a comparison of demographic profile and services).

Many of the issues related to providing after hours primary medical care, such as inadequate workforce, inappropriate remuneration, safety concerns, reduction in home visits that have been identified in this study have also been identified at a national level.

In the Northern Territory a recent estimation by the NTRHWA of the ratio of GPs to population in Darwin is 1:1605 which compared to the General Practice in Australia 2000 benchmark of 1:898 indicates Darwin is under-resourced by 44%.

As with this study, nationally there is recognition that changes must not adversely affect existing services, but enhance their capacity. There is clear recognition at both a national and local level that there are great advantages and challenges associated with achieving collaboration and cooperation between GPs and other stakeholders.

Expressed Need - (the services people actually use)

The Emergency Department – Royal Darwin Hospital (RDH) indicate that not only is adequate care available, but the numbers of presentations in the period after 10pm does not require dual health care providers in this time frame. Hospital Emergency Department staffing numbers can not be reduced in these hours, even if presentations are low. Therefore, it is a most appropriate use of resources available in Darwin to utilise the RDH Emergency Department for medical services between the hours of 10pm and 8am.

People who present to the Emergency Department present for different reasons. Either it is their chosen service provider, there is no other service available or their health care requirements can only be met in that service. Due to the complexities associated with Aboriginal health eg: multiple diagnosis, high levels of chronic disease and high levels of

injury many Aboriginal people require the extended range of investigation and health assessment services which are only available within the hospital emergency department.

A small number of stakeholders indicated that current after-hours primary medical services needed to improve their cultural appropriateness. This included having staff who have undertaken some cultural awareness training, waiting times of no more than one hour and recognition of the range of support services available to aboriginal people in the community.

GPs, Stakeholders and Consumer's indicate the expressed need for access to an after hours pharmacy that is situated close after hours primary medical care clinic(s).

7 TESTING THE CURRENT MODEL

Current service provision:

- There are six after hours primary medical care clinics in the greater Darwin area. These clinics owned and/or operated by GP principals who employ GPs to work in the clinic.
- The majority of GPs provided a limited after hours home or residential care visiting service to patients from within their own patient group.
- Royal Darwin Hospital services approximately 197 people per week from within the primary health care management category.

The study suggests that the need is not for additional late night services but for enhancing the existing after-hours primary medical care services. This is evidenced by the reduced hours of service now offered by Farrar Medical Centre. Similarly a late night service offered by Casuarina Night and Day and other GPs operating some years ago was also discontinued.

There has been no change in the number of people presenting to RDH Emergency Department for primary medical care following the fall in Farrar Medical Centre hours. The ability of RDH Emergency Department to manage the workload is demonstrated. Low numbers of cases are presenting in the 10.00 pm to 8.00 am time frame. Few people presenting require immediate medical attention.

Feedback from GP providers indicates a high level of interest in increasing access to GP workforce numbers. In reality it must be recognised that nationally there are low numbers of GPs available to be attracted to Darwin. The question then arises as to whether other local GP not currently working after hours could assist. Such GPs have indicated a moderate to low level of interest in participating in the provision of after-hours services, with the majority of these suggesting that their participation would be no more than once per month whether for week days or weekend services.

It is therefore necessary to 'work smarter' with the existing workforce and increase the attractiveness of providing after-hours primary medical care services through the current model. There will be challenges in achieving collaboration due to perceived competitive issues.

8 POSSIBLE SERVICE MODELS

8.1 Key Principles

Five key principles for the future have been identified through this study. These principles have been endorsed by GPs through the TEDGP. Therefore, any recommendation for future AHPMC needs to embrace all five principles:

1. Existing after hours services are enhanced;
2. Opportunities for stakeholder collaboration are maximised;
3. Security of providers and consumers is maximised;
4. Quality and cost-effectiveness of services is at least maintained; and
5. Ease of access to 'after hours' primary medical service is improved.

Within the study a range of service model options was explored. These included:

1. Medical deputising service with a co-operative roster;
2. GP after hours clinic co-located with the RDH Emergency Department;
3. Stand alone GP after hours clinic with co-operative roster;
4. GP operated after hours clinic with cooperative roster within RDH campus;
5. Extended current after hours clinics in Darwin, Casuarina, Palmerston and Humpty Doo;
6. A multi-disciplinary (GP, Registered Nurse, Aboriginal Health Worker) after hours clinic;
7. Local call centre operated by a GP, which provides telephone service only;
8. Local call centre operated by a GP, which can provide clinical services;
9. Call centre operated by a Registered Nurse/Aboriginal Health Worker with GP back up.

Several respondents indicated that a number of the models could work, however, they would require:

1. Co-operation between existing primary medical care providers and between primary medical care providers and tertiary medical services;
2. Collaboration in accessing adequate numbers of General Practitioners to be involved in after hours services; and
3. Coordination of services.

Through the feasibility study two models were identified as having the most potential to enhance current after hours services. These are the development of 1) a Collaborative Systems model; and 2) a Call Centre.

The Collaborative Systems model builds upon the existing after-hours clinics and RDH Emergency Department which are largely meeting the needs of the Darwin urban area. It proposes that any additional workforce required be met through utilising the services of other local GPs who have indicated potential interest participating in after-hours services on an occasional basis. The TEDGP would co-ordinate the supply of the workforce to after-hours clinics. Any call centre should support, rather than compete with this service.

A range of other strategies have been identified in the study to promote the availability of current after hours services.

8.2 Suggestions for enhancing the current services

8.2.1 Collaborative Systems Model

- A Collaborative systems model to operate a workforce supply service for current after hour clinics to extend the range of services available and potentially reduce the burden on existing GP providers;
- The Top End Division of General Practice would organise a register of GPs available to provide after-hours services to the existing clinics. Existing after-hours clinics requiring additional GP support would contact TEDGP to contact and allocate a GP from their register.
- Protocols outlining the relationships between practices, in relation to patients accessing after hours primary medical care will need to be developed.
- Development of a rostered workforce from within the above mentioned Collaborative system to address the after hours needs of people in residential care and nominated people from the aged and disable groups within the community.
- Workforce could be grouped along geographical lines. For example GPs who work/live in the Inner Suburbs area could be grouped to provide clinical hours to the Stuart Park after-hours clinic.
- The Collaborative systems model, coordinated centrally (eg: TEDGPs), could be financially viable through a set fee charged for provision of the GP. This fee would need to include a component that funds TEDGP operational costs. The after-hours clinic would pay the an agreed hourly rate for the period of service e.g. 8.00 pm to 10.00 pm. The appropriate fee for

service model should be identified as the proposed model is refined and agreed upon by GPs and the TEDGP.

The list of success factors cited in the *After Hours Primary Health Care Services in Australia, 'An analysis of research, current data and activity'*, report, November 2000 are considered to be essential to developing the right model of collaboration for the greater Darwin area. Many of the points listed have been cited as necessary to entice increased GP participation in after hours services, not provided from within their usual practice.

The list includes

- Mutual respect and trust;
- Common goals at the time of establishment;
- Common broad ideal and expectations of traditional general practice;
- A desire to ensure that patients receive appropriate and competent after hours care;
- A willingness to share workload to the benefit of all;
- Acceptance that colleagues will not “poach” patients;
- Limited guidelines rather than rigid rules and regulations;
- A desire to reduce after hours workload, without a reduction in continuity of patients' care;
- Little expectation or desire to seek financial reward through after hours work;
- A proportion of members, after hours income is retained to cover operational costs;
- The benefit of informal “peer review” ; and
- An element of selectivity linked with a recognition that there is an optimum membership size

(Veith et al 1999 p4)

8.2.2 Call Centre

- GPs, Stakeholders and Consumers expressed a moderate interest in the call centre concept. Respondent's and attendees at the GP forum requested further research to ensure the design of a call centre would enhance current after hours services in the greater Darwin area. Some concerns were expressed about providing health care advice via phone, without the opportunity to physically assess a patient and that call centre operators should have an adequate understanding of the services readily available to the caller.
- Some respondents indicated that a call centre must be protocol driven with careful planning to ensure the model is best suited to the environment of the greater Darwin public. The model should have the capacity to extend as rural and remote communities demand. Some consideration should be made to linking with existing call centres to provide a single access point to after-hours health care.

- The study identified a number of 'call centre' models. The aim of a call centre, staffed by either trained lay people, nurses or GPs, is to provide a first point of contact for consumers. The call centre can provide advice with or without the capacity for triage.
- Further exploration is required to ensure the 'call centre' is able to meet the specific requirements of the greater Darwin area, including a capacity to enhance current after hours services rather than compete with these services.

8.2.3 Other strategies to enhance current services

- Marketing of the availability and location of current after hours primary medical care services;
 - Development of a standardised information guide, provided for the public, by GP clinics, to guide the public's access to the network of 'after hours' primary medical services; and
 - GPs and the TEDGP should adopt a consistent message informing the public of the current after-hours services available in the area as well as the ambulance service number.
- GPDNT should lobby the Commonwealth government to re-examine rebates for after hours so they reflect the: actual time taken to provide the service; additional cost of providing an after-hours service and lifestyle restriction compensation for working after hours. The Health and Aged Care, After hours Primary Health Care Services in Australia, 'An Analysis Of Research, Current Data And Activity November 2000' report, identifies, increases in funding needs to be a mix of infrastructure payments and rebate adjustments.

Table 3 outlines the responses to the questions the feasibility study was required to address in relation to the recommended collaborative model.

Table 3: Recommendations for the Collaborative System Model

<i>Question</i>	<i>Studies response</i>
Who should be the fund holder?	Top End Division of General Practice who support GPs in service delivery.
Who should be the employer?	No change of current employment is required
How would the GP be paid?	TEDGP to coordinate payment.
Who is responsible for the after hours service?	Current after hours service providers. TEDGP should actively promote increased responsibility of GPs to ensure appropriate services, provided either by themselves or nominated after hours provider(s) are available for their patients. TEDGPs would maintain a register of GPs prepared to provide a level of after hours service through an after hours clinic, or on-call roster.
What is the agreed management structure for GPs and consumers?	Management structure is a collaborative system between existing after hours service providers, other General Practitioners, with this collaborative system to be

	coordinated by the TEDGP.
Are the clients needs being met?	<p>By enhancing current capacity for after hours care patients will have greater access which therefore has the opportunity to better meet the needs of patients.</p> <p>However, there will still be limitations, for example: GPs express concerns about the safety of home visits to patients unknown to them, and the very limited value of home visits due to access to appropriate equipment and treatment resources available during a home visit.</p>
What are the access issues for the community?	<p>Awareness of the range of after hours primary medical clinics in the greater Darwin area.</p> <p>Cost of transport for some individuals from Palmerston to RDH after 10pm.</p> <p>Access to GPs who will provide home/residential care visits for aged and disable members of the community.</p>
A contingency plan if the number of GPs changes	<p>Greater levels of cooperation between existing GPs will be required to maintain the current after hours services if the numbers of GPs in Darwin are decreased.</p> <p>Less pressure on the collaborative members to provide clinical after hours services if GPs numbers are increased.</p> <p>Implementation of a call centre to refer the public to the most appropriate service provider and provide guidance and support via the phone.</p> <p>Possible increase in the role of the Registered Nurse in General Practice.</p> <p>Exploration of the potential for existing AH clinics to co-operate or consolidate.</p> <p>Utilising GPs within after hours services between 6pm to 8pm (the highest period of demand in the after hours period). This deployment of pool GPs within existing after hours services is likely to be appealing to these GPs.</p>
Remuneration and fees to fund the GP	<p>Suggested remuneration is between \$100 and \$120 per hour.</p> <p>Alternatives include negotiation of a percentage of income the GP has generated. This suggestion may increase the potential for the emphasis to be on throughput of patient rather than quality of care.</p>
Is the suggested model in breach of the Trade Practices Act?	<p>No, it is not anti competitive and price fixing is not recommended.</p> <p>Any new after hours service would also have access to this pool of GPs as they currently would through a workforce agency.</p>
What will be the affect on relationships with other providers?	<p>Potentially the existing GPs providing after hours services will be able to reduce their clinical hours provided while maintaining the level of service.</p> <p>Provides the opportunity for greater collaboration between GPs through working relationships.</p> <p>May impact on the existing level of trust between GPs and Practices.</p>

9 CONCLUSION

Current after hours primary medical care services provided by after hours clinics are considered satisfactory despite identification of several areas of service gap. Therefore, access to after-hours primary medical care services for consumers should remain relatively unchanged, rather than introduce an additional after hours service. Enhancement of the current after hours services is recommended to secure their sustainability and suitability as after hours primary medical care services. This will strengthen their capacity to address service gaps and extend their services to meet demand as required. Enhancement can be achieved through a model of GP collaboration.

Achieving adequate levels of collaboration between GPs poses a range of challenges that exist locally and are also well documented on a national level. However, many current practices indicate difficulties in accessing GPs for their practices and would benefit from efforts carried out on their behalf to increase the number of GPs available in Darwin area. GPs would also benefit from increased confidence in the appropriateness and accessibility of after hours primary medical care available to their patients in their absence.

Top End Division of General Practice is well positioned to stimulate and coordinate a formalised process of GP collaboration whilst ensuring enhancement of current services meets the five principles to improving primary medical care after hours services.

Constant attention to attracting GPs not involved in after hours service delivery to become involved and to attracting GPs to operate in the Darwin area is required. Achieving and maintaining adequate numbers of GPs is essential to the sustainability of current services and to position those services to meet the increasing demand for services as the population grows and ages. This will require dynamic marketing and education strategies to consumers as well as changes to the Medicare rebate system that compensate GPs for lifestyle restrictions and the additional cost of providing after hours services.

10 ATTACHMENTS –

10.1 TERMS OF REFERENCE

The After Hours Primary Medical Care Study

Objectives:

The consultant shall examine and analyse the need for after hours primary medical care (AHPMC) services in the Darwin area. And attempt to develop a sustainable model that addresses the identified need for such services in that area and undertake a feasibility study to examine the need for an AHPMC located within the Royal Darwin Hospital.

Outcomes:

The Consultant will undertake a comprehensive needs analysis and feasibility study in relation to AHPMC services in Darwin and within the Royal Darwin Hospital.

In undertaking the study, the Consultant, through the After Hours Research and Policy Officer at GPDNT will:

1. Consult and meet with the Steering Committee to reach an agreed framework, which outlines the methodology of the study;
2. Consult with the independent Evaluator throughout the study;
2. Provide a short report to advise on the progress of the study;
3. Make a presentation on the findings of the needs analysis;
4. Submit a draft report one week prior to completion of the project for consideration by the Steering Committee.

Consultations to be undertaken through surveys and meetings with key stakeholders to include but not restricted to:

- Top End Division of General Practice;
- Commonwealth Department of Health and Ageing;
- NT Department of Health and Community Services;
- Health Insurance Commission (HIC);
- Royal Australian College of General Practitioners;
- Aboriginal Medical Service Alliance of the Northern Territory;
- Commonwealth Carelink Centre;
- GP Liaison Unit Royal Darwin Hospital;
- Emergency Unit, Royal Darwin Hospital;

- GPs who do after hours care;
- St Johns Ambulance;
- Pharmacists;
- Darwin Private Hospital; and
- Consumers.

Identify existing health service delivery patterns.

- Collect and review a geographic and demographic profile of the communities, health services (including current triage and call centre systems), planning, outputs and outcomes, epidemiology profile of the community, current health service utilisation patterns and health service resources available to the community.

Undertake an analysis of the data collected to determine health resources to target future health outcomes and a projection of future health services.

Undertake a feasibility study to determine the possibility of AHPMC service located within Royal Darwin Hospital.

Using the information obtained as a result of the needs analysis and feasibility study described above, the Consultant will attempt to develop and produce a sustainable model for AHPMC services that meets the needs of the community, addresses the gaps in current service provision and is supported by stakeholder groups.

A. Report

The final report is due on 31 May 2002.

The final report must include the following information:

- Report against the objectives and outcomes as set out in this agreement
- Where applicable, a comparison between the achievement of the outcomes and objectives of the study against the expected objectives and outcomes for the AHPMC program
- Where applicable, an explanation as to why any of the outcomes and objectives of the AHPMC Program were not achieved.
- Where applicable, recommendations on how any outcomes or objectives that were not achieved could be achieved in the future;
- A copy of the AHPMC model recommended for development under this study.

10.2 LIST OF STAKEHOLDERS

Name	Position	Organisation
Dr David Ashbridge	Regional Director	Top End Service Network Department of Health and Community Services (DHCS)
Mr John Amery	General Manager	Darwin Private Hospital
Ms Kim Davies	Manager	Crisis Line
Ms Fiona Elliott	Acting- Director of Nursing	Salvation Army Nursing Home
	Reception Staff	Holiday Inn – Hotel
	Reception Staff1	Top End Hotel
Ms Rosemary Jefferies	Director of Nursing	Tracey Aged Care and Chan Park Nursing Home
Ms Pauline Kittler	Nurse Consultant	Hospital In The Home- DHCS
Mr Mick McKay	Senior Officer	Saint John Ambulance Brigade
Dr. Tricia Nagel	Senior Medical Officer	Mental Health – DHCS
Dr Len Nataras	Medical Superintendent	Royal Darwin Hospital - DHCS
Ms Naomi Oliver	Project Officer	Aged and Disability – DHCS
Dr. Didier Palmer	Director	Emergency Department- RDH-DHCS
	Nursing Staff	Robertson Barracks Military Medical Services
Ms Bronwyn Russell	Project Officer- Mental Health Project	GPDNT
Mr Tony Rutter		Department of Health & Aged Care
	Reception Staff	Rydges Plaza
	Reception Staff	Saville Holiday Apartments
Ms Heather Sjoberg	Executive Officer	GPDNT
Ms Heather Swinburne	Manager	Carelink
Dr. David Thomas	Board Member	AMSANT
Dr. David Thomas	Medical Director	Danila Dilba
Ms Beverly Williams	Pharmacist	Pharmacy, Smith St. Mall
Mr. Tony Williams	Pharmacist	Pharmacy, Palmerston Shopping Centre
Dr. Paul Rysavy	Director	Alcohol and Other Drugs - DHCS

10.3 MORBIDITY / MORTALITY DATA**Social Atlas of Australia 1999**

		<i>Darwin (per 1000)</i>	<i>All Capitals (per 1000)</i>
Aboriginal and Torres Strait Islander People	1996	8.6	1.0
Dwelling rented from the State Housing Authority	1986	7.6	0.6
People Receiving unemployment benefit	1996	7.5	5.4
People reporting their health as fair or poor	1995	105	99
Infant deaths per 1000 live births	1992-95	10.3	5.8
Deaths of males aged 15-64 from all causes	1992-95	143	94
Deaths of females aged 15- 64 from all causes	1992-95	126	95
Deaths of people aged 15-64 from cancer	1992-95	117	98
Deaths of people aged 15-64 from lung cancer	1992-95	164	98
Deaths of people aged 15-64 from respiratory system disease	1992-95	193	87
Deaths of people aged 15-64 from accidents, poisoning and violence	1992-95	149	88
Admission of infectious and parasitic diseases	1995-96	106	92
Population per general medical practitioner	96-97	1642	1328

10.4 ACRONYMS

After Hours Services	AHS / ahs
After Hours Primary Medical Care	AHPMC
Department of Health and Community Services	DHCS
Central Business District	CBD
Full Time Equivalent	FTE
General Practice	GP
General Practitioners	GPs
General Practice Division Northern Territory	GPDNT
Medical Benefits Scheme	MBS
Primary Care Clinic Management	PCCM
Royal Darwin Hospital	RDH
The Centre for Quality and Productivity	TCQP
Top End Division of General Practice	TEDGP

10.5 STEERING COMMITTEE MEMBERS

Chair:

Maxine Clark – General Practice Division NT

Members:

Joy Cahill – Casuarina Night & Day Clinic

Tony Rutter – Department of Health and Ageing

Shane Dawson – Top End Division of General Practice

Bevan Richardson - Evaluator

David Ashbridge – Department of Health and Community Services

Heather Swinburne - Carelink

Heather Sjoberg - General Practice Division NT

Sarah Giles - Top End Division of General Practice Urban Practice Chapter

Keith Forrest – Farrar Medical Centre

Di Walsh – Consumer Representative

David Thomas – Danil Dilba

Adam Gordon, Sandra Smiles, Colette Pethick - TCQP

Project Management Group Membership

Maxine Clark – General Practice Division NT

Shane Dawson – Top End Division of General Practice

Bevan Richardson - Evaluator

Adam Gordon, Colette Pethick - TCQP

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