Models of Cooperative After Hours
Primary Medical Care (AHPMC) Provision

1. MEDICAL DEPUTISING SERVICES *(e.g. Australian Locum Medical Service, WA)*
Practices subscribe to Medical Deputising Services (MDS) that provide after-hours GP house-calls for their patients. The practice subscriptions fund the administrative aspects of the service while GPs are reimbursed by MBS after-hours items.

ADVANTAGES
1. Can service all patients within service boundaries (including patients with transport difficulties such as the elderly and residents of nursing homes).
2. Rewarding reimbursement for GPs through MBS after-hours items.
3. Substantial Commonwealth incentives are soon to be finalised for fully accredited MDS.

DISADVANTAGES
1. Only patients from participating practices are treated.
2. Home visits results in inefficient use of GPs time resulting in low throughput.
3. Difficulty attracting sustainable workforce - leading to reliance on overseas doctors who often have language difficulties and a poor appreciation of local health services.
4. Restricted area coverage.
5. No formal protocols or standardisation leading to potential inconsistencies in the service.
6. Viability based on adequate GP subscribers and adequate workforce.
7. Extremely costly and complex to establish/get accredited, with huge workforce required to cove home visit component of model, proving a barrier for local GPs to consider taking on the establishment and operation of a deputising service.

2. SHARED PRACTICES ROSTER *(e.g. Bayside Division After Hours Cooperative, Qld)*
General practices subscribe to a cooperative roster which is administered by a third party such as the Division. GPs from the participating practices are put on a rotating roster. Coverage is for entire after-hours period. The telephone is operated by a pager service. When on-call GPs are paged and they triage the patient and where necessary chose where to see the patient whether it be at home, in their own clinic, or at a private hospital. For remuneration GPs charge an upfront fee, patients can claim the MBS after-hours rebate and the Division collects the monthly membership subscription from each practice (typically $25 per practice). The Division is responsible for organising the rosters, faxing records of after-hours visits to the patient's regular GP, overseeing security arrangements for home-visits and ensuring back-up if on-call GPs fail to answer their pagers. The basic tenet upon which this model is commonly established is to provide traditional general practice type coverage to members' patients, on a not-for-profit, or low profit basis.

ADVANTAGES
1. Low administrative pressures.
2. Continuity of care for patients
3. Generally seen as a high quality service with patient satisfaction.
4. Allows GPs to maintain autonomy in billing and clinical practice.
5. High level of calls can be triaged by GP without visit
6. Model provides access to after hours MBS and PIP.

DISADVANTAGES
1. Only patients from participating practices are treated.
2. Many calls do not require visits but GPs still lose valuable sleep and are not remunerated for telephone conversations.
3. Low remuneration with GPs required to work in their practices the next day.
4. Low public profile and little ease to pressure on local hospitals.
5. No formal protocols or standardisation leading to potential inconsistencies in the service.

3. PRIVATE HOSPITAL ORGANISED ROSTER *(e.g. Rockhampton, Qld)*
GPs or GP cooperative is contracted to staff an after-hours primary care service at a private hospital or to be on-call for patients who present after-hours. Coverage is for entire after-hours period. The GPs generally collect all patient fees as remuneration for their services. The private hospital usually provides all administration, the facility, nurses, consumables, advertising and protocols and in return relies on the GPs to refer to in-house specialists and increase profile in community.

ADVANTAGES
1. Open to all consumers.
2. Secure working environment for GPs.
3. Good backup facilities.
4. GPs are usually well remunerated.
5. Access to After Hours MBS and PIP.

DISADVANTAGES
1. Viability of service for the private hospital hinges upon increase in specialist referrals and admissions to the private hospital.
2. On-call GPs sometimes complain of coercion by the hospital to attend presenting patients for whom an after-hours consultation is unnecessary.

4. PUBLIC HOSPITAL ORGANISED ROSTER *(e.g. Esperence District Hospital, WA)*
GPs are contracted to staff after-hours primary care facilities at the local public hospital. GPs are rostered to work on a rotational basis. GPs staffing the emergency department reside overnight and are paid a flat hourly rate by the State. Coverage is for entire after-hours period. The public hospital is responsible for all administration and supplies nursing staff and all consumables.

ADVANTAGES
1. Open to all consumers.
2. Secure working environment for GPs.
3. Good backup facilities.
4. GPs have a guaranteed income.

DISADVANTAGES
1. The service cannot be supplemented by MBS funds (considered double dipping).

5. GP COOPERATIVE CLINIC COLLOCATED WITH A PRIVATE HOSPITAL *(e.g. GP After Hours, Perth)*
GPs form a cooperative roster to staff an after-hours clinic independently administered but collocated with a local private hospital. The clinic is its own limited company either set up by the Division or has equal share-ownership by all participating GPs. Practices of participating GPs (and often non-participating GPs) refer their after-hours patients to the clinic. Operational and clinical protocols are agreed by participating GPs including an agreement not to “poach” the patients of other GPs. Administration is overseen by either the Division or a Practice Manager governed by a Board of Directors and includes considerations such as advertising and receptionist. Private hospital offers either:
• free or discounted premises at prospect of increased specialist referrals;
• facility, nurse and consumables and Clinic/Division pays for administration (billings split 50% to GP, 40% to hospital and 10% to Clinic or Division); or
• no assistance at all;
Coverage is typically from 19:00 to 23:00 on weeknights and on weekends opening between 13:00 and 16:00 and closing at 22:00. An upfront fee (typically of between $40 and $60) is charged to patients. A number of methods of GP remuneration exist including: GPs receiving 50% of billings; GPs being paid a flat hourly rate (of between $75 and $120); or GPs being paid a guaranteed minimum hourly rate or 50% of earnings (whichever is the greater). Most clinics require ongoing adjustments to patient charges and GP remuneration rates to remain viable.

ADVANTAGES
1. Open to all consumers.
2. Secure working environment for GPs.
3. Good backup facilities.
4. Generally have strong informal business arrangements with other services such as ambulance, pharmacists, radiologist and pathology services.
5. Generally seen as high quality service with high levels of satisfaction amongst consumers.

DISADVANTAGES
1. Upfront fees deter patients of lower socio-economic circumstances.
2. Clinics are unable to access after-hours MBS rebates so must charge patients as much as possible while still maintaining sufficient throughput to remain sustainable.
3. Excludes patients with transport difficulties.
4. Flat hourly rates paid by the clinic to GPs tend to be unsustainable except in the busiest periods and GPs risk low remuneration from evenly-split takings.

6. GP COOPERATIVE CLINIC COLLOCATED WITH A PUBLIC HOSPITAL UTILISING MEDICARE
Operates in the same way as a GP cooperative clinic collocated with a private hospital except that the public hospital cannot provide free or discounted premises if the GPs working at the clinic intend to collect MBS rebates (the HIC considers this to be double-dipping).

ADVANTAGES
1. Open to all consumers.
2. Secure working environment for GPs.
3. Good backup facilities.
4. Convenient alternative to the public emergency department.
5. Has significant impact on reducing demand on emergency department.

DISADVANTAGES
1. Cannot receive free or discounted accommodation, nursing staff or consumables from the hospital.
2. Upfront fees deter patients of lower socio-economic circumstances.
3. Excludes patients with transport difficulties.
4. Clinics must charge patients as much as possible while still maintaining sufficient throughput to remain sustainable.
5. Flat hourly rates paid by the clinic to GPs tend to be unsustainable except in the busiest periods and GPs risk low remuneration from evenly-split takings.
6. Continues to encourage primary care type clients to present to the Emergency Department/hospital after hours.

7. GP COOPERATIVE CLINIC COLLOCATED WITH A PUBLIC HOSPITAL UTILISING STATE AND/OR COMMONWEALTH FUNDING *(e.g. Maitland After Hours GP Service, NSW)*
Operates in the same way as a GP cooperative clinic collocated with a private hospital except that GPs are paid a flat hourly rate by the Government, the public hospital supplies premises, consumables and nursing staff and the service is made free to the public.

ADVANTAGES
1. Open to all consumers.
2. Secure working environment for GPs.
3. Good backup facilities.
4. Convenient alternative to the public emergency department.
5. Does not exclude patients of limited means.
6. Has significant impact on demand to Emergency Department.
7. Over time, builds relationship and trust between ED and GP cooperative.

DISADVANTAGES
1. Expensive.
2. Excludes patients with transport difficulties (unless funding provides support for).
3. Concern by some GPs of loosing fee for service and having no incentive to be efficient, e.g. if there are two GPs working at busy times (ie Sunday) one GP may be carrying the load while both paid the same.
4. Continues to encourage primary care clients to present to hospital after hours.

8. GP COOPERATIVE BASED IN CLINIC *(e.g. Ipswich, Queensland)*
GPs form a cooperative roster to staff an after hours clinic in the community. Practices refer their patients to the clinic. Generally only looking after participating practices patients to adhere to Medical Board restrictions unless registered as an after hours service. Often only open 1800 to 2100 on weeknights and 1300 to 2100 on weekends.

ADVANTAGES
1. Cooperative maintains autonomy with no pressure from third party (e.g. hospital).
2. Continuity of care for participating practices' patients.
3. Generally perceived as quality service with high level of satisfaction amongst patients.

DISADVANTAGES
1. Only patients from participating practices are treated.
2. Cost of facility, nurse, consumables and equipment reliant on service.
3. Security an issue, often having to employ security services or reliant on support from other services (e.g. security provided for pharmacy next door)
4. Reliant on pharmacies to be open.

9. NURSE/GP TELEPHONE TRIAGE *(e.g. HealthDirect, WA)*
Centralised telephone-in facilities where problems are dealt with over the telephone by an on-call nurse or medical practitioner. Patients can be switched through to local ambulance service, referred to hospital, local GP or home visit service as necessary.

ADVANTAGES
1. Positive benefit to GPs lifestyle by either shielding practitioner from unnecessary after hours calls, or through reduced number of nights on-call.
2. Community has rapid access to appropriate health advice or intervention.
3. Generally open to all consumers.
4. Potential to increase quality of service provision in the region, by meeting needs of consumers for information, while at the same time filtering unnecessary visits to ensure appropriate use of after-hours.
5. Potential for long term reduced cost for State Government through reduced demand for Emergency Department admissions to hospital.

DISADVANTAGES
1. Significant cost to administer.
2. Intensive training of staff, strict protocol development and anticipated medico- legal problems can be significant barriers.

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