Background Briefing Paper
GPDV Forum May 2006

Health call centres – divisions' issues

Overview

All state/territory governments in Australia and the commonwealth government have agreed to pursue a policy of making health information, advice and referral available to the public through health call centres (HCCs).

HCCs exist or are being established in most states and territories. The national one is still to be set up (though intended to begin operation in 2007) and Victoria's is due to be fully operational by July 2006. There are a number of issues about how this policy is implemented that need clarification and further development. Divisions of general practice have an interest in these issues, to ensure coordination of services between general practices and call centres, so that members of the public are offered consistent advice, experience continuity of care, and are clear about how to access health and medical advice and information and about how, when and where to access medical treatment. Divisions have a particular interest in the delivery of after hours primary medical services, for the benefit of general practice patients, and because of the impact of after hours services on GP recruitment and retention, especially in areas of workforce shortage. Divisions are likely to want to have the opportunity to have input into the implementation plans for this agreed health call centre policy. The Victorian Divisions' Forum in May is intended to begin that process by identifying some of the key issues that need to be addressed in implementing national and statewide health call centres.

This discussion paper outlines the policy context for the move to establish a national health call centre. The paper lists what the evidence suggests that a health call centre in Victoria – or Australia-wide – might be likely to achieve, and proposes some key issues for further consideration in developing implementation plans for health call centres. We hope that these and other issues can be discussed by participants at the Forum.

Policy context

The demand for after hours primary medical services has risen over recent decades, increasing demand on GPs. The shortage of GPs in many areas is well-documented, as is the nature of changed expectations of general practice by the doctors who enter it (including the expectation of working shorter hours and perhaps to work part-time, reluctance to become a practice owner and reluctance to engage in the business and organisational aspects of general practice). These factors have meant that GPs are increasingly reluctant to provide after hours services to their own patients, although many GPs use other systems to make after hours available while not providing it directly (including GP cooperatives and deputising services). In response to this scenario, as well as to increasing consumer expectations for extended hours services in health as in other industries and to concerns about increasing demands on hospitals for after hours services that might be appropriately dealt with in primary care settings, the Commonwealth government has funded work exploring options for better after hours primary medical services since 1999. ($43.4 million over 4 years was announced in the 2001-02 Budget; the 2004-05 budget announced $58.2m over four years for continuation of the After Hours Primary Medical Care (AHPMC) Program, and $106.2m over 5 years for new grants for after-hours GP clinics.) Consideration of call centres, and of a national call centre, was part of the AHPMC work. This year heads of

state/territory and commonwealth governments (COAG) have agreed to establish a national call centre, jointly funded by commonwealth and the states/territories. It will provide health information and advice, and referral, by triage nurses. This is consistent with developments both here and overseas in using call centres to provide all sorts of advice to consumers (one example from a different industry is NSW's LawAccess, which is highly rated by consumers).

Some of the experience of telephone triage in Australia has been in the context of after hours primary care services (e.g. as part of the funded trials). But it is important to remember that the national call centre network represents a shift in focus, from **after hours** *primary medical service* coverage, to *health* call centres, intended to operate **24 hours** a day, 7 days a week. The extension of operating hours and the wider health focus make it more difficult to be certain what the primary purpose of the call centres is. Likely purposes include:

- to reduce demand on other health services (specifically, on GPs or on Emergency Departments. This could apply to after hours presentations, or in-hours presentations, or both)
- to provide a better, or extra service to the public (to improve access for those who already tend to access services, or for those who can not access them now; or ensure that people access the most appropriate service for their needs by providing phone triage and referral, rather than having them choose the service without advice)
- to meet demand in rural areas where the health workforce numbers are inadequate to meet demand (or where resources are overstretched)

While some of these purposes may not be mutually exclusive, it is likely that implementation would be done differently, depending on what the main purpose was.

Evidence[1]

The evidence suggests that telephone triage by trained nurses with decision support software:

- is safe
- reduces demands on GPs for after hours consultations
- may reduce the overall demand for GP consultations, but may simply delay these to a later time
- makes little impact on other service utilisation (including use of hospital Emergency Departments and ambulance services)
- reduces the demand on hospitals to provide telephone advice
- is highly valued by the public
- receives a large proportion of calls relating to young children
- may address some but not all (or even most) of the barriers to access for those groups that experience the most difficulties in access now
- may result in some referred contacts which are unnecessary

Key issues for discussion

There is agreement by all current governments in Australia to pursue a policy of making information, advice and referral available to the public through health call centres. Already, states, territories and commonwealth governments have invested millions of dollars in developing and (in the case of some states/territories) implementing a health call centre policy. But there are

[1] For brevity, full references for these claims are not included in this paper. The policy issues paper that will be produced following the Victorian Divisions Forum will cite the references for these assertions, and include more detail about what the evidence indicates.

a number of implementation issues that need further development for the system to work as effectively as possible. Some of these are listed below, for further discussion by participants at the Forum.

Involvement of general practice

1800 numbers, or referral through general practices?
Some after hours projects signed up general practices to refer to the telephone service, so that all the patients of a particular general practice would reach the telephone service when they contacted their GP after hours. In WA, the HealthDirect line receives calls diverted from hospitals in a similar way (in hours as well as after hours). Some projects complemented this approach with a general phone number advertised to the public (usually a 1800 number). Because the national call centre network is intended to be a 24 hour service, and is not simply a substitute for general practice and other medical services, it will be directly available to any member of the public. This has the obvious consumer benefit of providing access for those who may not have a GP, or would be more likely to use a non-GP service after hours, but if the call centre hopes to cover the needs of those who want to contact their general practice after hours, then practices would also need to refer callers to the service. Is it intended to sign up general practices to refer callers for after hours services? If so, how will this be implemented? Is divisions' involvement sought?

Need for a real, live GP out of hours
In a significant number of calls received by a HCC, there will be a need to refer to a GP after hours. (For example, in a two-year period, WA's Health Direct assessed 29% of callers as needing to see a doctor either immediately or soon and within four hours (this excludes those referred specifically to hospital immediately); and an article in BMJ in 2000 on NHS Direct delivered from three sites found that, depending on the site, between 30-49% of triaged calls were referred to a GP).

How will local GPs be connected with the call centre to achieve this – especially in areas where there are GP shortages and/or no deputising services to refer to?

Early collaboration for integration
In the UK, one of the current challenges of NHS Direct (a 24-hour, 7day a week telephone service now run from many sites across England, Scotland and Wales) is how to integrate after hours GP cooperatives with NHS Direct. (There are approximately 300 GP after hours cooperatives in England, and there is patient registration with general practices so the system there is quite different to the one here.) Nevertheless, the UK experience may suggest that it would be useful to consider this integration issue at the outset, rather than leaving it till much later. Delaying a plan for the involvement of general practice until after establishment may not lay the best foundation for successful collaboration.

Referral to which private service?
Triage referral options for immediate care (emergency departments, ambulance) seem relatively straightforward. But referral to other services may be more complicated, in ways that don't appear in the literature reviewing the operation of NHS Direct, where the system is a public one. How will a call centre deal with referral to private services (including general practices, after hours clinics and deputising services) that are potentially in competition with each other?

Connection between GP and health call centre
Some after hours arrangements ensure communication about the episode of care from the after hours service back to the patient's regular GP. Is such a system envisaged for the Victorian – and later, national – health call centre?

An article in MJA (in 2002) about WA's Health Direct service documented increased numbers of calls at times when there is concern over public health issues, and suggested that demand at such times may prove overwhelming. This scenario suggests that it will be important to develop a clear understanding of the relative roles of GPs and call centres in the event of public health crises.

Change of service utilisation?

Will a health call centre enable more appropriate use of the available health services, or create extra demand for services? The evidence does not suggest that telephone triage is associated with reduced numbers presentations to Emergency Departments and use of ambulances (although a study of trends in use of NHS Direct and other immediate services in the first two years of its operation (published in BMJ in 2000) did suggest a small reduction in demand on after hours GP cooperatives, where demand has previously been increasing). How will the results be evaluated, so the public can be clear which of these possibilities is achieved?

After hours trial results

03-04 DoHA Annual Report says:
There is no one-size-fits-all model of after hours care provision. Early indications from projects and trials suggest that the most successful models are those that are flexible and adapted to suit local local conditions and support by the general practice/medical community.

How will this finding be played out in implementing a national call centre, in which an important component will be after hours?

There would usually be an expectation that the lessons from the trials are incorporated in further implementation. What does the evidence tell us so far?

- West Vic's after hours project has found that triage reduces after hours calls to GPs by over 60%. On the other hand, the national evaluation of the after hours trials suggested that none of them could be definitely linked to an increase in more appropriate service mix (e.g. decrease in GP home visits, emergency department and ambulance use and increase in presentations to GP clinics). (pp.6, 215-219)

- The MJA article on telephone triage in WA (2002) does not address changes in health service utilisation (except for reducing the ED of the burden of demand for telephone advice), but says there are at present only two specific outcomes supported by data, and neither of these is about changing service utilisation. On the other hand, McKesson claims in a 2005 document about financial and healthcare benefits of health call centres that there was a 25% reduction in after hours GP MBS items numbers after the introduction of Health Direct in WA (while use of those items increased in other states); and suggests that there has been a reduction in the increase in ED attendances (increasing by 1% in WA, compared to 6-8% in some other states).

- The national evaluation of the after hours trials contradicts the cost savings claim, in its finding that none of the trials (including HealthDirect in WA, which was not a

trial, but used in the evaluation as a control) were likely to lead to overall cost savings. (pp 215-219).

Access

An Urbis Keys Young literature review in 2002 suggests that health call centres may overcome some common barriers to access for those groups most disadvantaged in terms of access to health services (i.e. cost and transport), but are not likely to address others (e.g. inability of providers to deal with special needs groups, need for translation services, access to a telephone, continuity of care, discrimination experienced by some groups in some settings, gender/cultural sensitivity). This is particularly relevant given that COAG has suggested the benefit of a national health call centre would be to allow access for rural and remote populations, and mobile populations, and that the call centre would address mental health issues. How might barriers to access be addressed?

Health call centres – what for?

One of the key debates about call centres is about what impact they will have on overall demand for care and, if we are unsure, whether they are worth investing in. Martin Roland said in his 2002 MJA editorial:

If the net impact is to provide additional services, we do not know whether this is the best way to spend extra healthcare resources…Patients use them [call centres] and they are probably safe, but we do not know if they will reduce demand for existing services, or if they will merely provide patients with additional, albeit valued, service.

It would be useful to know what DHS and DoHA see as the primary purpose for health call centres. Is it:

- A new service,
- To provide redirection to existing services,
- To allow access for rural/mobile populations?

General Practice Divisions – Victoria Ltd
ABN 80 081 371 968 ACN 081 371 968
1st Floor, 458 Swanston Street
Carlton Victoria 3053
Tel: (03) 9341 5200 Fax: (03) 9348 1375
Email: gpdv@gpdv.com.au Website: www.gpdv.com.au