

AFTER-HOURS IN PRIMARY CARE: WHICH SOLUTIONS?

SYNTHESIS



AFTER-HOURS IN PRIMARY CARE: WHICH SOLUTIONS?

PASCALE JONCKHEER, CÉCILE DUBOIS, LIESBETH BORGERMANS, ELS VERHOEVEN, EMILIE RINCHARD, ANNE-MARIE BAUDEWYNS, TOON HAEZAERT, IMGARD VINCK, MURIELLE LONA, DOMINIQUE PAULUS.



■ FOREWORD

A couple of years ago, KCE issued a study report on the inappropriate utilization of hospital emergency services. The study was commissioned by the health authorities, and aimed at finding solutions for orienting patients towards services better matching their needs.

For the current study, the question came from the general practitioners (GPs) themselves, and, more specifically, from the 'circles' of GPs, in charge of the organization of night and weekend duty rounds. The question they ask is whether this task can continue to be fulfilled in all locations, in view of the heavy workload, the burden and sometime even the security threats associated with these duty rounds. The request did not stop them, though, to meanwhile develop alternative solutions and test them on the field in several locations. Hence, we could take advantage of their experience for the elaboration of realistic proposals for future solutions that would be satisfying the expectations of the population, the practitioners and the authorities. We wish to thank all persons who have shared their practical knowledge and experience with our researchers.

We hope that the analyses and the synthesis proposed by KCE will contribute to gather all potential approaches into a rational and effective organizational framework, proposing future developments that have until now never been explored in Belgium. Likewise, we hope that the patients, and especially the most vulnerable and destitute among them, whose problems often tend to lengthen the waiting queues in the emergency units, will find their ways in the future care landscape.

Jean-Pierre CLOSON
Assistant Chief Executive Officer

Raf MERTENS
Chief Executive Officer



■ SYNTHESIS

1. AFTER-HOURS IN PRIMARY CARE: WHAT IS THE PROBLEM IN BELGIUM?

Today, any person who needs medical care anywhere in Belgium during after-hours periods (evenings, nights, week-ends and public holidays) has the opportunity to contact a general practitioner (GP). The organization of this after-hours care mainly relies on “rota groups” organized by local GP circles. Within rota groups, GPs from a geographical area are in turn on call for the patient population of that particular area. All GPs have in parallel the legal obligation to ensure the continuity of care to their patients. However, an increasing number of GPs find it difficult to be available during long periods on call, as detailed in 1.1. The main problems identified by the authorities are described in 1.2. Finally, a data analysis and an overview of the current legislation complete the description of the current situation in 1.3.

The objective of the subsequent sections is to analyze alternative models for the organization of after-hours in general practice, the conditions for implementation, legal and organizational consequences.

1.1. GPs have increasing difficulties to perform the duty work

The topic of this report has been proposed to the KCE by the Federal Council of GPs Circles. Many problems concerning the GP after-hours services have been quoted by the profession:

- the decreasing number of GPs willing and available to be on call, in particular in rural and deprived areas, with an increasing pressure on the remaining work force;
- the negative impact of after-hours work on the attraction of the GP profession;
- the specific problem of duty in the dead of night when the GPs are on call for a limited number of patients (see definition in 1.3.2);
- the current legal framework that precludes from implementing some alternative solutions (see 1.3.3);



- other issues related to after-hours care as safety, outstanding bills and excessive patient demands (e.g. home visits during the night for futile reasons).

1.2. Budgetary and manpower concerns

The authorities were also concerned about the problem of after-hours for two main reasons.

First, the organization of after-hours care has budgetary consequences. The patients who consult emergency departments for little ailments generate unnecessary expenses. Moreover, the financing of alternative solutions requires growing budgets and their size is currently difficult to estimate.

Second, the possible future shortage of GPs puts in danger the organization of after-hours care in some areas.

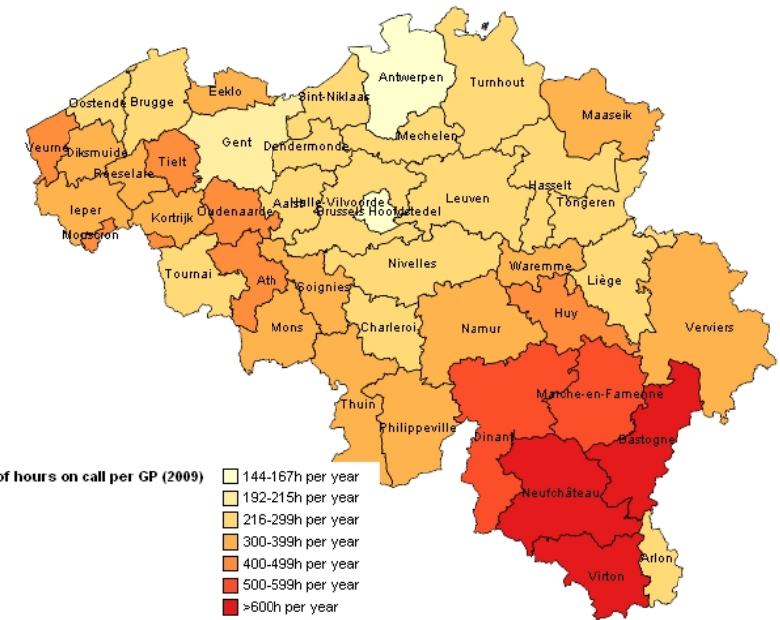
1.3. Actual current situation : workload and legislation

1.3.1. Differences in workload between areas

The MEDEGA database from the Ministry of Public Health provides for each GP the exact time of the period on call. Based on this information, the GP (or GP circle) perceives “availability fees” from the National Institute for Health and Disability Insurance (NIHDI).

Number of hours on call by month and by year

In 2009 the median number of hours on call per GP was 630 hours in rural areas, 326 hours in semi-rural areas and 224 hours in urban areas (see map).



Median number of nights on call

The number of nights on call has been defined in the analyses of the MEDEGA database as the number of periods including at least one hour on call between midnight and 6AM. The results for the year 2009 show a pattern similar to the differences noted in the previous paragraph:

- In rural areas, a GP is on average 3 to 4 nights on call per month. In semi-rural areas, the mean is 2 nights per month and in urban areas only 1 to 2 nights.
- two thirds of the GPs in rural areas were more than 30 nights on call for one year. In semi-rural areas, less than one in four had that many duties, while in urban areas, only 9% had 30 nights or more.

1.3.2. Differences in workload between day and night

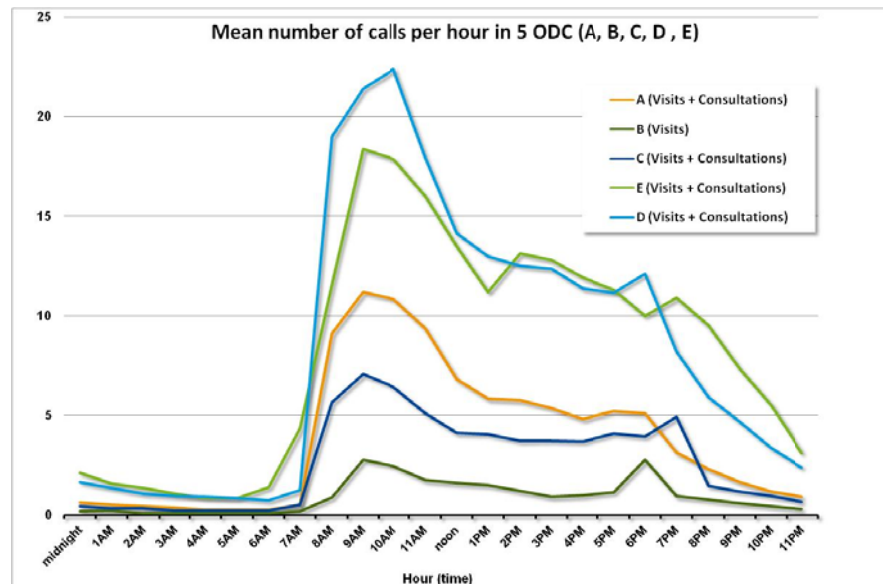
GPs find it particularly hard to be on call at the dead of night for just a few and sometimes trivial cases. “Dead of night” stands for the period where



the number of calls dramatically drops, but there is no universally accepted definition for the exact timing.

This study analyzed the number of calls per hour, to specify these “dead of night” periods. The detailed data on calls leading to a home visit or to a referral to a GP consultation were only available for 5 GP circles with unique call number (year 2010). All 5 circles showed similar patterns.

The number of calls leading to home visits or to a referral to a GP consultation decreases from 6-7 PM onwards (see the figure). The slack period with a very low number of calls (i.e. 1-2 calls per 100 000 inhabitants) is noted between 11 PM-midnight and 7 AM.



These data reflect the pattern of the patients' demands. However, in order to find acceptable solutions for duty in the dead of night, the analysis of the patients' calls should be combined with the GPs' actual perception of what is “night” work (e.g. 11 PM versus midnight).

1.3.3. Current legislation, interpretation and compatibility with alternative solutions

First, the article 422bis of the Penal Code states that a GP must provide medical assistance whenever he/she is aware that a patient is in serious danger. However, some of the new initiatives to optimize the delivery of after-hours care are hampered by a too restrictive interpretation of the legislation by many GPs. It is perceived as an obligation to visit the patient at home when requested, while art 422bis implies an interpretation of the circumstances to judge whether it is appropriate or not to visit the patient at home.

The perceived obligation of home visits generates two main problems.

- GPs feel unsafe in some circumstances with little means to identify situations at risk. There is currently no specific guidance to identify dangerous situations or to protect the GP in case of hazardous home visit.
- Home visits are much more time-consuming than consultations, in particular in rural areas: making unnecessary home visits raises questions of efficiency and quality of care (in case of concomitant urgent call).

The deontological code explicitly refers to art. 422bis Penal Code. The provincial councils of the Medical Order sometimes refer to the (too) restrictive interpretation of article 422bis Penal Code to condemn the GPs disciplinarily.

Second, the current legislation requires one GP on call per 30 000 inhabitants, whereas this GP can expect about one call per 100 000 inhabitants during the night (see 1.3.2);

Finally, the accreditation status requires conditions impossible to fulfill when working during after-hours only (i.e. medical records, continuity of care).



2. POSSIBLE SOLUTIONS AND CONSEQUENCES

Belgium is not the only country that faces problems with the organization of after-hours care. Other European countries are concerned about the accessibility, quality, safety and efficiency of after-hours care. In particular decreasing the use of emergency departments for minor ailments is a challenge but till now, no health care system has solved the problem.

This report includes a systematic literature review on the effect of new after-hours care models and a description of the new after-hours care models in 5 other European countries. Some models already exist in Belgium as experimental projects, sometimes on a large scale. Other ones could be considered in the medium term:

- Organized duty centres: cooperatives organized and medically staffed by the GPs of the area in which they operate;
- Telephone triage and advice system: a doctor or a medically trained staff member advises patients by phone or refers them to the most suitable professional;
- Specific solutions for periods in the dead of night i.e. one GP for larger areas and/or collaboration with local hospitals;
- Consultations by nurses, phone consultations (by nurse or by a physician): not yet on the Belgian agenda but both solutions could be considered in the medium term given the current GP demography.
- It is important to note that these solutions:
- Can possibly coexist in the same area;
- Might be considered as illusory in our current health care system (e.g. nurses) but could be considered for the future if the situation in Belgium would need more drastic solutions.

2.1. Organized duty centres (GP cooperatives)

2.1.1. *Different profiles between and within countries*

The model of (GP) cooperatives/organized duty centres (ODCs) is the most popular model in the Netherlands, Denmark and the UK: the organization differs between (and within) countries.

- In the Netherlands GP cooperatives are supervised by the GPs and staffed by nurses and practice assistants (medically trained personnel). This staff is responsible for triage and/or assistance with consultations.
- In the UK a large staff is also involved e.g. telephonists, duty managers, nurses, emergency care practitioners. The skill mix varies between organizations: some exclusively employ GPs while others also employ nurses.
- In Denmark the GPs themselves do the triage: nurses and administrative staff are employed as well, but not for triage.
- In France and Italy cooperatives are staffed with GPs or other physicians.

2.1.2. *Impact: positive for GPs' and patients' perception, unclear for the health care system*

The review did not identify any study to compare the quality of care between GP cooperatives and traditional rota group models.

The set up of cooperatives has usually a positive impact on the GPs' perception: less workload, better quality of life and job satisfaction. This perception depends on their previous situation (rota system, individual organization) and on their personal desire to adopt a new system.

Most studies conclude that patients are also satisfied. The literature draws attention to the accessibility of the cooperative: transport is a crucial problem for some users (e.g. parents with young ill children, elderly patients). Some countries set up systems to provide home visits when necessary.

The impact on the health care system is not clear: a possible decrease in the number of GP home visits, little impact on the use of emergency services. A study concluded that the costs for the health care system are



higher than the usual GP consultations (without additional financing for the logistics and staff).

2.1.3. *Quality indicators*

Quality indicators for after-hours care have been developed in The Netherlands and in the UK. The UK developed a system for accreditation of cooperatives and a “National Quality Requirements” system includes many quality procedures e.g. complaints procedures, GP audits, mandatory reports of the GP on duty to the usual GP. Unfortunately the results of the measurements are only published in a few research papers.

2.1.4. *A solution for an increasing number of GP circles in Belgium*

2.1.4.1. *Financing of out-of-hours centres*

In Belgium also, the quest for new solutions led to the financing of a growing number of out-of-hours centres (ODCs). The first “experimental posts” were set up in small cities and rural areas (since 2003). They are financed by the National Institute for Health and Disability Insurance on an annual basis. Budgets are based on the ODC’s demand with details on their expenses (more than two thirds relate to personnel costs). “Urban posts” were later set up in big cities and their financing is more stable (defined in a Royal Decree).

The number of ODCs gradually increased to up to 29 in 2011. They now cover about one third of the Belgian population.

Till now the ODCs have been set up on the request of GPs seeking an response to their local problems. Yet, little is known about the needs at national level. The NIHDI therefore initiated a study to identify the optimal spots where to locate ODCs throughout the country. Another objective at the short-term is to develop new ways of financing to replace the current one based on short periods.

2.1.4.2. *Wide range of costs, poor standardization*

The budget allocated to an ODC currently relies on its motivated request with data on activities and financing. In 2011, the NIHDI allocated €10.3 million to the 29 ODCs.

- There is a large heterogeneity between ODCs’ expenses, even within similar areas, partly explained by different types of investments;

- There is a substantial difference between the number of contacts during days and nights (with a minimum of 1 patient per 10 hours): this finding in line with the statistics described above (see 1.3.2).

Comparisons between ODCs remain difficult because they widely differ in terms of opening times, other sources of financing, type and density of the population covered. The outcomes are in theory identical between ODCs but the available data do not allow any conclusion on the cost-effectiveness of the system.

The average cost per contact varies between €17 and €23 (without medical fees) i.e. a range of €0.15 to €5.08 per inhabitant. In The Netherlands and France the costs per inhabitant are estimated around €14 and €6 respectively. This estimation is €7 in the UK where the National Audit Office further showed that rurality is an important cost driver.

2.2. *Unique call number with triage*

2.2.1. *A widely used solution in other countries*

A regional or national unique call number with triage system is in use in Denmark, The Netherlands, the UK and France. The objective is to provide the most appropriate response, tailored to the patient’s need (and not request): emergency team, GP home visit, referral to a GP surgery, other information related to the care organization.

The organization of the triage system varies between countries. In Denmark a GP is responsible for the triage, in The Netherlands, it is usually a triage nurse (supervised by a GP) and in the UK a nurse or other trained personnel.

Success factors have been identified for the quality of the triage system: a training program for the personnel, guidelines to support their decision, use of computerized decision support, one unique triage system for the whole acute care chain (to standardize the answers to similar situations and to orient to the right care provider at the right time).

Other quality procedures include e.g. the supervision by a physician, peer review groups, the development of quality indicators (e.g. for waiting times and delay before optimal solution).



2.2.2. *Impact: positive on GPs, half-hearted by patients*

The introduction of triage systems led to a reduction in the GP workload in other countries, in particular, to less home visits.

Weak points are the poor communication skills of the personnel, the waiting times on the phone and the uncertainty about the delay before home visit.

The safety of triage by a non-physician is also discussed in the literature: the few available data show no change in mortality, hospital admissions and GP contacts during the day following the triage.

2.2.3. *Pilot experiences in Belgium*

2.2.3.1. *A standardized organization*

In Belgium a pilot project of unique call number (project 1733) has been launched in some regions since 2009. A professional dispatching sort out any medical call and follows standardized protocols set up in collaboration with GPs. The calls of the patients with primary care problems are:

- either transferred to the GP circle;
- or receive a direct answer according to the problem: advice to delay the contact, to go to the local ODC, home visit.

2.2.3.2. *Economic consequences: difficult to estimate*

The extension of the pilot project to all Belgian regions would cost around € 2 521 500 during the first year, with $\frac{3}{4}$ of the sum devoted to personnel costs. Too few data are available in the literature to estimate the running costs after a few years as well as the potential gains (e.g. in terms of reduced number of home visits, delayed demands, solved problems).

2.2.3.3. *Several legal issues to consider*

A unique call system with triage by non-medical personnel requires an adaptation of the current legislative framework. It is important to have a clear definition of the decision modalities following a patient's call in order to cover the telephonist's and GP's possible liability.

Moreover, the legal status of the telephonists needs clarification. If the assessment of the patient's problem is considered to be a kind of (preliminary) anamnesis, the profession of the telephonist and his/her legal competences need to be defined in the Royal Decree n° 78. If not, no

amendments are necessary: a legal basis can be found in the existing legislation for the personnel of the 100/112 services for emergency aid. There is currently no uniform start or end time of after-hours: it would be opportune to harmonize at national level in case of unique call number.

2.3. *Specific solutions for the dead of night: larger areas and/or contracts with hospitals*

2.3.1. *Two alternatives implemented in a few Belgian areas*

Two main solutions have been set up by GP circles to alleviate the burden of duty periods during the dead of night.

The first solution is an agreement between adjoining GP circles to reduce the number of GPs on call during these quiet periods. The implementation of this solution has limitations:

- First, in territories near the border (often rural areas with a shortage of GPs), there is no adjoining GP circle to share the forces;
- Second, as mentioned above, the legislation requires one GP on call per 30 000 inhabitants, whereas this GP can expect about one call per 100 000 inhabitants during the night (see 1.3.2);
- Finally, distances in rural areas are a limit to merge large territories.

The second solution is an official agreement between the GP circle and local hospitals to send the patient to the emergency departments during the dead of night. In the currently running Belgian initiatives, the triage is performed either by a GP (from the GP circle) or by the personnel of the emergency department.

2.3.2. *Required legal adaptations for implementation in Belgium*

The first solution would require to align the legally required number of GPs on duty to the expected number of calls at night.

For the second solution, continuity of care is guaranteed and no legal amendments are needed. However, the use of an external triage system would require amendments in the legislation as stated in 2.2.2.



2.4. Consultation by specifically trained nurses

2.4.1. *A solution abroad*

In the Netherlands and in the UK, nurses supervised by GPs perform triage but also face-to-face consultations. Moreover, for minor injuries or illnesses, the UK has nurse-led centres, accessible without appointment.

2.4.2. *What do patients think about nurse consultations?*

The literature shows that patients might be dissatisfied when they expect a consultation with a physician. The authors suggest to provide clear information on the organization of after-hours services to all patients, prior to contact, in order to foster realistic expectations.

2.4.3. *Required legal adaptations for implementation in Belgium*

Today, the competences of nurses are limited by law. Some technical and medical acts are restricted to nurses with a specific qualification. Nurses are competent to assist diagnoses and treatments, but they are not entitled to diagnose or to decide on treatment themselves. Consultation by specifically trained nurses would require legal changes as to the definition of the qualification and the acts that they can perform.

2.5. Phone consultations

2.5.1. *Solution into force in other countries*

In the Netherlands and the UK, specially trained nurses (or practice assistants) can give telephone advice, always supported by (national) guidelines (on paper or computer-based).

In Denmark triage and telephone consultations are solely provided by trained GPs. Financial incentives foster this option and about half of the contacts end up with advice only.

2.5.2. *What do patients think about telephone consultations?*

Some studies show that telephone consultations may be a source of dissatisfaction for patients who prefer a face-to-face consultation. However, other studies and the Danish situation (with a GP on the phone) show that patients appreciate the ease of using the telephone, the speed of response, the advice and reassurance received, with a feeling that they do not waste the doctor's time.

2.5.3. *Required legal adaptations for implementation in Belgium*

Today, GPs can legally perform consultations by phone since they are free to choose the means needed for diagnosis or treatment. It would be useful, however, to elaborate guidelines or protocols setting criteria for the good practice of phone consultations.

If one would consider to give more competences to nurses in the practice of telephone consultations, the legislation on the practice of nursing needs to be adapted as well.

2.6. Recruiting supplementary workforce: who will volunteer ?

Finally, some GP circles also recruit physicians specifically for the after-hours service. This situation is paradoxical: if these "volunteer GPs" do not practice their job with their own patients they cannot benefit from the GP license and accreditation. This service is well appreciated by the GPs who seek help in rural areas but the solution needs an adaptation of the current health care system, to make it more attractive for potential GP candidates and to ensure that patients are cared by professionals with adequate training (either GP or other specific training).



3. POLICY MEASURES TO IMPLEMENT ALTERNATIVE SOLUTIONS

The table below summarizes the policy measures identified in other countries. They allow for ad hoc regional variations taking account of local needs and geographical factors.

POLICY MEASURES ON AFTER-HOURS CARE

STRUCTURE	<ul style="list-style-type: none"> • Development of standardized procedures at national level (budget, care models, protocols) to be adapted according to the local situation • One single regional/national phone number for after-hours care • Involvement of multidisciplinary staff in new models • Specific training of the staff, including communication skills • Support of GP cooperatives in areas upon request of GPs, based on regional planning for an optimal accessibility • Possible integration of GP after-hours services in the hospital, in collaboration with GPs • Evidence-based clinical guidelines for referring and prescribing in after-hours care • Information and communication technology including electronic patient files and online connection to the GP care for efficient information exchange between “office hours” and “after hours” care providers • Budget tailored to an efficient system with possible alternative (mixed) ways of financing: e.g. payment per hour on call of GPs, payment of phone consultations, financial incentives to consult the first line of care (versus emergency department) • Implementation of triage systems (guideline-based and computer-based) for GP cooperatives, emergency departments and ambulance care, assessing the urgency of the patient’s complaint
PROCESS	<ul style="list-style-type: none"> • Supervision procedures if triage by assistants/nurses • Telephone consultations by doctors when suitable

POLICY MEASURES ON AFTER-HOURS CARE

- Registration of patient data: sociodemographic characteristics, problems, diagnosis, additional needs, response to the demand
- Education of patients on the most efficient use of after-hours services

QUALITY ASSURANCE PROCEDURES

- Definition and implementation of national quality requirements and indicators for after-hours services (see possible sources from Belgian research (8.1.2) and UK National requirements at <http://www.out-of-hours.info/documents.php>) e.g.:
 - standards for the time to answer calls, perform clinical assessments and home visits
 - systems for identifying life-threatening conditions
 - indicators for prescribing and referring
 - patient-centered indicators (satisfaction etc)
- Accreditation of organizations providing after-hours care
- Organization of audits

Authors and foreign experts further highlighted some issues to consider when opting for an alternative solution:

FURTHER ISSUES TO BE CONSIDERED

GENERAL ISSUES	<ul style="list-style-type: none"> • Support of new initiatives by the main stakeholders e.g. professional bodies, GPs, authorities
ORGANIZATION ISSUES	<ul style="list-style-type: none"> • Acceptable number of shifts and time schedule tailored to the GP on call
PATIENT SATISFACTION	<ul style="list-style-type: none"> • Information: optimal services according to their needs, components of the service they can expect • Waiting times: reduction and information • Accessibility of care for patients unable to travel



4. CONCLUSION

This report scrutinized the possible alternatives for the organization of after-hours in primary care. The starting point was the care providers' and authorities' point of view. The data have shown that rural areas face a specific problem of workload during after-hours periods. Moreover the current organization is not adapted to slack periods.

Some caveats should be mentioned:

- The perception of the users was out of scope of this research: this information has been summarized from Belgian and foreign studies. However not all points could be covered e.g. the specific problem of access for the minorities and for the users from low social class.
- The report focused on the circles that experience problems. Many GP circles still perfectly function to the great satisfaction of the GPs and their patients. There is perhaps nothing much to do now within these circles provided that:
 - Their system is viable in the long term;
 - The user's interests remain at the heart of their decisions.
- This report did not find the magic bullet to solve the problem according to the type of area but the Belgian data and the literature emphasize that solutions have to be adapted in rural and border areas.

The researchers analyzed the main models implemented in Belgium and elsewhere. Some of them would require legal amendments to be implemented in our country. The literature offers further information on their pros and cons, with respect to one or several specific dimensions at stake. These dimensions requiring an optimal solution are summarized in the table below: it illustrates the issues to be analyzed before implementing any of the models. The ultimate objective is to find a solution, or, more likely, a combination of solutions offering a balanced response for each of the dimensions of the left-hand column of the table.

		Unique call number with triage	Out-of-hours centre	Merge areas during slack periods	Collaboration with local hospital	Phone consultation	Nurse consultation	Volunteer MD
GPs	GP workload							
	Quality of life							
	Security							
	Continuity of medical information							
	Adaptation to the local situation							
Patients	Continuity of care (treatment & feed-back to the GP)							
	Answer to medical & psychosocial needs (e.g. home visits)							
	Waiting time							
	Communication with health professional							
	Accessibility & Security							
	Quality of medical care							
Authorities	Costs							
	Human resources							
	Legislation to amend							

The experience of other countries added further issues to consider, in particular the required standardization of the procedures and the planning of an evaluation based on indicators.

In all cases the future decisions should aim:

- To simplify the access to all patients for services;
- To offer services tailored to the needs,
- To increase the efficiency of the after-hours health care resources, in particular during slack periods.

Finally, one should bear in mind a parallel way to tackle the problem is to increase the attraction of the GP profession and of the after-hours work in particular. Recommendations have been proposed in the KCE report 90 and to prevent the burn-out in the report 165.



■ RECOMMENDATIONS^a

The KCE recommends the development of an action plan in collaboration with all stakeholders concerned to solve the problem of after-hours in general practice. This plan has to take into account the patients' needs, the doctors' desires, the possibilities to collaborate with other health professionals and structures, the capacity of the authorities to meet the expense, the required changes in legislation, the deontological sides and their uniform implementation. Different solutions have to be combined to reach the objective aforementioned, taking into account the current local situations.

For the patient call, KCE recommends bringing a unique call number into general use, which offers the advantages of simplicity for the patient, security for the doctor and the registration of calls for system assessment purposes.

- Define with local interested parties whether the 1733 call should be routed to the switchboard of the local circle for primary care problems or whether a solution should be provided by the 1733 telephone operator whatever the type of problem;
- Legislate on the subject of the legal status of call handlers, their training and competencies and the need for a protocol to underpin their decisions;
- Draw up these protocols (emergency mechanisms, referral to the first line, postponement of consultation, etc.);

KCE recommends the implementation of different solutions adapted to local situations to follow-up calls, in consultation with local circles. There are multiple possibilities, including:

- Merging territories during slack periods, in which case legislation will have to be amended in terms of the population covered by a doctor on call;
- Cooperation agreements with local hospitals during slack periods:
 - the triage modalities will have to be defined between the parties;
 - the existence of a triage system (if other than the 1733 system) will have to be included in the legislation;
 - In any case a contact with a general practitioner (telephone, visit) should be possible.
- Creating organised duty centres:
 - A geographic distribution based on the data currently available must ensure optimum

^a The KCE is the only responsible for the recommendations given to the public authorities



- accessibility for patients that can travel;
 - This distribution should favour areas that have no hospitals to facilitate access to first-line of care, capable of handling the majority of requests;
 - If a consultation by nursing staff is envisaged
 - The qualifications of these staff would have to be regulated;
 - The list of acts that can be performed by them must be reviewed because consultations are currently the exclusive domain of doctors;
 - If telephone consultations are envisaged:
 - Protocols defining the situations in which the service provider can (or cannot) carry out such a consultation would have to be drawn up (see France, Netherlands);
 - If they were to be carried out by nurses, the law and the regulations would have to be amended as explained in the previous point;
- For any type of organisation, the following elements must be taken into account:
- For the patient:
 - Information (media, folder) concerning the efficient use of after-hours services;
 - During after-hours periods, accurate information specifying the optimum service for the problem and what can be expected (including waiting times, accessibility);
 - Possibility of home visits for patients unable to travel (for medical reasons, retirement homes, social reasons). Triage protocols must stipulate as far as possible the circumstances relating to the inability to travel;
 - For GPs:
 - General practice needs to be made more attractive according to the recommendations of the KCE report no. 90 (training and working conditions);
 - After-hours work needs to be made more attractive, especially in terms of working conditions: acceptable frequency, definition of limited working periods, adaptations during illness or pregnancy, measures to ensure the safety of doctors;
 - Definition of a status and the conditions of exercise (training, competencies) for “after-hours doctors” to offer an attractive status and to guarantee the quality of care for patients;
 - Information for doctors concerning the absence of a legal obligation to make home visits during after-hours periods. The home visit option elaborated for the triage



protocols should serve as a general guideline for doctors confronted with this issue;

- **In terms of resources:**
 - Adequate financing if the unique call number solution is extended to the entire country (in particular during the launch, for staff training);
 - During slack periods, efficient solutions should be set up to optimise the use of resources (collaboration and referrals between the first and second lines);
 - Possibility of telephone consultations: to be encouraged and financed where situations allow (50% of calls in Denmark);
 - Standardised financing of organised duty centres, taking into account both the activity and the density of the population;
- **In terms of communication technologies, set up systems (or extend current experimental projects) in order to ensure:**
 - The availability of patient medical record for first- or second-line service providers during after-hours;
 - Information for the usual GPs as soon as they return to work;
- **Routine standardised data collection for each type of service (triage, organised duty centres, emergency services) in order to assess their quality and efficiency, using indicators available abroad (including activities, user satisfaction, financial data).**



COLOPHON

- Title :** After-hours in primary care: which solutions? - Synthesis
- Authors :** Pascale Jonckheer (KCE), Liesbeth Borgermans (Medsat), Cécile Dubois (KCE), Els Verhoeven (FPS Public Health), Emilie Rincharde (independent lawyer), Anne-Marie Baudewyns (FPS Public Health), Toon Haezaert (FPS Public Health), Ingrid Vinck (KCE), Murielle Lona (KCE), Dominique Paulus (KCE).
- External Experts :** Guy Delrée (Association des Médecins Généraliste Famenne-Ardenne), Jean-Paul Devries (Cercle Médical Meuse et Samson), Filip Dewallens (Dewallens & Partners advocatenkantoor), Tom Goffin (KULeuven), Wim Haenen (FPS Public Health), Jan Heyrman (K.U.Leuven), Guido Istas (administrator Domus Medica and GP circle, Sterrebeek), Luc Maroy (National Institute for Health and Disability Insurance), Guillaume Mathot (SSM-J, Jeunes généralistes de la Société Scientifique de Médecine Générale), Igne Parmentier (MG-action), Juliette Renard (FPS Public Health), Roger Renders (Huisartsenkring Deurne-Borgerhout), Yves Rosiers (Federal GP circles council), Jean-François Soupart (Forum des Associations de Généralistes de la Communauté Française de Belgique asbl), Johan Sterkendries (Société de Médecine de Wareme et Environs asbl), Alain Steyers (Fédération des Associations de Médecins Généralistes de Bruxelles), Didier Thillaye du Boullay (SOS Médecins), Marcel Van der Auwera (FPS Public Health), Roel Van Giel (Jong Domus), Michel Van Hoegarden (FPS Public Health), Bernard Vercruyse (Federal GP circles council), Els Verhoeven (FPS Public Health).
- Acknowledgements:**
- For complementary information about Belgian initiatives: Dimitri Gaethofs (general practitioner, Oudenaarde), D. Jonas (call centre 1733, Mons), G. Maraschiello (Fédération des Associations des Médecins Généralistes de la Région de Charleroi), Koen Steel (ODC Brugge), S. Stipulante (FPS Public Health)
- For the data collection and analysis: Marguerite Betermiez (FPS Public Health), Mickael Daubie (National Institute for Health and Disability Insurance), M. Horn (FPS Public Health).
- For their contribution to the draft of the legal part: Vincent Mahieu (FPS Public Health), Xavier Van Caeter (FPS Public Health).
- For her comments on the legal and deontological part : A.S. Sturbois (National Council, Medical Order),
- For the synthesis of the legal part in English : Bureau d'avocats Cairn Legal
- For the validation of the information on their country : Emgan Querellou (Directeur SAMU29 pour le Centre 15 du Finistère, Brest), Isabelle Aubin-Auger (Collège National des Enseignants Généralistes), Linda Huibers (Universiteit Nijmegen), Jo Williams (Quality Care Commission), Cynthia Bower (Quality Care Commission), Sean Boyle (Commission for Social Care Inspection), Lone Flarup (University of Aarhus, Denmark), Christensen Morten Bondo (University of Aarhus, Denmark), Massimiliano Panelaa (Universita degli del Piemonte Orientale « Amedeo Avogadro » Dipartimento di Medicina Clinica E Sperimentale, Italia)
- For their valuable help and support : Anja Desomer (KCE), Stephan Devriese (KCE), Luc Hourlay (KCE), Christian Léonard (KCE), Stefaan Van De Sande (KCE)



External Validators : David Robert Dunt (University of Merbourne), Pascale Meeus (National Institute for Health and Disability Insurance), Hilde Philips (University of Antwerp)

Conflict of interest : None declared apart from a membership to GP organizations or institutions involved in the organization of after-hours services (cf. mentions above)

Layout : Sophie Vaes, Ine Verhulst

Disclaimer :

- **The external experts were consulted about a (preliminary) version of the scientific report. Their comments were discussed during meetings. They did not co-author the scientific report and did not necessarily agree with its content.**
- **Subsequently, a (final) version was submitted to the validators. The validation of the report results from a consensus or a voting process between the validators. The validators did not co-author the scientific report and did not necessarily all three agree with its content.**
- **Finally, this report has been approved by common assent by the Executive Board.**
- **Only the KCE is responsible for errors or omissions that could persist. The policy recommendations are also under the full responsibility of the KCE**

Publication date : January 6th 2012

Domain: Health Services Research (HSR)

MeSH : Family Practice ; After-Hours Care; Primary Healthcare

NLM Classification : W 84

Language : English

Format : Adobe® PDF™ (A4)

Legal depot : D/2011/10.273/89

Copyright : KCE reports are published under a “by/nc/nd” Creative Commons Licence
<http://kce.fgov.be/content/about-copyrights-for-kce-reports>.



How to refer to this document ? Jonckheer P, Borgermans L, Dubois C, Verhoeven E, Rinckard E, Baudewyns A, Haezaert T, Vinck I, Lona M, Paulus D. After-hours in primary care: which solutions? – Synthesis. Health Services Research (HSR). Brussels. Belgian Health Care Knowledge Centre (KCE). 2011. KCE Reports 171C

This document is available on the website of the Belgian Health Care Knowledge Centre

