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ORIGINAL RESEARCH ARTICLE

Are the New General Practitioner Plus Centers the Correct Government Response to a Lack of Pediatric After-hours Care for Parents?

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Providing timely and appropriate primary health care after-hours is a major policy issue confronting many Western governments. Increasingly, consumers are seeking care from emergency departments, for health problems that would be better serviced by a primary care professional. Mindful of this issue both State and Federal government in Australia have established and funded General Practice Super Clinics to provide after-hours care in low socioeconomic areas for vulnerable populations. A key policy requirement of funding is the provision of after-hours care. This paper takes a case study of parents seeking after-hours, non-emergency care for their sick child. This study illustrates the way in which GP Super Clinics provide an appropriate response to this issue, but the analysis questions whether or not this can be achieved under the current arrangements.

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INTRODUCTION

When a child is sick it is both traumatic and distressing for parents. Parents believe they need to access health services quickly. This paper reports on research that investigated why parents take their sick child to the emergency department (ED) of a large public hospital, when a primary care service such as a family physician or general practitioner as they are called in Australia would be more appropriate. The study was conducted in Adelaide, South Australia, and focuses on non emergency presentations to the Women's and Children's Health Network (WCHN) emergency department (ED), the State's only paediatric public tertiary hospital. The parents claimed that a lack of after-hours services led them to use the ED for non-emergency care. The paper begins with an overview of the Australian public health care system focusing on the provision of primary care. A thematic analysis taken from narrative transcripts of parents follows. This section outlines the parent's reasoning for the care decisions they make for their child. In the final section we comment on the capacity of the newly established General Practice Super Clinics to reduce presentations to ED and meet the needs of parents with a sick child.

THE AUSTRALIAN CONTEXT

Public health care in Australia is provided through Medicare, a universal insurance system. Under Medicare, General Practitioners/family physicians (GP) are paid by the Federal government through a rebate scheme for all services. As fee for service private providers, GP are not required to deliver after-hours care. Public hospitals, including emergency departments (ED) are funded by the State and territory governments, with tied funds from the Federal government. This funding arrangement can result in considerable cost shifting between the Federal government and the States (Commonwealth of Australia, Medicare Australia Act, 1973 amended 2008; Howard, 2003). For example, when consumers seek hospital care for what is ostensibly a primary care event; the costs are born, by the States, rather than the Federal government, if they seek treatment directly from their GP, this is reimbursed by the Federal government. The difficulty for the States and territories is that under the Medicare Australia Act they are required to provide free and timely care to all eligible citizens so that those who present at an ED must be seen and treated free of charge (Medicare Australia Act 1973, amended 2008). However, the Medicare Act does not require General Practitioners (GPs) to provide free access to primary care. As a consequence many GPs may charge a co-payment or gap fee directly to patients for services provided (Medicare Australia Act 1973, amended 2008).

THE GENERAL PRACTITIONER SERVICES IN AUSTRALIA

General Practitioners (GPs) or family physicians are the key providers of primary care services in Australia and as such influence both the cost, distribution and supply (Hall & Van Gool, 2000; Baker, 2011; Woodruff, 2011). While private providers or small

businesses, they are paid by the Federal government on a fee for service basis for all primary care medical services (Medicare Scheduled Rebate). Access to specialist medical services, such as a surgeon is only through a GP referral (Baker, 2011). GPs can either charge the patient a gap fee, the scheduled fee set by the Federal government or bulk bill¹. Where GPs charge the scheduled fee the patient pays 15% of the costs, where the GP charges above the schedule fee, the patient may pay considerably more, although there are limits on the patients' out of pocket expenses. If the GP bulk bills the patient only pays 85% of the scheduled fee set by the Federal government. GPs determine the geographical area of their private practice and the amount of gap fees charged to the consumer (Hall & Van Gool, 2000), although there are financial incentives for them to set up practices in remote, rural and outlying suburbs, and to bulk bill, especially in the case of children and for those on welfare.

The shortages of GPs in remote, rural and outer suburban Australia creates regional monopolies as these GPs are self employed practitioners with no, or restricted competition. This gives these medical practitioners the significant advantage of charging gap fees strengthened by medical shortages, professional dominance and limited alternatives for services (Kenny & Duckett, 2004; Baker, 2011). Further, there is an inverse correlation between need and length of consultation time, with those requiring more services due to poverty and chronic illness receiving less time, less prevention and lower rates of referral to specialists (Furler et al., 2002; RACP, 2005). This creates a significant disparity in health access between rural and urban populations (Kenny & Duckett, 2004). Furthermore, within urban populations there are access disparities. For example, outer suburban areas have limited health access as GPs are less likely to set up practices in areas of low population density, among low socioeconomic groups or in areas with few community resources, given that their income is dependent of a fee for service model (Public Health Information Development Unit, 2006).

EMERGENCY DEPARTMENT UTILIZATION RESEARCH

There has been considerable research on what is termed 'inappropriate' use of Emergency Departments (ED) for primary care. Internationally research indicates that the chronically and mentally ill and /or the poor are more likely to seek non-urgent (primary) health services in hospital emergency departments than other population groups (Savage, 2003; Glover, Hetzel & Tennant, 2004; Lega & Mengoni, 2008; Shah & Cook, 2008; Baker, 2011). In Australia, children 0-5 (23%) and adults over 60-80 (14%) years use ED for primary care (PC) at higher rates (44%) than other population groups (Siminski et al., 2008). The reliance on inconsistent, ill-timed and haphazard health access increases the likelihood of these populations, such as children, having exacerbations of illness and a higher frequency of acute episodes requiring further admissions. This is especially

¹ Bulk billing is a term referring to the practice by GPs of accepting the Medicare Scheduled Rebate fee from the Federal government as the sole payment for a service rather than the additional cost of a gap fee. The gap fee or co-payment fee is an out of pocket fee incurred by the patient.

important in the provision of timely and consistent health care for children, due to the developmental milestones that may be delayed due to ill health (Wadsworth & Butterworth, 2006). In addition, parental factors such as stress, anxiety, and previous health services use are thought to inform patterns of familial health service usage (Janicke, Finney & Riley, 2001; Janicke & Finney, 2003). This US research found that patterns of health care use commence in childhood and are the best predictors of future health services use patterns (Janicke, Finney & Riley, 2001; Janicke & Finney, 2003).

Hastings et al. (2008) and Suruda et al. (2005) highlight the influence of socioeconomic status as a significant predictor of ED services. Although these two studies were conducted in the UK and US respectively, the results are important as they illustrate factors outside the family that determine, and are used to predict, ED usage. Both studies used attendance data, socioeconomic data, social demographic figures such as neighborhood income, and health insurance provisions as predictors of ED utilization. These studies found that poor health predicted ED use and deprivation increases ED use. However, the reliance on ED for the provision of care for children is not straight forward, and may not be directly linked to chronic illness, lack of knowledge, or socioeconomic status, but rather to a lack of out-of-hours services (Baker, 2011) along with the fact that the sudden onset of illness in children is unpredictable, and may have long term deleterious health outcomes (Peacock & Peacock, 2006). These circumstances impacting on ED use point to an over use of ED by both adults and children that is unsustainable and ineffective for most developed nations (Kenny & Duckett, 2004).

TRIAGE PRIORITY

In Australia, all presentations at public hospital emergency departments are subjected to a process of prioritization, using the Australasian Triage Scale that consists of an evaluation of the patients' condition to assess the level of urgency required for treatment (Commonwealth Department of Health and Family Services, 1997 reviewed 2006 [CDHFS]). This scale rates clinical urgency in hospital-based EDs across Australia and New Zealand (CDHFS, 1997). It was developed to assess the need for immediate clinical intervention and determine performance parameters for patient flows in ED. Patients are assessed on arrival by an appropriately trained triage registered nurse who monitors their clinical signs and progress through ED (CDHFS, 1997). Triage identifies patients needing immediate clinical attention and patients that can wait. The patient's condition is assessed using a priority rating of between 1 to 5 with Priority 1 determining 'very urgent' clinical intervention, for example an abnormal vital sign such as heart rate, and treatment at level 5 condition being able to wait 120 minutes or longer (CDHFS, 1997; van Veen, Steyerberg, Ruige, van Meurs, Roukema, van der Lei & Moll, 2008). Priority 4 and 5 indicates a presenting condition that could wait to be seen for 2 hours or more and this often indicates a condition that could be treated by a primary care service such as the local GP.

At the Woman's and Children's Health Network [WCHN] all triaged presentations are recorded at the ED. Analysis of all presentations between October –December 2007 and 2008 indicated an increase in the rates of attendances for triage levels 4 and 5 from 10,822 (2007) to 11,262 (2008). During this period, the increase in priority 5 was 64.8%. These

increases were statistically significant (Parry, 2012). All presentations at the hospital for this period were categorized by postcode with 46.9% of parents residing in the lowest socioeconomic areas as defined by the Australian Bureau of Statistics (2011). This suggests poverty or deprivation continues to be a possible influencing factor in the use of paediatric ED for primary care.

METHOD

Study Design

The larger study employed a mixed method approach to examine what factors led parents to use the ED in preference to primary care services for their sick child. A qualitative narrative inquiry was used in order to illuminate the quantitative data that reported on increased use of priority 4 and 5 presentations in the larger study. Mixed method research designs are used to answer “the what and how” questions of a research project (Woolley, 2009; Pluye, Gagnon, Griffiths & Johnson-Lafleur, 2009). In the larger study, the mixed methods approached comprised the Hospital Admissions Status (HAS) ED quantitative data which is the WCHN administrative and clinical data set that supplies information on the types and rates of service usage, and an analysis of the South Australian Social Health Atlas (Glover, Hetzel, Glover, Tennant & Page, 2006) demographic and epidemiological data, that provided an understanding of the families’ access to services (rates of GP service provision, income – demographic) and the severity of illness (triage priority) (epidemiological). The qualitative data were provided through narrative parent interviews, a focus group with a culturally and linguistically diverse mothers’ group (CALD), interviews with ED staff, and community service providers.

Sample Selection

Eighteen parents were interviewed using this method of narrative inquiry. All eighteen mothers accessed the ED in 2009 for primary care services for their children. All the children were assigned a priority 4 or 5 triage score indicating that ideally care should have been provided by their local GP.

Analysis

This paper reports on the narrative inquiry used by the researchers asking the participants to tell their story. The stories that emerge are examined within the context of how the participants are situated in their social world and what sense they make of this world given its various socio-political layers (Kohler Riessman, 2002; Czarniawska, 2004; Lieblich et al., 1998; Daiute & Lightfoot, 2004). Narrative interviews and thematic analysis enable the researcher to gain insight into how the participants, in this case, the mothers, make sense of their child’s illness and their decision to use the ED. The collection of many

stories or narratives of similar events allows the researcher to sift through these stories in order to discover recurring patterns and themes (Kohler Riessman, 2002). In order to ensure a consistency of themes, narratives should be drawn from participants from similar social milieus (Bertaux, 1995; Kohler Riesman, 2001).

In the narratives retold below the parent's s convey the trauma and drama of having a sick child and the events that led them to taking their child to the ED for a condition that was primary care in nature which in other circumstances should have been treated by their local GP. These parents also describe previous episodes when their child was sick and what factors in that situation influenced their decision to use the Women's and Children's Emergency Department for conditions triaged at priority 5.

Each interview was transcribed verbatim. After reading each transcript a summary of the interview was prepared by the first author and common stories were identified. These common stories explored the events and explanations for several health access occasions providing a categorical content perspective (Lieblich et al., 1998, p 113). These summaries were then analyzed to explicate parent's conceptualizations of their child's journey through the health care system. Six major themes were identified in the narratives using the content analysis as described in 'A model for the classification and organization of types of narrative analysis' in Lieblich, et al (1998, p 12). While this approach identifies recurring stories, it does not seek to quantify the number of accounts. These were; i) A lack of GP services, ii) Children are a specific health consumer group, iii) Locum GP services not available, iv) Familial differences in health service use, v) The implications of constructions of being a 'good' parent, and vi) The cost of attending a GP. This paper only focuses on the theme of 'lack of GP services'. This theme was divided into two; firstly, lack of Out-of-hours care services by general practitioners and secondly, too few GPs per head of population. Both themes suggest that parents had no alternative but to take their child to the ED.

Measurement

The eighteen participants interviewed were categorized according to their socioeconomic status given that the research indicates that the majority of priority 4 and 5 ED attendees are from low socioeconomic populations and that the major rationale is linked to deprivation (Savage, 2003; Glover, Hetzel & Tennant, 2004). Identification of their address also provided information on GP coverage per area (Table 2). Socioeconomic status was measured using the Socio-Economic Index for Areas (SEIFA) score (ABS 2006). The SEIFA score is a nationally derived indicator of deprivation using a 17 item measure of each postcode area's affluence (ABS, 2006). The SEIFA Index of Relative Social Disadvantage (IRSD) is divided into quintiles, with the lowest quintile representing the highest levels of deprivation and social disadvantage.

Table 1 below places each of the seven mothers quoted (de-identified) (e.g. family 1 was the first family interviewed) in this paper into a socioeconomic category and indicates each family's access to GP services (Table 2) and their levels of deprivation using the SEIFA IRSD score with a higher score indicating low levels of deprivation and a low score

indicating higher levels of deprivation. Table 1 shows that not all mothers interviewed came from the highest levels of deprivations. For example, nine families were living in areas of high socioeconomic status according to the SEIFA IRSD postcodes. Further, Table 2 illustrates the relationship between SEIFA IRSD scores and the provision of GP services. The mothers participating in the study have been assigned pseudonym and are listed in the table. This allows the reader to identify their SEIFA IRSD score e.g. Mary lives in SEIFA IRSD area code 1 in the lowest SEIFA IRSD quintile.

Table 1

Area of Family by the Numbers of Population Per GP and Area SEIFA IRSD Quintile Score (Families from Areas of the Highest Pediatric ED Use)

Family Code	Total	SEIFA IRSD Area Code	Quintile	Comments
1, 2, 14, 15, 17, Margaret, Mary	5	1	Lowest (highest levels of deprivation)	Family 1 not fully employed, family 2 single parent family
6, 10, 16, Cali, Nickie and Geoff	3	2	Low	
13	1	3	Middle	
		4	High	
3, 4, 5, 7, 8, 9, 11, 12, 18 Katie, Kris	9	5	Highest (lowest levels of deprivation)	Family 5 is a single parent family living in a highest SEIFA IRSD quintile area.

Ethics

This research received ethical approval from Flinders University, Social and Behavioral Research Ethics Committee, 4409, and the Women's & Children's Health Network (WCHN), CYWHS REC2156/3/12, before proceeding.

RESULTS

A Lack of GP Services during Weekends

In the telling of their story all the mothers suggested that they used the WCHN ED as there was a lack of GP access for unplanned and after-hours services in their area. This was regardless of their socioeconomic area or family circumstance. The following stories by Cali and her husband, Garwood illustrate this issue.

Cali, Garwood, and son Freddie lived in a semi-rural, low SEIFA IRSD area, approximately one hour by road from the WCHN ED. The three bedroom old family home

was situated on a 20 acre block with almond trees. They had few neighbors (geographically speaking) in this predominately market garden area. Although they did not have many close neighbors, and no immediate family, they had many close family relatives such as cousins, friends, and neighbors for assistance and support when they needed it. However, the isolation from services is a salient point and it is interwoven throughout the narrative. The distance to health care and the very limited hours of GP service provision is highlighted most starkly by Cali. She explained why she went to the WCHN ED (commonly referred to as the Women's and Children's) after-hours. She provides an insight into the lack of GP access including the lack of after-hours locum access. This example also demonstrates how the experience informs future health access.

... by this stage it was Saturday evening because of this, well we rang the GP. We didn't have access to our local services because our doctor closes at midday, 1pm on Saturday, and so we thought the next best option is the Women's and Children's. They're experts in child health care, so that's how we changed to them, that was on the Saturday and then they asked us to come back for a follow-up appointment on the Monday. The other one the other time we used the Women's and Children's would be back in March or April, when Freddie decided to bungee jump off the bed ... And it was on a Saturday afternoon, so we don't have a locum service available here, There is no locum doctor that will come here. I guess because of our isolation or limitation in health provision I'm not sure, but, no, we don't have a locum practice that's available to us (Cali).

One of the main reasons parents use the WCHN ED is a lack of alternative services in their area on weekends and after-hours. Cali's family lived 36.5 kilometers from the hospital so there is considerable cost and time involved in attending the city based hospital. In this semi-rural area the small population of 1682 residents (ABS 2006) is one reason for the lack of services as it is not cost effective for GP to open for extended hours. This means that for unplanned, urgent, emergencies and after-hours care, parents need to seek care at the WCHN ED as it is the only alternative.

Cali also states 'so that's how we changed to them' indicating that this scenario has influenced her future choice in health access for her child, although she also acknowledged the low population as a reason for the lack of after-hours GP services. This experience initiated a change in her future health seeking behavior, so that she uses the ED as a matter of preference.

Too Few General Practitioners (GPs) Per Population

Cali's story focuses on the lack of after-hours GP services in outer metropolitan areas; however, it does not explain the lack of services in highly populated areas identified in the next story. A number of families interviewed living in highly populated areas claimed they

also lacked access to GP services. The limited GP service provision was both during business hour (Monday to Friday 8.30 am to 6 pm) and after-hours. This presents another issue for parents trying to access primary care for their children when there are too few GPs to population. The extract from Margaret's interview demonstrates that even in areas where there is a high population there is a lack of GP and after hour's services.

Margaret has five children, three live at home with her and her husband, Donald. The two youngest children have severe disabilities that require ongoing assistance. One child has autism and becomes very distressed with strangers in the house so this interview was conducted over the telephone. At the time of interview her husband, Donald was earning approximately \$45,000 per annum and the family relied on a careers allowance to help them make ends meet. Their home is in a newer housing division less than 10 years old. The area is one of the lowest SEIFA IRSD areas in South Australia. Margaret was very forthcoming and showed considerable insight into the health system, which she said, was due to her ongoing and extensive use. Four of her five children have ongoing health issues.

In the narrative below Margaret identifies the lack of services. She explains that this is the result of the high ratio of population to the low numbers of GPs. Margaret spoke in general terms rather than her specific needs at this point, and provided useful insight into the needs of this lowest SEIFA IRSD area where illness rates are higher (PHDIU, 2010). In this area, there are 2,529 people per GP (Tennant, 2009; PHDIU, 2010). This differs from the Cali's family, where the ratio of GPs to population was 1,106 people per GP. Lack of access to GP services may occur in both low and high population areas.

The doctors here are doing the best they can (pause) but the area has grown so rapidly, the amount of people living in this area now is 4,000 people and now 350 new houses are being built and another 500 to be developed and there can be 4-5 people per house ... They have a Nurse Practitioner clinic in the shopping centre, they're great with diabetes and stuff and they are very busy but you can always get in. The locum service here is only half time at 4 and ½ hours overnight [coverage of the locum service], for a GP appointment [for a child] you can wait 4 days. I can wait up to 3 weeks. I don't want to burden them [GP] so I go as little as possible. Our last doctor had to leave and set up a practice where it's less busy. I should go regularly to keep an eye on my health but it's hard to get in (Margaret).

Margaret is aware of the strain placed on the GP by the lack of other services or other GPs in this growing housing development area. The growth in this area is not supported by the provision of health services thus new families buy into an area that is inexpensive but does not have access to GPs, immunization clinics and other community health services needed by young families. Margaret reasoned that using WCHN ED alleviates some of this pressure on the GP. She said she delays attending the GP for her own health, as the GP is too busy although, she does have the option of using a Nurse Practitioner clinic for health checkups.

The content analysis of the transcripts illustrated the extent of this issue. Other parents living in the inner suburban areas also noted the lack of GP and after hour's services. This is illustrated by the quotations below from Nickie, Geoff, Katie, Kris and Mary. The last two quotes by Katie and Kris are significant, living in an area that has a high ratio of GPs to population at 1 GP to 659 persons (See Table 2).

... he [son] started coming down with something (pause) a high fever, and he was unwell and nothing was open so we took him back [WCHN ED] ... the doctors around here are only open between 9[am] to 5.30[pm]... we have no locum services that comes around here (Nickie and Geoff).

... normally it's the GP but if the GP is busy or not open then it's the Women's and Children's emergency (Mary).

... he [son] had a high temperature ... nothing is open after-hours and our GP is shut on a Wednesday as well ... I mean our GP is great with the kids but his hours are limited and I didn't want to wait for the locum (Katie).

... unless it is an emergency we would always use the GP... but if it is after-hours, our GP is open eight-fifteen until six or seven o'clock at night, through the day. And it's eight until twelve on Saturday mornings. We have a locum but the time we needed it [locum service], we needed to wait four hours for the locum to arrive and you are put on a list and if the others in front of you take longer, then you wait longer (Kris).

These narratives illustrate the difficulties parents have in accessing unplanned care when there is a lack of GP services available in their area irrespective of population. The provision of services occurs through several processes that are linked to the socio-political constructs of health service provision.

Lack of Services rather than Deprivation Explains ED Use for Primary Care

The lack of primary care services provision was the major recurring theme in all the interviews. All parents interviewed, regardless of their SEIFA IRASD area score highlighted the lack of GP or alternative health service provision as a major influence on their use of WCHN ED for primary care. This limited availability of services impacts on familial patterns of health access with different family members using different services, for example, parents will take their child to the WCHN ED, but wait several weeks to see a GP for their own health care needs.

The use of ED for care that constitutes primary care that could be provided in the community overburdens ED services (Bradley 2005). Rather than deprivation, including the cost of primary care (Lu, Leung, Kwon, Tin, Doorslaer & O'Donnell, 2007), and a limited knowledge of health care alternatives to ED (Lega & Mengoni, 2008; Stein, Andersen & Gelberg, 2007; Adamson, Ben-Shlomo, Chaturvedi & Donovan, 2003; Roberts & Mays, 1998), this study found a lack of primary care service provision explains the seemingly 'inappropriate' use of pediatric ED.

The families interviewed demonstrated differing patterns of health access between family members. As noted, parents usually use the GP, even when the only available appointment may mean a seven day wait. However, parents are of the view that access to health care for their child must be prompt. They are aware that what may appear a minor ailment in an adult, such as a temperature, may escalate in a child and so seek immediate care. Given that some GPs in their areas had no appointment spaces and were booked for up to three days in advance, these parents took the only option available to them and took their child to the Emergency Department. Children's access to a health service is often determined by the availability of immediate services, and previous experience. If parents have had to seek care from the Woman's and Children's hospital in the past due to lack of services in their region, they are more likely to continue to do so when their child has another illness event. Parents also noted that they were aware, that if they failed to seek care for their child, others may perceive them as negligent. This also motivated their behavior.

General Practitioner Plus and Primary Care

Both the Federal and State governments are aware of the issue of uneven distribution and lack of GP access, and have responded through the funding of GP Plus and GP Super Clinics. These Federally, and in the case of South Australia, State government funded public health initiatives are designed to address the deficit in health services, by providing increased access to health and support services in areas of most need. The clinics provide primary, nursing and allied health care professionals, delivering a variety of health and primary care needs and reduce patient time through the provision of diagnostic services. The GP Plus centers are a State government initiative drawing on the 'old community health centre' model of service provision at the local level and are governed via regional health services. In both the GP Plus and Super clinics the medical services are conducted as private for-profit practices with Federal funds reimbursing the GPs. Federal or State grants provided directly by the Federal or State governments for the employment of allied health professionals and nurses.

In the original proposals for GP Plus and Super Clinics the aim was to establish one centre to every 100,000 population (SA Health Department 2007), with proposals for after-hours and seven day week operating hours. Country centers would also provide overnight beds. Four centers are already operational south of Adelaide at Marion (SEIFA IRSD, low quintile), Aldinga (SEIFA IRSD, low quintile), in the west at Woodville (SEIFA IRSD, low quintile), and the north Elizabeth (SEIFA IRSD, lowest quintile). The GP Super Clinics

operate under a similar model (Table 2). Under the agreement with the Federal government they are also required to provide after-hours services (Roxon 2010) and extended hours of services for allied health professionals (8am -10pm) (Department of Health & Ageing, 2009). Like the GP Plus Centers, the Super clinics provide the possibility for privately operated general practice services to co-locate to the clinics providing integration with existing privately run services (ACHSM, 2011).

Table 2

Area of GP Plus and GP Super Clinics by the Numbers of Population Per GP and Area SEIFA IRSD Quintile Score

Area of the GP Plus/Super Clinics	The Number of GPs Per Head of Population	SEIFA IRSD Quintile Score for the Area 1-5
Aldinga	1 GP per 2,462 people	Low = 2
Marion	1 GP per 2,142 people	Low = 2
Munno Para/Playford North	1 GP per 2,883 people	Lowest = 1
Elizabeth	1 GP per 1,687 people	Lowest
Modbury	1 GP per 2,762 people	High
Noarlunga	1 GP per 4,585 people	Lowest
Port Pirie	1 GP per 1,262 people	Lowest
Woodville	1 GP per 2, 022 people	Lowest
Ceduna (rural)	1 GP per 906 people	Low

The major flaw with the design of both the State and Federal super clinic models is that there is an expectation of cooperation and collaboration with other existing private-for-profit health services in an area. This is a naive approach, given that the GP Super clinics will compete with scarce, but existing GP Services, diagnostic services, including other very large clinics run by GP corporations. For example, the South Australian Government briefing paper notes:

It is not the intention of GP Plus Health Care Centers to be set up in competition with general practice, private allied health services or local pharmacies. It is also recognized that some large corporate general practices may already be providing extended services to their patients (South Australian Department of Health 2007, p. 11).

As a consequence of these contradictions, the agreements between the Super clinics and the local GPs in private practices allow the local GP population to prevent GP Plus and GP Super Clinic GP from providing competitive services during the 9 am to 5pm time slot or normal GP's working hours, despite the fact that these services may charge a significant gap fee, and do not have the capacity to see children in a timely manner. Table 2 highlights that the placement of GP Plus and Super Clinics are in areas of high need and limited GP provision well below the State average of 1.86 GPs per 1000 people (ABS, 2006).

Interviews with service providers at the GP Plus centers indicated that while they can provide after-hours services, patients cannot book an appointment, and clinics have difficulty finding GPs to offer these services during the after hour time slots (Schriever, 2012). In short, the very issues that explain the lack of GP private services that existed in these suburbs, continues to exist in the super clinics. Negotiations by both Federal and State governments continue to perpetuate the lack of services as the new GP Plus and Super

Clinics cannot provide additional services that compete with the GPs in private practice. Services can only be provided when the other private practices are closed. This means the Super Clinics can only offer GPs after-hours, when the private services are closed. Sadly, building a Super Clinic does not deal with GP shortages or lack of alternative services.

The use of GP Plus and Super Clinics could extend the services provided by other health professionals, such as Nurse Practitioners and Physiotherapists. There is capacity within the GP Plus and Super Clinic models for extended practice for nurses and allied health professionals as well as paramedics (SA Health Department, 2007). It would be possible to extend primary and emergency services at the suburban level by allowing nurses, and paramedics to take up an extended role. While there have been some tentative trials in extending the role of paramedics, this proposal will also come up against objections from local GPs in private practice. Thus, the existing GP practices have prevented the implementation of a variety of health services that could meet consumer's needs. Similarly, the GP Plus model proposes telephone health information services (SA Health, 2007). The mothers interviewed for this research found that these services were useful for general child rearing information, but not so when they needed advice on urgent unplanned care. There was also a tendency for parents from low socioeconomic areas not to use the phone services or to be aware of them.

DISCUSSION AND CONCLUSIONS

Previous research on the use of EDs by parents has concentrated on quantitative data sets and surveys of parents waiting in ED (Janicke, Finney & Riley, 2001; Janicke & Finney, 2003; Bradley, 2005; Coughlan & Corry, 2007). This process has not allowed for the exploration of several episodes of health care access, or allowed the parents to reflect on the availability of services to treat children. Further, the research by Janicke, Finney and Riley (2001) and Janicke and Finney (2003) states that patterns of use that commence in childhood are predictors of future health services use patterns. This is consistent with the parent's accounts offered here, although it should be noted that they made several attempts to find local services before taking their child to the Woman's and Children's hospital and that the decision to do so was not simply a matter of individual deprivation. It is also about availability, or deprivation of the suburb.

This research has also highlighted that the factors influencing parents' decision making are structural. The policy directives and negotiation between government and GPs has determined the level of primary care provision available for parents. The parent's narratives and quantitative data of the number of GP services per population illustrate the dearth of services that are available and suitable for children. Parents are caught between needing to have their child seen quickly due to the unknown nature of the illness, and a lack of accessible and appropriate service provision in the suburbs. They have no alternative than to take their child to the Emergency Department.

The use of services which address the needs of children in a preventive, timely and appropriate fashion is needed to circumvent deleterious health outcomes. This is achievable by ensuring the access for children is free and prompt. While ED provides this, it is

designed to address short term acute health issues. The development of alternative health services such as GP Plus and GP Super Clinics has the potential to address the overuse of ED for primary care and provide parents with alternatives to ED. However, the alternatives need to cater for children directly not as an adjunct service and the services need to be available when children are ill, and to be free. As demonstrated above, it is unclear as whether the GP Plus and GP Super Clinics will provide these requirements.

While this study exposes some of the policy flaws in the establishment of the GP Super clinics, it is not without limitations. Like all qualitative studies the views of the 18 families interviewed are not necessarily representative of all of those using the WCHN ED service, and in this paper only seven story fragments are reported. This is due to issues of word limitations. The eighteen mothers interviewed did not all come from low SEIFA IRSD areas and hence were not representative of the populations using ED for triage 4 and 5 presentations. The study has also focused on children. Many health professionals would regard children as an atypical case.

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