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The NSW Single Front Door: Transforming Access to Healthcare

Introduction

The NSW Single Front Door (SFD) initiative represents a significant strategic reform aimed at enhancing the efficiency, accessibility, and integration of the state's health system. Developed in response to increasing demand on emergency departments (EDs), persistent health system fragmentation, and the growing role of digital health, the SFD is designed as a navigation tool that connects people to the right care at the right time.

Health systems worldwide are shifting toward models that prioritise person-centred, timely, and coordinated care as a means of improving outcomes while containing costs. The SFD aligns with this global direction, seeking to deliver value by reducing unnecessary hospital use and improving the user experience, especially for lower acuity presentations. It plays a critical role in bridging the gap between hospital services, virtual care innovations, and community-based providers such as general practitioners (GPs) and allied health teams.

Importantly, the SFD is not a standalone service but a system-wide integrator that leverages existing infrastructure to guide people more effectively through their care journey. By reducing duplication, streamlining triage, and targeting high-demand pressure points, the SFD strengthens health system resilience and sets the groundwork for longer-term reform, including more equitable access and better health outcomes.

This paper focuses on the barriers and enablers to implementation of this model for consumers, primary care providers and mental health services.

What is the NSW Single Front Door?

The SFD is a 24/7 telephone and digital health assessment and navigation service, delivered by Healthdirect Australia. By calling 1800 022 222 or accessing the online service, NSW residents speak with registered nurses who use clinical decision-support tools to assess symptoms and direct people to the most appropriate care pathway.

Launched in 2022 under the NSW Government's $124 million Emergency Department Relief Package, the SFD is part of an evolving model of care that links people with:

- GP and nurse-led virtual care services
- GP Urgent Care Clinics
- Community-based primary and allied health
- Hospital virtual EDs and outpatient services
- After-hours GP clinics and home visiting doctors
- Mental health support (forthcoming expansion)

The focus is on managing lower acuity health needs in non-hospital settings. Critically, the service does not replace emergency services. People requiring emergency care are still directed to call 000 or attend EDs. There will need to be communication and system change processes established and implemented to ensure effective linkages with the soon to be established 1800 Medicare line.

Why is the NSW Government dDoing tThis?

The decision to implement a Single Front Door model in NSW is underpinned by multiple drivers. First and foremost is the overcrowding of emergency departments, which continues to be a critical issue

across metropolitan and regional hospitals. Rising presentations—many of which are low-acuity—place strain on ED staff, increase wait times, and delay care for those with more urgent needs. According to Bureau of Health Information reports, only 60% of patients in some NSW hospitals are seen on time, and this figure worsens during influenza seasons or major public health events.

Secondly, there is growing recognition of the need to help consumers navigate a fragmented system. People often report confusion about where to go for care, especially outside of normal hours, or if they do not have a regular GP. This contributes to inefficient service use, health inequity, and patient dissatisfaction. The SFD provides a clear pathway, supported by trained clinical staff and decision-support tools, to match a person's health needs with system capacity.

Thirdly, the government is committed to increasing uptake of digital health and virtual care models. These services offer flexible, scalable, and cost-effective ways to manage population health needs, particularly in remote areas or for people with mobility issues. The SFD helps accelerate adoption by serving as a bridge to these innovations.

Linkages to Existing Services

Rather than duplicating or replacing existing health services, the NSW Single Front Door (SFD) is designed to enhance system integration and streamline access to a broad range of care options already available in the community and hospital system. By acting as a centralized triage and navigation point, the SFD connects people to the most appropriate service based on acuity, need, location, and availability.

Key linkages include:

- Virtual Care Services: The SFD connects consumers to state-funded virtual services such as VirtualKIDS and VirtualADULTS, enabling people to receive timely, real-time care at home. These services reduce unnecessary hospital visits by providing clinical advice, prescriptions, and care escalation plans.
- General Practice: Where appropriate, the SFD redirects consumers to their usual GP for continuity of care. If a person does not have a regular GP or cannot get an appointment, the system can search for available GPs, including bulk-billing or after-hours providers.
- Urgent Care Services/Clinics (UCCs): These clinics provide accessible, GP-led care for non-life-threatening conditions. The SFD helps direct suitable individuals to these clinics to relieve pressure on E.Ds.
- Mental Health Services: The Mental Health Single Front Door, currently under development, aims to offer targeted triage, safety planning, and links to crisis and community mental health services.
- HealthPathways and Referral Systems: The SFD is designed to align with HealthPathways and local referral networks, offering consistent clinical guidance and streamlined transitions between services.

Barriers for Consumers

Despite its many strengths, the NSW Single Front Door faces significant consumer barriers that may undermine equitable access and overall uptake. These challenges must be proactively addressed to ensure the SFD meets its objectives and serves all segments of the community. Challenges include:

- Low Awareness: Many people remain unaware of the SFD, especially those not actively engaged with the health system. Public awareness remains low in multicultural and newly arrived communities.
- Digital Exclusion: Internet access and digital literacy are needed to use online SFD services. Vulnerable groups such as older adults or rural residents may face challenges.

- Lack of Health Literacy: Accurately describing symptoms and understanding triage outcomes can be challenging for people with limited health literacy, affecting confidence and trust in the system.
- Trust and Preferences: Some consumers prefer in-person care or feel safer attending EDs directly. Cultural norms and generational views may also influence preferences.
- Out-of-pocket Costs: While many referrals are to public services, some result in fees or copayments, creating barriers for low-income or uninsured consumers.

Challenges for Primary Care Providers

The shift of patients from hospitals to community and primary care settings is a central premise of the SFD, but it places considerable pressure on general practice. General practitioners are already facing increasing demand due to population growth, chronic disease prevalence, and workforce shortages. When the SFD redirects patients away from EDs toward primary care—particularly at short notice or for urgent appointments, it can create further bottlenecks and may impact practice viability.

Workforce capacity is a key concern. Many practices report being unable to accommodate walk-ins or same-day requests without compromising care quality or staff wellbeing. This is exacerbated by GP attrition, difficulty attracting new graduates into primary care, and limited incentives to expand service hours. Without additional investment, the SFD risks placing unsustainable demands on a workforce already under pressure.

There are also concerns about communication and clinical governance. In many cases, referrals from the SFD to primary care occur without full handover, shared records, or clinical context. This makes continuity of care difficult, especially for complex or high-risk patients. Addressing these issues will require better integration of digital tools (e.g., secure messaging and shared care plans), clearer referral protocols, and investment in health IT infrastructure.

Importantly, primary care leaders have emphasised that continuity of care must be protected. Referrals made through the SFD should default to a patient's usual GP where possible. Otherwise, there is a risk of fragmenting care and weakening the patient-GP relationship.

Clinical feedback from GPs reveals frustration with the complexity of navigating multiple entry points—virtual ED, standard ED, after-hours services, etc. There is strong demand for a unified point of contact and the ability to speak directly with a clinician for rapid guidance. Simplifying these access points would help ensure the model is useful, usable, and sustainable from the provider perspective.

Finally, the Medicare fee-for-service model does not align well with the rapid-response, short consultation model needed to absorb redirected patients. Practices may be disincentivized to participate without funding reform or enhanced support.

Expanded Mental Health Integration

The development of a Mental Health Single Front Door is a major opportunity to enhance system navigation for one of the most vulnerable and complex patient populations. Mental health consumers often face a fragmented system with siloed entry points, variable service availability, and limited after-hours support.

The Mental Health SFD will offer direct clinical triage by mental health-trained professionals, ensuring people in distress are assessed promptly and safely. It will also facilitate referral to the most appropriate mental health pathway—whether that be a crisis team, local psychologist, general practitioner, or community-based service.

Importantly, the mental health front door will need to be culturally sensitive, trauma-informed, and integrated with existing services like the Medicare Mental Health Line, Lifeline, and regional suicide

prevention programs. PHNs and Local Health Districts will play a key role in co-designing this model to reflect local service landscapes and needs. Data sharing and aftercare protocols will be essential to ensure follow-up and prevent repeat crises.

Similar to general practice, the community mental health sector will be under increased pressure to respond to greater demand for services. This is likely to require further investment in community mental health care.

Implementation Considerations

Successful implementation of the Single Front Door model depends on more than just the availability of triage staff and virtual care options. It will require coordinated planning, stakeholder engagement, and adaptive governance across multiple layers of the health system.

Key implementation considerations include:

- Stakeholder engagement: Sustained collaboration between PHNs, Local Health Districts, GPs, and NGOs is essential to align referral pathways, manage demand, and build system trust.
- Workforce capability: Call centre nurses must be supported with ongoing training, supervision, and escalation protocols. Similarly, downstream services (e.g., UCCs, GPs) must be equipped and resourced to absorb redirected patients.
- Digital integration: Real-time access to provider availability, referral tracking, and integration with patient records (e.g., My Health Record) will support continuity of care and reduce duplication.
- Communication and promotion: Community-facing education campaigns must be inclusive, culturally appropriate, and consistent across digital and traditional channels.
- Monitoring and quality assurance: Robust data systems are needed to track outcomes, equity of access, wait times, and patient satisfaction. These insights should feed back into ongoing improvement.

Without these implementation pillars in place, there is a risk that the SFD will be underutilized, misunderstood, or fail to achieve its full potential.

Conclusion

The NSW Single Front Door initiative marks a pivotal step in redesigning how people access urgent and non-emergency healthcare. By enabling earlier intervention, better triage, and more efficient service navigation, it holds the potential to deliver tangible benefits across the health system—fewer ED visits, shorter wait times, improved patient satisfaction, and better health outcomes overall.

However, realizing this vision will require concerted effort, collaboration, and investment. Awareness campaigns must reach all communities—including multicultural communities and digitally excluded populations. Likewise, GPs and community mental health services must have access to clear referral pathways and where possible a single point of contact. This will also require active promotion and awareness campaigns.

General practice and other community-based health services must be supported to respond effectively to new demand. Virtual care services must be continuously evaluated, scaled, and refined.

Crucially, PHNs, Local Health Districts, and the NSW Ministry of Health must work together to align service planning, avoid duplication, and monitor outcomes. If done well, the Single Front Door will not only improve current system performance but also lay the foundation for a more integrated, equitable, and person-centred healthcare system in the years to come.

Discussion Questions

1. How can the Single Front Door be tailored to better meet the needs of culturally and linguistically diverse communities?
2. ~~What role should PHNs play in supporting general practices and commissioned mental health services to handle increased demand from SFD referrals?~~
23. How can virtual care services be made more accessible and trusted by vulnerable or digitally excluded populations?
34. What changes are needed to ensure primary care is adequately supported to deliver urgent care at scale?
4. What are the critical factors to ensure the single front door is user friendly for primary care providers?
5. What role should PHNs play in supporting general practices and commissioned mental health services to handle increased demand from SFD referrals?