Rural urgent care frameworks

POSITION STATEMENT

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

College position

It should be a core principle of the national health care system that every Australian irrespective of where they live should have free access to emergency medical care. State governments, through national funding arrangements, are delegated responsibility for ensuring this access.

The College understands that the vision for rural urgent care frameworks and Urgent Care Centres (UCCs) is to make it easier for rural people to see a doctor or nurse when they have an urgent, but non-life-threatening need for care. However, the UCC model as implemented in certain states represents a fundamental abrogation of the State government's responsibility to provide this care free of charge.

Funding models which fail to appropriately acknowledge and remunerate the medical practitioners who are providing services in UCCs will only serve to exacerbate the existing inequities in healthcare funding and access which are already experienced by rural and remote Australians.

Urgent care frameworks and Urgent Care Centres across Australia

There is need for clarity about the definition of Urgent Care Centres as they apply both at the national and state level. There are a range of different funding and delivery models operating across Australia which are variously described as 'Urgent Care Centres', 'Urgent Care Clinics, and 'Priority Care Centres'.

For example, the models referred to as Urgent Care in New Zealand and in the Australian Capital Territory involve the Centres and their staff being wholly funded through those governments, with staff being paid on salaried arrangements. An Urgent Care Centre in Queensland would be referred to as a small state government owned Rural Hospital Emergency Department, where all facilities and equipment and staff salaries would be paid through the state funding arrangements.

In Victoria the model involves UCCs functioning as Emergency Medicine Departments with facilities and equipment being funded by the State. These UCCs are within facilities with aged care and acute beds and are often nurse led with on-call medical support. They are intended for low level triage only. Medical staff salaries are not funded by the State and must either be paid through patient billing to MBS or charging patients privately.

South Australia operates a hybrid model with a combination of emergency department care, private billing, and Medicare rebates.

In a separate and additional initiative, the Federal Government has committed $135 million over 4 years to fund 50 Medicare-funded Urgent Care Centres. These would be predominantly urban facilities and will offer fully bulk-billed services. This terminology will potentially create more confusion, creating a situation where federal government funded UCC's will be free of out-of-pocket costs, whereas for example, the current UCC model in Victoria will not.

Problematic UCC models

The Victorian Health Department's UCC model involves the Centres functioning as Emergency Medicine Departments with facilities and equipment being funded by the State. However, medical staff salaries are not funded by the State and must either be paid through patient billing to MBS or charging patients privately. A similar UCC model has been trialled in South Australia.

Funding

The College has concerns that funding arrangements such as those currently in place in Victoria and being trialled or considered in other jurisdictions insufficiently support both doctors and their patients in rural areas. It is widely accepted that MBS does not reflect the essential costs of medical care. This will either require presenting patients to pay a gap fee, or the providing medical practitioner will not be adequately remunerated by accepting the MBS rebate. This is especially true in the context of emergency care which necessarily occurs at times of personal inconvenience to practitioners and involves 24/7 availability.

Under this arrangement, rural and remote doctors are paid less for the same services that doctors in cities provide. There is no justification for the difference. They are also faced with the very difficult personal choice between forgoing provision of emergency care to their patients (who may not be able to afford gap payments) or providing the services at a personal loss.

This is a systemic problem which results in people living in rural and remote areas receiving less funding support for their emergency care than their counterparts in cities. Given the estimated $4 billion national underspend on people in rural and remote areas due to their lower use of government funded health services that already exists, this inequity is particularly unacceptable.

It is also worth noting that this contributes to the inequity of healthcare between metro and rural. Private Health Cover is also not available to support them in accessing the services provided by these Centres. Ambulance cover is also charged to patients, and many choose to drive themselves often at considerable personal risks as the costs may be prohibitive or to use services run by volunteers who are themselves members of the local community.

Fragmentation

Phase 1 of the Victoria Department of Health's UCC consultation demonstrated that this model has created patient confusion over the services UCCs provide; the health practitioner providing care (whether doctors, nurses or otherwise); and the out-of-pocket costs payable. It is likely much of this confusion arises from the reasonable presumption of patients that emergency care costs would and should be covered by their state or territory government.

More broadly, the piecemeal approach adopted in various states is reactive, and should be replaced with a more strategic plan which addresses local need, available resources and reconsiders how urgent care is provided.

Principles of care for rural urgent care frameworks

1. Access

All urgent care should be provided by the State free of charge. This is especially important for people living in rural and remote areas.

2. Define capabilities

UCC frameworks should be flexible enough to allow communities to tailor the care they provide to meet community need in their particular area. A "one size fits all" approach should not be adopted. The key principle of care closer to home should be maintained where possible. Rural hospitals are hubs for the whole community, with the benefits of access to a wider range of services, including diagnostic imaging services, benefiting primary care providers as well as the broader community. Treating patients in their community is much more cost effective both for the patients and for the health care system.

3. Ensure integration

An integrated statewide and strategic approach should be taken to the provision of urgent and emergency care, including partnerships between state and health services regarding emergency networks, referral pathways, and the development of statewide clinical guidelines.

4. Virtual care

Over-reliance on access to specialist clinical advice and support through virtual care as part of the UCC framework should be avoided. Where telehealth and digital health approaches are used in urgent care services, these should be accompanied by a set of specific guidelines regarding suitability, and should take cognisance of the training needs of staff involved in the process both local and distal, for example, upskilling nursing staff to work without doctors present e.g. in physical examination skills, and ensuring any urban-based clinicians have a relationship with the local healthcare team, and an understanding of the rural and remote context in which care is being delivered. Although virtual care can be a useful tool, it should never be regarded as a substitute for face-to-face care.

5. Workforce

Medical staff in UCCs in rural areas should expect at least the same remuneration for urgent care services as they would receive providing urgent care in cities. This is necessary for fairness, and to avoid creating a barrier to providing doctors in rural communities. Rural doctors in UCCs should not have to rely on MBS billing to provide a heath service which the state is required to provide. In the context of Victoria, the Rural Doctors Association of Victoria (RDAV) Visiting Medial Officer (VMO) contract model could provide useful guidance, and salaried options should also be considered. Workforce models must be flexible and must consider staffing shortages across all sectors. The UCC framework also needs to address the current disparities in payments between employees and locums. Our members report that in some emergency departments, locum doctors are being paid twice as much to do the same job as a local employee and are also receiving paid accommodation. This disincentivises the local workforce.

6. Education, training, and support

UCCs need to be supported by provision of appropriate and accessible education and ensuring appropriately recourse and supportive working environments. For example, diagnostic imaging, both x-ray and especially ultrasound, provides a valuable tool for rural doctors. Ultrasound is particularly powerful in assisting diagnosis in the emergency situation. While there is an increasing trend to rely on patient evacuation in these situations, there are many situations in which retrieval may not be possible or desirable. Upskilling Rural Generalists to use radiology equipment locally would increase access to these services in small towns and potentially reduce the need for transfers. More generally, providing opportunities for all rural GPs to upskill/maintain and/or gain the necessary skill set to work in UCCs, with training being provided in the rural context through the utilisation of remote supervision models would allow health services to tap into the existing skillset and knowledge base of a locally-based workforce.

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live, and pay respect to their Elders past present and future.