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

College Submission
June 2022

Feedback on the Draft Strategic Framework on the future of Urgent Care in Rural Victoria

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care***. It progresses this through providing quality Fellowship training; professional development education programs; setting and upholding practice standards; and through the provision of support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

Comments

The College welcomes the opportunity to provide feedback on the draft Framework for Urgent Care Centres (UCCs) in rural Victoria and to relay the concerns of our members with respect to this proposal.

It is 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 UCCs is in theory to make it easier for rural Victorians to see a doctor or nurse when they have an urgent, but non-life-threatening need for care. However, in the view of our members, the current UCC model in Victoria represents a fundamental abrogation of the State government's responsibility to provide this care free of charge to rural and remote Victorians.

The funding model also fails to appropriately acknowledge and remunerate the medical practitioners who are providing these services. It exacerbates the existing inequities in healthcare funding and access which are already experienced by rural Australians.

General Comments

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'.

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 a separate and additional initiative, the Federal Government has committed $135 million over 4 years to fund 50 Medicare-funded Urgent Care Centres. This will potentially create more confusion, creating a situation where federal government funded UCC's will be free of out of pocket costs, whereas the current UCC model in Victoria will not.

Urgent Care Centres in Victoria

There are currently 50 Urgent Care Centres across Victoria, which, alongside 28 primary injury services, provide different levels of emergency care, supported by local on-call doctors.

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, staff salaries are not funded by the State and must either be paid through patient billing to MBS or charging patients privately.

Phase 1 of the UCC consultation demonstrated that there is patient confusion over the services UCCs provide; the health practitioner providing care (whether doctors, nurses or otherwise); and the out of pocket costs payable. While national clarification is required, there is a particular need for clarity about the definition of Urgent Care Centres in Victoria, to reduce the current patient confusion.

Funding

The College has strong concerns regarding the current funding arrangements for Victorian UCC's. 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 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 systematic framework 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 these inequities for people living in rural and remote areas are exacerbated and that 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.

Areas of Focus

The College makes the following comments regarding the areas of focus/proposed high level initiatives:

1. Define

The College welcomes the commitment to ensuring the key principle of care closer to home is 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.

Rural generalist practitioners work under unique circumstances; with a scope of practice and working environment which is very different to urban practice. These practitioners are often the only readily available doctors and commonly take on roles ordinarily the preserve of specialists in the cities. It is therefore imperative that in developing a capability framework for urgent and emergency care Rural Generalists are included in the process. The Rural Generalist model of care has a proven track record in providing high-quality, accessible care which meets community need.

In attempting to define the required capabilities for urgent care services it is important that a "one size fits all" approach is not adopted, and the capability framework is flexible enough to allow communities to tailor the care they provide to meet community need in their particular area.

2. Integrate

The College is pleased to note an integrated statewide approach will 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.

The College would caution against reliance on access to specialist clinical advice and support through virtual care. Although virtual care can be a useful tool, it should never be regarded as a substitute for face to face care. The use of Telehealth in urgent care services needs to be accompanied by a set of specific guidelines regarding suitability, and must take cognisance of the training needs of staff involved in the process, for example, upskilling nursing staff to work without doctors present e.g. in physical examination skills.

The cost of accessing specialist clinical advice via virtual care should also be considered, as should the location of the specialists providing care. Our members report that several public health services are currently using private emergency department telehealth services where the specialist doctors providing service are based overseas.

Other strategies could be employed to promote more community-based care and avoid referrals to hospital emergency departments. In particular, streamlining of access for rural providers to after-hours imaging would allow them to bypass the emergency department. One of our members provided the following feedback:

"Allowing streamlining of access to services would prevent the current system of the patient being seen by the RG, then transferred to the regional ED, being seen again by the doctor in ED (often more junior that then original RG), the test being ordered, waiting for results, then the regional centre being left with the patient even if the result is normal. Using a mild-moderate head injury for example, it

would be great if I could transfer a patient directly to the CT scanner and if normal, then receive them straight back. Transport could wait and the patient has completed avoided the regional ED."

Members have also expressed concern about the use of a central triage hotline, especially given the variation in the level of services that can be provided by each individual UCC. Unless the hotline could be developed to include the capability to distinguish between the range and types of services provided by each UCC, there would be a risk of skilled UCC's being bypassed when they are able to provide the service required.

3. Workforce

The College supports the move to develop sustainable urgent care contractual and employment arrangements for GP VMOs. Medical staff should not have to rely on MBS billing to provide a heath service which the state is required to provide. The Rural Doctors Association of Victoria (RDAV) VMO contract model could provide useful guidance, and salaried options should also be considered in Victoria.

Workforce models must be flexible and must consider staffing shortages across all sectors. Whilst increasing the role of paramedics out with traditional settings might be an option, this will only be achievable if there are sufficient paramedics to take on these additional roles.

One option might be for health services to employ more junior medical staff, to cover both the ward and the urgent care centre with supervision from local General Practitioners or Rural Generalists. A move towards statewide credentialling would be welcomed, however this must include statewide recognition of Rural Generalists on specialist awards to ensure the same pay for the same work.

The 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.

The need to encourage the rural health workforce to remain rural, through the provision of education and supportive working environments has never been greater. 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.

4. Access

The College agrees that all urgent care should be provided by the State free of charge and welcomes the move to remove out of pocket costs for patients. This is especially important for people living in rural areas.

Summary

In the view of the College, the proposed Victorian UCC model represents a fundamental abrogation of the State government's responsibility to provide emergency care at no cost to rural and remote Victorians.

The funding model also fails to appropriately acknowledge and remunerate the medical practitioners who are providing services to Urgent Care Clinics. It exacerbates the existing inequities in healthcare funding and access which are already experienced by rural Australians.

The wider community needs clarification regarding the definition of Urgent Care Centres as they apply both at the national and state level. In Victoria, this should involve clear information about any patient costs involved when UCC services are accessed.

ACRRM recommends that the Victorian Government review its approach to providing emergency care for people living in regional and rural areas of the State. The College would be happy to contribute to the development of alternative models of care that support affordable access to emergency care services and appropriately support the rural medical practitioners who are providing this care.

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