# Concerns identified by medical doctors working in urgent care clinic models in Australia

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**Background and objective**

Since 2019, numerous urgent care clinic (UCC) models have been introduced to Australia. This study investigates concerns raised by medical doctors working in UCC models.

**Methods**

A convenience sample of medical doctors working in UCC models in Australia since 1 July 2023 were invited to participate in a custom-designed 22-item online survey. This was advertised through The Royal Australian College of General Practitioners (RACGP), The Royal New Zealand College of Urgent Care (RNZCUC), corporate general practices, UCC peer groups and on LinkedIn.

**Results**

Overall, 52 responses were received. Descriptive statistics and qualitative descriptive content analysis was used to identify concerns raised by participants, which included: capacity, accreditation standard, qualifications and experience of medical doctors and nurse practitioners, training, funding, public education and UCCs taking work general practitioners (GPs) could do if appropriately funded.

**Discussion**

Four practical solutions to the seven concerns were: (1) adoption of Medicare Benefits Schedule UCC item numbers for UCCs and general practices; (2) introducing recognition of extended skills for UCC medical doctors through the RACGP; (3) developing an Australian UCC standard; and (4) increased public health campaigns.


**THE URGENT CARE CLINIC (UCC)** model for the treatment of patients who have non-life-threatening urgent conditions (NLTUCs) has been rapidly introduced to Australia.[1] However, this model is not without its concerns from the medical doctors who staff these UCCs. UCCs are an option for patients who are unable to see their general practitioner (GP) in a timely manner, and who do not require treatment in a hospital emergency department (ED). Although Australia is a recent adopter of UCCs, this model has existed internationally for more than 50 years.[2]

UCC models exist in many Western countries and have significant differences compared to the general practice model; namely, opening extended hours, walk-in availability, radiology on-site, accreditation standards and an independent certifying body.[2] The Australian landscape consists of five models that are fully government funded: (1) federally funded primary care-based (n=87), starting in June 2023;[3] (2) state-funded, primary care based in South Australia,[4] New South Wales[5] and Victoria[6] (n=5, 10, 11, respectively); (3) state-funded, hospital-based in Queensland[7] and Victoria[8] (n=7, 7, respectively); (4) state-funded nurse practitioner (NP)-led in Canberra[9] and Queensland;[10] and (5) virtual models.[11] Private models include GP[12] and ED-physician led.[13]

With the changes required in the adoption of the UCC model, change management is needed within the complex healthcare sector. Clinician engagement is crucial to create sustained change for quality improvement.[14]

## Aim

This study explored the perceptions of medical doctors working in Australian UCCs with the goal of formulating solutions to concerns raised by participants.

## Methods

### Questionnaire design

No suitable validated questionnaires were identified for use in this study, so development of a custom-designed questionnaire was required.

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**Table 1. Items, variable groups and question details in 'Doctor-led Urgent Care Models' in Australia[A]**

| Item | Variable groups | Details |
|---|---|---|
| 1 | Location (State or Territory) of work | 1 question, categorical, 9 options |
| 2 | Demand exceeds the capacity of the one doctor–one nurse model | 1 question, open ended |
| 3 | Lack of direction on operational issues | 1 question, open ended |
| 4 | Standards used in the absence of an Australian Standard | 1 question, categorical, 8 options (multiple options allowed) |
| 5 | UCC lead doctor qualification | 1 question, categorical, 7 options (multiple options allowed) |
| 6 | UCC doctor qualification and experience | 1 question, open ended |
| 7 | UCC NP qualification and experience | 1 question, open ended |
| 8 | Gaps in knowledge and experience of GPs working in UCCs requiring upskilling | 1 question, open ended |
| 9 | Day-to-day operational funding | 1 question, categorical, 8 options plus comments (multiple options allowed) |
| 10 | Current and future funding for UCCs | 1 question, open ended |
| 11 | The public need education as to which presentations are appropriate for UCCs and which are appropriate for an ED | 1 question, open ended |
| 12 | GPs could perform UCC work if appropriately funded | 1 question, open ended |

[A] A copy of the questionnaire, with answers, can be obtained by contacting the corresponding author.

ED, emergency department; GPs, general practitioners; NP, nurse practitioner; UCC, urgent care clinic.

This was designed based on a literature review conducted as part of PhD research,[15] a subsequent literature review of UCC models in Western countries, and further identification of issues in UCCs by the authors. The questionnaire had 22 questions, which included categorical and open-ended questions to identify either a priori or emergent items (Table 1). Of these 22 questions, 21 items were identified and there were 16 themes. The first 12 items with eight themes were deemed by the authors to relate more to the performance of the medical doctors working in UCCs and will be discussed in this study. The other items and themes were deemed to be operational issues and will be the basis of a planned further study.

### Questionnaire review

The survey was reviewed by three GPs who provided feedback on face and content validity, as well as functionality. One of the GPs was also a senior federal government bureaucrat from the health sector and a public health physician. Changes were made based on the feedback provided.

To create interest in the survey prior to deployment, the survey was presented at the first Royal Australian College of General Practitioners (RACGP) 'Urgent and emergent presentations to primary care' Specific Interest Group (SIG) on 17 October 2023. This served as an initial forum to launch the study. At this meeting, medical doctors leading significant and differing models of UCCs in Australia were asked to present the UCC models they were working on and discuss how they managed issues that they faced.

### Sampling

Convenience sampling was used to select medical doctors who had extensive expertise in UCC models in Australia since the first Medicare UCCs opened on 1 July 2023. Medical doctors were invited to participate in this online study administered through Qualtrics (Seattle, WA, USA; www.qualtrics.com/blog/calculating-sample-size). To maximise participation, the study was distributed in six ways: (1) three RACGP 'Urgent and emergency presentations to urgent care' SIG newsletters (emailed every four months); (2) three Royal New Zealand College of Urgent Care (RNZCUC) 'Australasian Faculty' newsletters (emailed every four months); (3) emails to medical doctors in two corporate general practices operating UCCs; (4) emails to two urgent care peer groups; (5) emails to Primary Health Networks (PHNs) managing UCCs who the lead author relates to; and (6) an invitation to participate in the study through a LinkedIn page on 26 April 2024. The study was open between 2 September 2023 and 5 June 2024, and closed after no further results were received for 30 days. During this time, numerous Federal Medicare UCCs were opening and have continued to open with a potential pool of at least 127 clinics to sample if all were open; they received the invitation to participate in the survey and decided to complete the survey.

### Data analysis

Numerical data were summarised and displayed using descriptive statistics (Tables 1–5). Qualitative descriptive content analysis was performed using the six stages of the Framework method.[16]

### Ethics

Ethical clearance was provided by the University of the Sunshine Coast (A232000).


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**Table 2. Themes, item numbers, types of questions and responses for 'Doctor-led Urgent Care Models' in Australia**

| | Theme | Item | Type of question | Responses (n) |
|---|---|---|---|---|
| 1 | Location | 1 | Categorical | 49 |
| 2 | Capacity | 2 | Open | 22 |
| 3 | Accreditation standard | 3 | Open | 13 |
| | | 4 | Categorical | 69 |
| 4 | Qualifications and experience | 5 | Categorical | 66 |
| | | 6 | Open | 47 |
| | | 7 | Open | 10 |
| 5 | Training | 8 | Open | 12 |
| | | 9 | Categorical | 98 |
| 6 | Funding | 10 | Open | 8 |
| 7 | Public education | 11 | Open | 6 |
| 8 | GPs could perform UCC work if appropriately funded | 12 | Open | 3 |

GPs, general practitioners; UCC, urgent care clinic.

## Results

A total of 52 participants completed the online survey. Out of eight open-ended and four closed questions, 12 items were identified, which were narrowed down to eight themes listed below. Response rates to each question differed, with lower rates of response for the open-ended questions compared to the categorical questions. Nevertheless, some participants provided multiple responses to open-ended questions (Table 2). The last question in the survey was open-ended asking respondents about 'Concerns of medical doctors working in UCCs' and highlighted issues in themes two to eight. This last question had a total of 73 responses, most of which were multiple responses (n=21) and some of which were single responses (n=16).

### Themes

*Location*

The largest number of medical doctors participating in the research worked in Queensland (n=14, 29%). This was followed in descending order by New South Wales (n=8, 16%), Tasmania (n=9, 18%), Victoria/South Australia (both n=7, 14%) and Western Australia (n=3, 6%). No medical doctors working in Capital Territories completed the survey.

*Capacity*

The largest concern by medical doctors completing the survey was the capacity of UCCs to treat patients in a timely and safe manner. This concern included numbers of patients using the service, isolation in terms of one doctor working alone and safety when the UCC is at capacity.

Medical doctors shared concerns that there were 'too many patients', 'only one doctor per shift', 'large numbers' of 'patients waiting in their cars for extended periods – hours sometimes (eg kids with fever)', and that there was 'only one doctor and nurse on'. Other concerns included 'managing patient load, particularly at the end of the day (ability to leave near on-time)', 'workflow during' the 'end of shift', being 'understaffed', having 'excessive presentations' and 'increasing pressure to see more patients per hour'. 'Finding staff including lack of staff cover for sick leave' and 'finding GPs to work in the clinic who are experienced Specialist GPs in a rural community' also affected the capacity of UCCs to manage patients. There were also concerns raised about the one doctor model.

Working alone was a concern for some medical doctors. Medical doctors expressed concern at being the 'sole doctor which can be isolating at times with limited collegiality', 'isolation (generally only one doctor in an UCC at a time)' and 'working by yourself' with 'nobody else to ask for a second opinion', which can be 'very isolating and lonely'. There were also safety concerns identified when UCCs are running at capacity.

Medical doctors identified concerns about what happens when UCCs are overwhelmed. They had 'concerns around capacity and when reached, the potential to turn away the patient who becomes the "collapse in the car park"' and concerns about 'adverse events during patient surges'. Although capacity to provide a safe service was important, the next theme related to accreditation.

*Accreditation standard*

In the absence of a national accreditation standard, UCCs use standards belonging to different organisations, which included The Royal Australian College of General Practitioners (RACGP), The Australian College of Rural and Remote Medicine (ACRRM), The Royal New Zealand College of Urgent Care (RNZCUC), The Australasian College for Emergency Medicine (ACEM), State Government or PHN (Table 3). Included in this theme were doctor's concerns that could be resolved if there was a national accreditation standard for operational guidance including investigations, oversight and consistency between UCCs.

Imaging and pathology services were mentioned several times both in-hours and out-of-hours. One doctor had 'no access to onsite radiology', others had issues with 'imaging and pathology not onsite' and 'imaging and pathology not available after hours'. Medical doctors were concerned about the 'lack of after-hours facilities to support out work (eg imaging and bloods)'. One doctor had an issue with timely reporting of X-rays, citing 'trouble referring to fracture clinic without a formal report of X-ray', and another had an issue with being able to discuss X-rays with a radiologist sharing their 'inability to discuss imaging results with a radiologist' as there was 'no radiologist on site'.

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**Table 3. Standards used for Australian UCCs**

| Standard | Number of responses (n=69)[A] |
|---|---|
| RACGP or ACRRM | 30 (43) |
| State Government or PHN | 15 (22) |
| Not known | 9 (13) |
| RNZCUC | 6 (9) |
| ACEM | 5 (7) |
| Nil | 2 (3) |
| Rather not say | 1 (1) |
| Other | 1(1) |

[A]Data are presented as n (%).

ACEM, Australasian College for Emergency Medicine; ACRRM, Australian College of Rural and Remote Medicine; PHN, Primary Health Networks; RACGP, Royal Australian College of General Practitioners; RNZCUC, Royal New Zealand College of Urgent Care; UCCs, urgent care clinics.

Other medical doctors specifically mentioned qualifications and standards.

Medical doctors raised concerns about 'the lack of a specific Australian qualification in Urgent Care Medicine (like they have in New Zealand)' and 'lack of a national accreditation standard leading to patient confusion especially where there are two UCCs in a town'. Other concerns raised included 'reliance on reception for initial triaging', 'follow-up of results', 'no clinical lead' and 'follow-up results of tests that I have ordered'. Another important theme was qualifications and experience.

### *Qualifications and experience of medical doctors and NPs*

Lead UCC medical doctors mostly had one or more specialty qualifications (Table 4). There was a vast difference in qualifications and experience of doctors, which ranged from the basic Bachelor of Medicine, Bachelor of Surgery (MBBS) qualification to Fellowship of the Royal Australian College of General Practitioners (FRACGP) and/or Fellow of the Australian College of Rural Remote Medicine (FACRRM) and ED, intensive care unit (ICU), UCC or rural and remote experience. The number

**Table 4. Qualifications and experience of lead medical doctors, medical doctors and NPs working in UCCs**

| Qualifications and experience | Lead medical doctors (n=66) | Medical doctors (n=47) | NPs (n=10) |
|---|---|---|---|
| MBBS | | 1 | |
| PGY3 and above | | 1 | |
| PGY4-5 with ED experience | | 1 | |
| PGY8+ | | 1 | |
| Primary care experience | | 1 | |
| ED and/or UCC experience | | 1 | |
| ED Registrar experience | | 1 | |
| ED experience – 6 months | | 1 | |
| ED experience – 3 years | | 1 | |
| ED experience – 4 years with ALS | | 1 | |
| GP Registrar | | 1 | |
| GP Registrar with interest in urgent care | | 1 | |
| RACGP/ACRRM/ACEM Registrars with ALS2 | | 3 | |
| FRACGP | 43 | | |
| FACRRM | 9 | | |
| FRNZCUC | 4 | | |
| FRACGP/FACRRM | | 21 | |
| FRACGP/FACRRM and recent ED experience | | 1 | |
| FRACGP/FACRRM and ED experience | | 2 | |
| FRACGP/FACRRM and UCC experience | | 1 | |
| FRACGP/FACRRM and UCC or ED experience | | 2 | |
| FRACGP/FACRRM and significant ED or rural and remote experience | | 1 | |
| FRACGP/ALS2 | | 1 | |
| FRACGP/FACEM with ALS1 or 2 | | 1 | |
| FRACGP/FACRRM and at least 6 months' experience in UCC, ED or rural and remote medicine | | 1 | |
| FACEM | 3 | | |
| Unknown | 3 | 1 | 1 |
| Other | 4 | | |
| NP registered with AHPRA | | | 3 |

Table continued on the next page

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of responses for NPs was low (n=10); however, most required Australian Health Practitioner Regulation Agency (APHRA) registration and experience in EDs, UCCs and ICUs. In addition to the wide range of qualifications and experience of participants, there were also gaps identified in the skill sets of UCC staff that could be minimised by providing training.

*Training*

Based on the questionnaire, there were concerns about the gaps in knowledge in connection with the management of emergency presentations outside of the skill sets of some medical doctors working in UCCs. These included 'inappropriate presentations such as chest pain or mental health patients', 'acute emergencies', 'patients presenting with life threatening illness' and 'drug-seeking patients'. In addition to the above, fracture management was highlighted, with responses including 'radiology reports not available on time and depending on GP's radiology skills' and 'lack of formal training and professional development in fracture management'. Finally, Medicare compliance was noted because of medical doctors being concerned about 'the risk of Medicare audit', and 'concerns about Medicare billing – occurs against my name but I have limited access to the reports'. There were also concerns raised about skill levels.

'Variation in skill levels of nurses and medical doctors' was raised as a concern. One doctor suggested 'RN needing upskilling with suturing and plastering', and another was concerned that 'front desk lacks critical thinking'. After the theme of training, the next most common theme raised was funding.

*Funding*

Medical doctors were concerned about 'financial viability', because 'current models for bulk billed urgent care is based on a break model and private billed urgent care has small margins of return approximately 12%' and were worried about if 'funding' is 'inexplicably cut with subsequent decrease to hours and wages'. They wanted 'appropriate funding', 'ongoing funding' and 'appropriate Medicare Benefits Schedule (MBS) items for urgent care'. Sources of funding for UCCs include Federal Government, State Government, PHN, Medicare, Workcover and private billing. One UCC had both Federal and State Government funding for the same clinic (Table 5). After funding, the next most common theme was educating the public about the proper use of UCCs.

**Table 4. Qualifications and experience of lead medical doctors, medical doctors and NPs working in UCCs (cont'd)**

| Qualifications and experience | Lead medical doctors (n=66) | Medical doctors (n=47) | NPs (n=10) |
|---|---|---|---|
| NP registered with AHPRA with ED and ICU experience | | | 1 |
| NP registered with AHPRA and prior ED experience | | | 1 |
| NP registered with AHPRA and prior experience in ED or UCCs | | | 1 |
| NP registered with AHPRA and 3 years' ED experience | | | 1 |
| NP and in scope for urgent care | | | 1 |
| No NPs in clinic | | | 1 |

Data are presented as n. Blank cells indicate no data available.

ALS, advanced life support training (with unspecified, 1- or 2-day course); AHPRA, Australian Health Practitioner Regulation Agency; ED, emergency department; FACEM, Fellowship of the Australasian College for Emergency Medicine; FACRRM, Fellowship of the Australian College of Rural and Remote Medicine; FRACGP, Fellowship of the Royal Australian College of General Practice; FRNZCUC, Fellowship of the Royal New Zealand College of Urgent Care; GP, general practitioner; ICU, intensive care unit; MBBS, Bachelor of Medicine and Bachelor of Surgery; NP, nurse practitioner; PGY, postgraduate year training; UCC, urgent care clinic.

**Table 5. Funding sources of Australian UCCs**

| Funding source | Number of responses (n=98) |
|---|---|
| Federal Government | 20 (20) |
| State Government | 23 (23) |
| PHN funding | 6 (6) |
| Medicare | 21 (21) |
| Workcover | 9 (9) |
| Private | 9 (9) |
| Not known | 7 (7) |
| Both Federal and State funding in the same UCC | 1 (1) |
| Rather not say | 2 (2) |

Data presented as n (%).

PHN, Primary Health Network; UCC, urgent care clinic.

*Public education*

The were several concerns that related to public education about which patient presentations should present to UCCs. Medical doctors highlighted concerns that ' "urgent care" is "sometimes assumed to be walk-in GP clinics or that's what the practice would like it to be" and "patients not understanding that it is not a hospital and presenting with serious conditions that would have been better calling an

ambulance and being directed direct to the ED"'. Doctors noted that there was 'blurring of clinical lines between patient presentation safely managed in primary care and patient presentations that should present to the ED and that there were the 'type of presentations which should be going to a GP but present to UCC as they don't have a GP' and a 'lack of patient understanding of "urgent" care versus "emergency care"'. The final theme reflected the desire of some medical doctors to provide urgent care services in their own general practice.

#### *GPs could perform UCC work if it was appropriately funded*

Some medical doctors commented that general practice could do the work of UCCs if they had appropriate remuneration. Responses included 'UCCs are taking work GPs could do if appropriately funded'. Some GPs expressed: 'I am doing work that could be done in any GP practice if the GP received the same level of funding'. They also indicated that patients are 'better managed in a standard GP setting', but patients are 'not wanting to pay out-of-pocket costs', 'UCCs take funding away from primary care' and 'if primary care was properly funded, UCC wouldn't be needed'.

## Discussion

This study found seven important themes: (1) capacity; (2) accreditation standard; (3) qualifications and experience of medical doctors and NPs; (4) training; (5) funding; (6) public education; and (7) GPs could perform UCC work if appropriately funded. As four of the authors are industry experts with involvement in UCCs, having either national UCC medical lead, operations or educational roles, the decision was made to frame the discussion based on four practical solutions addressing all seven themes, identified in national and international literature. These include: (1) urgent care item numbers; (2) qualifications relevant to urgent care; (3) adopting an accreditation standard; and (4) increased public health campaigns. Each will be discussed in turn to highlight practical solutions to concerns raised by medical doctors in this study.

### Urgent care item numbers

The themes of 'capacity', 'funding' and 'GPs could perform UCC work if appropriately funded' could be mitigated by the addition of MBS urgent care item numbers for general practices and UCCs providing urgent care services. In New Zealand (NZ), urgent care item numbers provide remuneration to general practices and UCCs for the administration of intravenous antibiotics, intravenous rehydration and urinary catheterisation.[13] These item numbers provide a more than four-fold increase in remuneration for some fractures; for example, non-displaced distal radius fractures compared to funding in NZ.[17,18] These additional item numbers could provide funding to allow a greater number of medical doctors to be able to work in UCCs per shift and financially encourage GPs to provide urgent care services to patients.

### Qualifications relevant to urgent care

Frameworks that recognise appropriate training in urgent care exist in other Western countries. The USA accepts emergency physician, family physician and physician qualifications for varying levels of UCCs[19] and has a 'Fellowship in the College of Urgent Care Medicine' for physicians, NPs and physician assistants.[20] The UK has a Fellowship in Immediate Medical Care.[21] NZ is the only country where urgent care has its own vocational scope through the RNZCUC.[22] Australia does not yet have a framework recognising an urgent care skill set or the qualifications of medical doctors for funding purposes who could work in UCCs.

Medicare UCCs recognise the FRACGP and FACRRM qualifications for the claiming of full Medicare benefits, but do not recognise the Fellowship of the Royal Australasian College of Physicians (FRACP), Fellowship of the Australasian College for Emergency Medicine (FACEM) or Fellowship of the Royal New Zealand College of Urgent Care (FRNZCUC)[23] qualifications. Allowing medical doctors with these specialty qualifications other than those with FRACGP and FACRRM qualifications to claim UCC MBS numbers could provide an extra workforce for UCCs, improve overall skill sets of medical doctors working in UCCs and provide employers with confidence of the doctor's abilities to work in UCCs. Extra training could occur in conjunction with the RACGP training.

### Accreditation standard

Australian Medicare UCCs receive guidance through an onboarding pack,[23] but currently there is no national accreditation standard. Such a standard could mitigate the concerns under the theme of 'qualifications and experience', especially for medical doctors providing UCC leadership and include 'follow-up of results', 'lack of national accreditation standard leading to patient confusion especially when there are two UCCs in a town', 'reliance on reception for initial triage' and the categories of 'access to onsite imaging and/or pathology' and 'lack of a national standard'. In the absence of an Australian accreditation standard, the[24] RNZCUC Standard 2015 is being used in UCCs in Australia.[23] This standard outlines requirements for medical leads that includes responsibilities for clinical oversight, requirements for being on-site, and review of medical records, performance, adverse events and ongoing training.[24] The standard also mandates procedures for nurse triage competency and review, and receptionist roles in identifying life-threatening conditions.[24] Adopting a UCC standard in Australia, like the one adopted by RNZCUC,[24] would provide solutions to four categories of concern raised in this study.

### Public health campaigns

In addition to educating GPs on the management of presentations outside of the skill sets of GPs working in UCC that expose the clinic to risk, it is also important that public education (theme seven) be carried out so patients choose the ED for presentations that are potentially life-threatening and beyond the scope of the UCC (eg chest pain, mental health presentations and conditions requiring timely access to reported radiology investigations).[25] The Federal Government has been proactive in providing resources to educate patients about which facility is most appropriate for a patient's condition, including the ED, general practice and UCC.[26] Another government source of information is Heath Direct, who refer appropriate patients to a UCC via their website and whose triage nurses can refer patients to UCCs via telehealth.[27] However, further public health campaigns are needed to educate patients about when it is appropriate to present to an UCC.


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## Limitations

Several limitations/biases for this study were noted. First, only 52 responses were received. Second, the bias for the study is towards State and Federal Government-funded UCCs.

## Conclusion

This Qualtrics study of medical doctors working in UCC models in Australia since 1 July 2023 received 52 responses. Twenty-three items were identified in the survey, 12 of which were discussed in this study and 11 of which will be discussed in a further study. From the 12 items identified in this study, eight themes were discussed: (1) location; (2) capacity; (3) accreditation standard; (4) qualifications and experience; (5) training; (6) funding; (7) public education; and (8) GPs could perform UCC work if appropriately funded. Practical solutions to themes identified were: additional urgent care item numbers; qualifications relevant to urgent care; an urgent care standard; and public health campaigns.


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Competing interests: JWA works part time as an Associate Professor of Urgent Care at the University of the Sunshine Coast. In his role at the university, he has taught seminars in conjunction with ForHealth. JWA is also the RACGP 'Urgent and emergency presentations to primary care' Specific Interest Group Chair', the Australian Convenor for the RNZCUC, and the Australasian Agent for the World Organisation of Family Doctors (WONCA) Emergency Medicine Special Interest Group. JWA has received honorariums when teaching fracture management and upskilling doctors to better manage emergency presentations to primary care. MM works as National Manager Integrated Care Pathways and Partnerships with ForHealth. MM collates relevant data across the network that is part of the delivery of Urgent Care Education Workshops. MM is the Advocacy and Government Relations Lead for the Australasian College of Paramedicine.

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