

Australasian College for Emergency Medicine

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Rural Health Action Plan

June 2021

About

The Australasian College for Emergency Medicine (ACEM) is the not-for-profit organisation responsible for training emergency physicians and advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.

Our vision is to be the trusted authority for ensuring clinical, professional and training standards in the provision of quality, patient-focused emergency care.

Our mission is to promote excellence in the delivery of quality emergency care to all our communities through our committed and expert members.

Acknowledgements

ACEM acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our Melbourne office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

ACEM acknowledges Māori as tangata whenua and Tiriti o Waitangi (Treaty of Waitangi) partners in Aotearoa New Zealand.

Rural, Regional and Remote Committee (2018–2022*)

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*Includes members from the 2018 to 2020 committee period

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Foreword

As the peak professional organisation for emergency medicine in Australia and New Zealand, ACEM has a duty to the emergency medicine profession and the wider community to uphold the highest possible standards of emergency medicine care.

Over the past decade, the ACEM Rural, Regional and Remote (RRR) Committee has been providing the ACEM Board and its councils leadership and advice regarding policies and standards for all aspects of emergency care in rural, regional, and remote areas. Acknowledging the challenges of health access and provision in rural areas, the committee is driving health equity and emergency care access in rural, regional and remote areas as a priority for the College.

We are therefore very pleased to present to you ACEM's inaugural Rural Health Action Plan, which outlines the College's commitment to improving health equity across rural, regional and remote Australia and Aotearoa New Zealand, and to ensure high standards of emergency care are accessible to all.

We need to work towards increased rural training opportunities, a more equitably distributed workforce, increasing our evidence base on rural issues, pivotal to improving RRR services, and ensuring education and training opportunities are readily available for all our colleagues providing care to RRR communities. We also encourage you to read this document and consider how your emergency department is contributing supporting rural emergency care services.

We'd like to take this opportunity to thank the current and previous members of the RRR Committee who have contributed to this important piece of work. The committee will oversee the implementation of this action plan and report back to the membership on its progress.



John Bonning
President



Niall Small
Chair
Rural, Regional and Remote
Committee

Acronyms

ACEM (the College)	Australasian College for Emergency Medicine
Action Plan	Rural Health Action Plan
AIHW	Australian Institute of Health and Welfare
ASGS-RA	Australian Statistical Geography Standard – Remoteness Area
CAPP	Council of Advocacy, Practice and Partnerships
CMO	Career Medical Officer
COE	Council of Education
ED	Emergency Department
EMC	ACEM’s Emergency Medicine Certificate
EMD	ACEM’s Emergency Medicine Diploma
EMAD	ACEM’s Emergency Medicine Advanced Diploma
EMET	Emergency Medicine Education and Training
FACEM; Fellow	Fellow of the Australasian College for Emergency Medicine
G23 Guidelines	ACEM Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce
IRTP	Integrated Rural Training Pipeline
MHrED	ACEM’s Mental Health in Rural Emergency Departments Project
MMM	Modified Monash Model
RRR Committee	Rural, Regional and Remote Committee
S12	ACEM Statement on Delineation of Emergency Departments
SIMG	Specialist International Medical Graduate

Definitions and scope

ACEM Member

ACEM has a range of membership categories, the requirements of which are set out in its Constitution and associated regulations.

In this Action Plan, 'ACEM members' or 'members' include (but are not limited to):

- **ACEM Fellows/FACEM** A Fellow of ACEM (FACEM) has either:
 - completed the FACEM Training Program; or
 - completed all requirements as a Specialist International Medical Graduate (SIMG) under the College's Specialist Pathway.
- **ACEM Diplomate** An ACEM Diplomate (Dip EM (ACEM)) has satisfactorily completed the requirements of the College's Emergency Medicine Diploma (EMD) training program and been formally admitted to Membership of the College.
- **ACEM Certificant** An ACEM Certificant (Cert EM (ACEM)) has satisfactorily completed the requirements of the College's Emergency Medicine Certificate (EMC) training program and been formally admitted as a Certificant member of the College.
- **ACEM Advanced Diplomate** An ACEM EMAD Diplomate (Adv. Dip EM (ACEM)) has satisfactorily completed the requirements of the College's Emergency Medicine Advanced Diploma (EMAD (forthcoming)) and has been formally admitted as an Advanced Diplomate member of the College.
- **Pre-Hospital and Retrieval Medicine (PHRM) Diplomate** A PHRM Diplomate has satisfactorily completed the requirements of the Pre-Hospital and Retrieval Medicine Diploma. The diploma is delivered jointly with the Australian and New Zealand College of Anaesthetists (ANZCA), the College of Intensive Care Medicine (CICM), the Australian College of Rural and Remote Medicine (ACCRM), and the Royal Australian College of General Practitioners (RACGP).

A full list of ACEM's membership categories are available on the ACEM website.

ACEM trainee

Unless stated otherwise, in this Action Plan 'ACEM trainee' or 'trainee' refers to any of the following.

- **FACEM trainee** A medical practitioner undertaking the FACEM Training Program. Successful completion qualifies practitioners for registration as a specialist emergency physician in Australia and Aotearoa New Zealand and the award of Fellowship of the Australasian College for Emergency Medicine. (FACEM)
- **ACEM EMC trainee** A medical practitioner training in emergency departments (EDs) to develop the knowledge and skills to manage and treat patients with common emergency presentations.
- **ACEM EMD trainee** A medical practitioner training in EDs to develop adequate knowledge and sufficient clinical experience to be safe and efficient emergency medicine practitioners.
- **ACEM EMAD trainee** A medical practitioner who has successfully completed the ACEM EMD program. The EMAD program builds upon the trainee's emergency medicine knowledge and skills to enable them to independently manage and treat a wider variety of and higher complexity emergency presentations, with telephone support from emergency specialists within the ED network, when required.
- **PHRM trainee** A medical practitioner with a strong background in critical care skills undertaking a placement at a Conjoint Committee of PHRM (CCPHRM)-accredited training site. DipPHRM trainees are required to apply their critical care skills in the PHRM environment.

Rural, regional and remote emergency medicine workforce

ACEM recognises that EDs are comprised of a range of health practitioners. The emergency medicine workforce in rural, regional and remote areas includes the following.

- FACEMs
- FACEM trainees
- ACEM Certificants, Diplomates and Advanced Diplomates
- ACEM EMC, EMD, EMAD and PHRM trainees
- Trainees and specialists of other colleges, such as Fellows of the Australian College of Rural and Remote Medicine (ACRRM), Fellows of the Royal Australian College of General Practitioners (RACGP), and Fellows of the Division of Rural Hospital Medicine in Aotearoa New Zealand (Royal New Zealand College of General Practitioners (RNZCGP))
- Career Medical Officers (CMOs) and other medical officers working in hospital EDs and other emergency care settings
- Nursing staff, including emergency nurse practitioners
- Allied health practitioners
- Other hospital support and administrative staff

ACEM is responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Aotearoa New Zealand and Australia. In recognition of these roles and responsibilities, and where ACEM can best direct its influence, this Action Plan focuses on:

- ACEM members, including FACEMs, ACEM Certificants, ACEM Diplomates, ACEM Advanced Diplomates (see definition of ACEM members above);
- ACEM trainees; and
- the relationships between ACEM members and its trainee workforce, as well as the broader emergency medicine workforce.

Rural, regional and remote classification

As noted in ACEM's [Position statement on rural emergency care](#), there are multiple classification systems for defining hospitals and/or EDs and/or geographic location, both within ACEM and by Australian and Aotearoa New Zealand governments. The different definitions are context specific (for example, training and education, accreditation, ED delineation) and articulate different factors such as geographic distance, population and access to tertiary hospitals. See [Appendix One](#) for further information on different classification systems.

For the purposes of this Action Plan, the term "rural, regional and remote" includes:

- **within Australia** all locations outside of Australia's capital cities without access to a tertiary hospital; and
- **within Aotearoa New Zealand** all locations outside of greater Auckland, Christchurch, Hamilton or Wellington. All EDs within greater Auckland, Christchurch, Hamilton or Wellington are classified as metropolitan.

The definition is not intended to be exclusive but rather to broadly capture non-metropolitan areas experiencing lesser access to emergency care. The definition should be interpreted within the purposes of the Action Plan to increase equitable access to healthcare in rural, regional and remote areas.

Emergency medicine networks

There are many types of formal and informal "networks" relevant to emergency medicine in rural, regional and remote areas, including functional/clinical networks and training networks. Use of the term "network" may differ depending on the context and jurisdiction.

The formal networks referred to in this Action Plan include the following.

- **Emergency Medicine Network (EM Network)** An EM Network is comprised of a Level 1 (large, multifunctional tertiary or major referral) or Level 2 (major regional, metropolitan or urban) hospital providing outreach services to non-specialist providers of emergency care in other medical settings.^{3,4} See [The role and importance of EM Networks in rural, regional and remote areas](#) for further information on the role and importance of EM Networks.
- **An Emergency Medicine Training Network (EM Training Network)** An EM Training Network is defined as a group of hospitals that have formally agreed to a coordinated education and training program for emergency medicine trainees. Each hospital within the network must individually satisfy the mandatory criteria for accreditation. For detailed criteria and network requirements, please refer to ACEM's [FACEM Training Program Site Accreditation – Requirements \(AC549\)](#).⁵
- **Emergency Medicine Education and Training (EMET) Network** The EMET Network refers to the 49 EMET Hubs supported by ACEM to facilitate and support roll-out of the EMC, EMD and EMAD, and deliver training and supervision to doctors who do not have specific emergency medicine training, and the teams they work with in hospitals and health services with EDs or emergency services. See [ACEM's strategic context](#) for more information on the EMET program.

Introduction

ACEM believes that everyone has the right to timely, safe and quality emergency care. One of ACEM's strategic priorities is equity through advocacy; ACEM is committed to influencing key decision makers through advice and proactive advocacy to achieve improved access and outcomes for people who need to attend an emergency department, wherever they are.

In the latest census, more than eight million Australians – approximately one third of the population – lived in non-capital cities and communities.⁶ Similar to Australia, Aotearoa New Zealand's population is concentrated in regions, with Auckland, Canterbury and Wellington recording the highest population size. More than half (53%) of its 4.85 million people live outside of these cities.⁷

Both Australia and Aotearoa New Zealand's public health systems are funded and delivered on the basis of universal access to healthcare, regardless of location. In practice, this principle has not consistently delivered equity of either availability of or access to healthcare. People who live in rural areas have shorter lives and higher levels of injury, illness and disease risk factors than those in major cities.

This is an ongoing trend. For example, the first report of the Australian Institute of Health and Welfare (AIHW) on rural health in 1998 found that Australia's rural and remote populations have poorer health than their metropolitan counterparts with respect to several health outcomes, higher hospitalisation rates for some causes of ill health, and higher mortality rates and consequently lower life expectancy.⁸

This long-term trend requires concerted, coordinated action from healthcare funders, service providers, consumers and other key stakeholders to improve population health outcomes. However, in both Australia and Aotearoa New Zealand, there is a gap in rural health action planning, particularly in the area of emergency care.

ACEM believes that it can play a key role in improving health equity in rural, regional and remote areas, especially in emergency medicine. As the peak professional organisation for emergency medicine in Australia and Aotearoa New Zealand, ACEM influences the practice of emergency medicine through the development of standards, training, policy development, advocacy, accreditation and continued education of its members. The College can further influence its membership in the practice of emergency medicine as it relates to rural, regional and remote communities.

Health equity in rural areas is highly complex and is influenced by many intersecting and pervasive issues. ACEM's strategic plans to address equity for Māori,⁹ Aboriginal and Torres Strait Islander peoples¹⁰ are highly relevant - inequity in rural areas involves many common influences and issues, as well as presenting additional and unique challenges.

In order to be effective, the College needs a strategic vision that brings together its work and embeds a focus on rural health across its operations. The Action Plan articulates the College's role in addressing health equity in rural areas and aims to strategically coordinate work across the College to maximise the impact of the College's work to improve health equity.

The development of the Action Plan was led by ACEM's Rural, Regional and Remote (RRR) Committee and overseen by the College's Council of Advocacy, Practice and Partnerships (CAPP). The plan was shaped by input from a wide range of ACEM committees, ACEM staff and individual members and trainees.

This is the first Rural Health Action Plan. It focuses on building the foundations for understanding how best to strengthen emergency medicine in rural, regional and remote areas, particularly workforce, research, collaboration and service provision, planning and development. We expect to develop another action plan for the year 2024 onwards that will build on these foundations and focus on the next stage in improving health equity in rural, regional and remote areas.

Strategic context

Equity through advocacy is a key strategic priority for the College. ACEM's [Strategic Plan 2019-2021](#) includes a commitment to work with members, trainees and wider stakeholders to develop and promote an ACEM strategy on the future emergency workforce to address distribution challenges, with particular focus on the needs of rural, regional and remote communities.¹¹

Rural, regional and remote policy, advocacy and strategic partnerships

ACEM has a long-standing commitment to rural health, and throughout its history the entity overseeing this work has taken various forms. The RRR Committee was established by the College in 2010, taking over from the previously named Rural and Regional Committee. The role of the RRR Committee is to:

- provide leadership and advice to CAPP regarding policy and standards for all aspects of emergency care in rural, regional and remote areas;
- advise CAPP on issues relating to the recruitment and retention of Fellows of the College to rural and regional areas;
- advise CAPP, the Council of Education (COE) and any other ACEM entities, as applicable, on issues relating to the recruitment, retention and training of College trainees in rural and regional areas;
- provide comment and advice to CAPP on those aspects of healthcare delivery (such as administration, nursing, retrieval medicine and pre-hospital care) that impact on the provision of emergency care in rural, regional and remote areas; and
- liaise with other organisations and colleges on issues of common ground, as deemed necessary and directed by CAPP and/or the ACEM Board.¹²

ACEM's [position statement](#) on rural emergency care was first published in 2012 and is regularly reviewed. It sets out ACEM's policy positions and key principles for achieving timely, safe and quality emergency care in rural areas.¹³

ACEM's advocacy is strengthened by its membership of rural, regional and remote healthcare-focused organisations, including:

- Australia's National Rural Health Alliance;
- Rural Health Alliance Aotearoa New Zealand; and
- the Joint Consultative Committee (JCC) regarding ACEM's EMC, EMD (and now EMAD) with RACGP and ACRRM.

ACEM also collaborates and consults with a range of medical colleges, government bodies/health authorities and other organisations with an interest in rural, regional and remote healthcare.

Rural, regional and remote education and training

ACEM is one of a small number of medical colleges where trainees can base themselves in regional areas and only need to rotate to a metropolitan centre to undertake their six-month Major Referral training time.

ACEM manages a number of projects and initiatives under its National Program, with grants funded by the Australian Government that aim to develop, strengthen and support a skilled and confident workforce of emergency doctors in rural, regional and remote areas.

- The EMC, EMD and EMAD training programs: competency-based education programs that provide doctors working in EDs with the specific knowledge and clinical experience to advance their practice without pursuing training to Fellowship of ACEM. These programs benefit CMOs, junior medical officers, visiting medical officers and general practitioners, including doctors completing an emergency medicine component as part of the RACGP or ACRRM Fellowship.
- A Special Skills Placement, developed by ACEM, that enables ACEM trainees to train in rural or remote health for three to six months. ACEM has also developed a Special Skills Placement in Aboriginal, Torres Strait Islander and Māori Health which often takes place in rural, regional and remote settings.
- The EMET Program, which has been building the capacity of our regional, remote and rural health workforce – including medical specialists, general practitioners and nurses who are not specifically trained in emergency medical care – to confidently provide urgent and critical care across rural, regional and remote parts of Australia since 2011. It provides education, training and supervision to doctors and the teams they work with, to develop their skills in treating critically ill or complex trauma patients. It also provides supervision and support for doctors working in EDs to complete the EMC, EMD and EMAD programs and supports hospitals to provide outreach training to the teams in smaller hospitals on a wide range of skills and areas required for emergency medical care.
- The Integrated Rural Training Pipeline (IRTP) initiative aims to deliver a sustainable, Australian-trained future medical workforce for rural, regional and remote communities. It provides greater opportunities for graduates interested in rural careers to maintain connections to rural communities while they complete post-graduate training. An IRTP post enables a specialist trainee to complete at least two thirds of their Fellowship training within a rural region, with metropolitan rotations where necessary to meet college education and accreditation standards.
- The Specialist Training Placements and Support (STPS) Program, which provides registrars with exposure to a range of healthcare settings outside of traditional public teaching hospitals. Of these, 62.5 per cent of the posts (or 35.5 FTE of 57 funded) are located in rural and remote locations and provide training opportunities and rotations in rural and remote medicine, retrieval medicine, or critical care.

Other current work by the College in relation to rural, regional and remote education and training includes:

- The ACEM Mental Health in Rural EDs (MHrED) project, which is building a one-stop website providing clinical and service development resources addressing mental health presentations in rural EDs and Urgent Care Centres. With the dual focus of better patient outcomes and improved service delivery, the resources will be freely accessible to all Australian health professionals and support staff working in, or interested in, emergency care.
- The development of ACEM's [COVID-19 Toolkit for Rural Emergency Care Facilities in Australasia](#).¹⁴

Work across the College to address equity in access to emergency care

The College acknowledges that equity in access to emergency care is impacted by a broad range of complex factors. While the Action Plan focuses on health equity from a rural, regional and remote perspective, this intersects with a broad range of work already underway across the College to address:

- Workforce and wellbeing issues for emergency physicians and trainees across all stages of their career, including the establishment of the Workforce Planning Committee.
- Health system advocacy, in particular around access block, including the development of revised access measures and time-based targets for patients presenting to EDs.
- Mental health, including the development of a Mental Health strategy and Action Plans for Australia and Aotearoa New Zealand.
- Equity for Māori and Aboriginal and Torres Strait Islanders peoples in emergency medicine, including Cultural Competence training, ACEM's Reconciliation Action Plan, Te Rautaki Manaaki Mana – the College's strategy for increasing equity for Māori, and the establishment of the Indigenous Health Committee (replacing the previous Indigenous Health Subcommittee).
- Gender equity, including the establishment of the Advancing Women in Emergency Medicine Section and the development of a College statement on gender equity.

The role and importance of EM Networks in rural, regional and remote areas

ACEM believes that every rural community in Australia and Aotearoa New Zealand should be part of an EM Network. Emergency care in rural, regional and remote areas is provided in health facilities by staff across different specialty areas including emergency physicians, general practitioners, rural generalists, nurses, health workers, paramedics and volunteer ambulance officers (including nurses and paramedics with extended emergency care skills). Each healthcare facility will have a unique model of service that reflects the mix of skills, availability and experience of the individual team members. This should be adequately resourced without compromising clinical services at the larger referral regional or metropolitan hospital.

Effective emergency care networks ensure that high quality care starts within the community and pre-hospital system and that patients with needs beyond what that facility can provide are rapidly and safely transferred. This may include bypassing local smaller services to minimise delays in providing definitive care.

ACEM endorses the development of models of EM Networks whereby regional or metropolitan hospitals provide support to smaller rural facilities. This includes clinical support, professional development and continuing education, telephone advice, telemedicine and medical retrievals. Outreach services should also include the shared development and implementation of policies and procedures in emergency medicine that support sound clinical governance and decision-making.

Each EM Network should appoint a FACEM to lead and oversee the development and maintenance of the EM Network. These networks should support improvements in emergency medical care by using evidence-based practice to decrease variation in decision-making and outcomes, and also promote collaboration through partnerships between practitioners across the EM Network's region.¹⁵

See also:

- [ACEM COVID-19 Toolkit for Rural Emergency Care Facilities in Australasia](#), which discusses the important role of EM Networks in regional pandemic planning.¹⁶

Background

Inequitable access to emergency care in rural, regional and remote areas

The sustainability of the emergency medicine workforce across Australia and Aotearoa New Zealand is affected by increasing workload, workplace culture, health system factors and emergency physician burnout, as well as employment status issues. These issues are exacerbated in rural, regional and remote areas by the geographic maldistribution of the existing workforce (see figures 1 and 2). Despite the growth of the specialty, an equivalent increase in the number of trainees and FACEMs working in rural, regional and remote areas has not occurred.

ACEM's *Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce* (the G23 Guidelines) recommends minimum staffing levels required to provide quality patient care. Compared with metropolitan EDs, even fewer EDs in rural, regional and remote areas have sufficient FACEMs and senior decision makers when benchmarked against ACEM's G23 Guidelines,¹⁷ resulting in inequitable access to local specialist emergency care.

Geographic maldistribution of the medical workforce is one factor associated with disparities in patient access to healthcare, as well as with health outcomes. While differences in health outcomes are multifactorial, and not solely due to workforce disparities, improving geographic distribution will contribute to more equitable health outcomes for rural communities.

Geographic maldistribution of FACEMs and trainees

In 2019, across Australia and Aotearoa New Zealand, the majority of FACEMs working in a hospital setting (71 per cent in Australia, and 51 per cent in Aotearoa New Zealand) were working in a metropolitan public hospital as their primary workplace.¹⁸ Just over a quarter (26.1 per cent) of all FACEMs worked in a regional/rural area, with 23% of FACEMs in Australia and 49 per cent of FACEMs in Aotearoa New Zealand working in regional/rural locations as their primary workplaces (Figure 1).¹⁹

Almost half (46 per cent) of new FACEMs (six to 12 months post-Fellowship) worked in metropolitan areas only, 33 per cent worked in a regional/rural/remote area only, and 21 per cent worked in both metropolitan and regional/rural/remote areas. This had increased from 2014 when only 12.9 per cent of new FACEMs were working in regional/rural areas.²⁰

In 2019, only 17.7% of trainees in Australia were working in regional/rural localities as their permanent workplace, compared with 36.6% of trainees in Aotearoa New Zealand (Figure 2).²¹

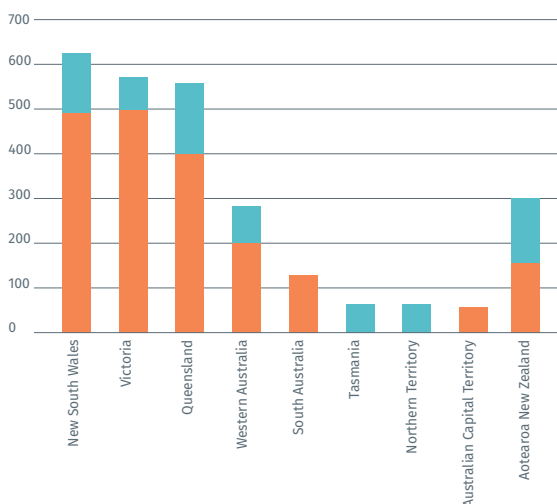


Figure 1
Distribution of FACEMs' primary workplace, by region and remoteness in 2019 (n = 2622)²²

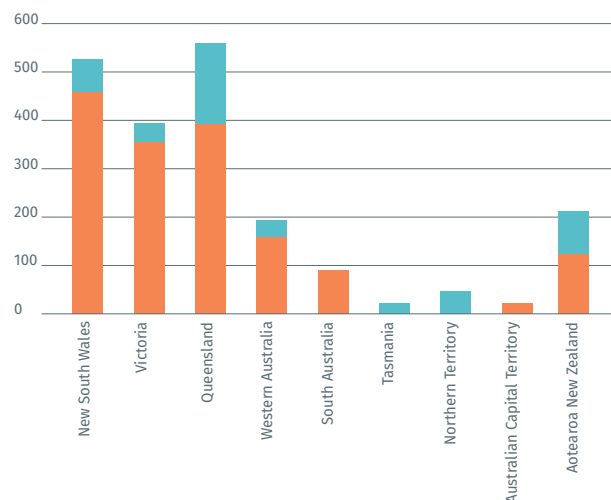


Figure 2
Distribution of FACEM trainees' primary workplace, by region and remoteness in 2019 (n = 1988)²³

● Metropolitan ● Rural or Regional

Inequitable ED staffing levels/ratios

In 2018, only 23.5 per cent of all Aotearoa New Zealand EDs and 22.7 per cent of all Australian EDs met the minimum FACEM staffing recommended in ACEM's G23 Guidelines.

At the time of reporting, over one-third (37.9%) of Australian ACEM-accredited major hospital EDs were meeting ACEM's G23 Guidelines. Two-thirds (66.7%) of metropolitan hospital EDs in Aotearoa New Zealand were meeting the G23 Guidelines.

No EDs in Tasmania, the Australian Capital Territory and the Northern Territory met the G23 Guidelines. No small/medium regional hospitals in Australia and no regional hospitals in Aotearoa New Zealand were meeting the minimum FACEM requirements.²⁴

In addition:

- ACEM-accredited small/medium regional hospitals (and private hospitals) in Australia had the lowest ratio of emergency medicine specialists to FACEM trainees compared to larger hospital peer groups.
- Regionally located ACEM-accredited EDs in Australia and Aotearoa New Zealand were more likely to report having unfilled FACEM FTE and unfilled trainee FTE, with 71.4% of large regional and 66.7% of small/medium hospitals in Australia reporting unfilled FACEM FTE, compared with 26.7% of major hospitals and 37.9% of large metropolitan hospitals.²⁵ In Aotearoa New Zealand, 54.5% of regional hospitals reported unfilled FTE, compared with 42.9% of metropolitan hospitals.
- In Australia and Aotearoa New Zealand, large and medium metropolitan hospitals had a higher number of emergency medicine specialists and trainees per ED attendances compared to large regional hospitals.²⁶

Many rural, regional and remote EDs in particular still rely heavily on a locum workforce. As reported in ACEM's 2018 Site Census survey, regional EDs were more likely than others to be employing locums, with 100% of small/medium regional EDs in Australia employing locums. Overall, ED locums represent a significant portion of the ED workforce, with recent data showing that half of Aotearoa New Zealand (50%) and over a third (33.9%) of Australian EDs employed locums.²⁷

Impact on health outcomes for patients in rural, regional and remote areas

As illustrated above, patients living in a rural, regional and remote area have lower access to FACEM-led care than those living in metropolitan areas.

This has an amplified impact on Māori in Aotearoa New Zealand, as a greater proportion of Māori attend EDs located outside of metropolitan areas than non-Māori. In 2017-2018, 69% of Māori ED patients attended EDs in regional locations. In comparison, only 51% of non-Māori ED patients attended EDs in regional locations.²⁸

It also has a distinct impact on Aboriginal and Torres Strait Islander peoples in Australia. According to the 2016 Australian Census, Aboriginal and Torres Strait Islander peoples are more likely to live in urban and regional areas than remote areas.²⁹ However, the proportion of the population that identify as Aboriginal and/or Torres Strait Islander is much higher in regional, remote and rural areas than metropolitan areas. Aboriginal and Torres Strait Islander people represent 1.7 per cent of the population in major cities, but represent 4.4% of inner regional, 7.9% of outer regional, 18 per cent of remote and 47 per cent of very remote populations.³⁰

In 2014-2015, Aboriginal and Torres Strait Islander peoples accounted for a higher proportion of all ED presentations in very remote (50 per cent) and remote areas (35 per cent), compared to three per cent of ED presentations in metropolitan areas; however, they were over-represented across all of these areas in comparison to their proportion of the general population – 45 per cent of people living in very remote areas, 16 per cent of people living in remote areas and 1.5 per cent of people living in metropolitan areas were Indigenous.³¹

Inequitable access to FACEM-led emergency care is part of the wider issue of inequitable access to healthcare in general. Patients living in rural, regional and remote areas face difficulties in accessing treatment in a reasonable timeframe, less choice in provider and less access to specialist services.^{32,33} For patients this might look like:

- not having a usual GP or place of care;³⁴
- needing to present to an ED because no GP is available when needed;³⁵
- needing to travel long distances and undergo lengthy stays away from home to access health services;³⁶
- delayed diagnosis, transfer and treatment;³⁷
- difficulties in self-managing chronic conditions;³⁸ and
- compromised continuing recovery after returning home creating a 'vicious cycle of increasing ill health'.³⁹

The impact of inequitable access to healthcare is seen in the poorer health outcomes experienced by people living in rural, regional and remote areas, when compared to those living in metropolitan areas. For example:

- In Australia in 2017, potentially avoidable deaths made up 17 per cent of all deaths. For males and females, the rate increased with remoteness. The rate for females in very remote areas was 3.3 times as high as major cities, and the rate for males in very remote areas was 2.3 times as high as major cities.⁴⁰
- In Australia in 2015, the burden of disease in remote and very remote areas was 1.4 times higher than that for major cities.⁴¹
- From 2013 to 2017, Australians living in remote and very remote areas were 'about twice as likely to die from suicide when compared to Australia overall'.⁴² In Aotearoa New Zealand, the suicide rate is higher for those in rural areas than in urban areas.⁴³
- In Aotearoa New Zealand, people living in rural towns have lower life expectancy than people living in cities or surrounding rural areas.⁴⁴

Inequitable health outcomes for Aboriginal and Torres Strait Islander peoples are worse in rural, regional and remote areas.

In general, Aboriginal and Torres Strait Islander peoples across Australia experience poorer health outcomes than non-Indigenous people. For example, AIHW data suggests that Aboriginal and Torres Strait Islander are more likely to present to EDs for mental health reasons. Indigenous Australians make up about three per cent of the Australian population, but comprise about 11 per cent of all ED mental health presentations across the country.⁴⁵

Aboriginal and Torres Strait Islander peoples in rural and remote areas experience significantly worse health outcomes than non-indigenous peoples. Aboriginal and Torres Strait Islander peoples experience greater prevalence of chronic disease compared with non-indigenous people, including higher rates of diabetes, end-stage kidney disease and circulatory disease. Incidence of chronic disease increases with remoteness, in some cases significantly, with Aboriginal and Torres Strait Islander peoples from a remote area 60% more likely to have circulatory disease than those in major city or rural areas.⁴⁶ The AIHW's *Aboriginal and Torres Strait Islander Adolescent and Youth Health and Wellbeing* report (2018) found that Aboriginal and Torres Strait Islander people in remote areas were more likely to report high or very high psychological distress (40% or 10,400) compared with Aboriginal and Torres Strait Islander people in non-remote areas (32 per cent or 35,000).⁴⁷

Inequitable health outcomes for Māori may be worse in rural, regional and remote areas

In general, Māori experience significantly worse health outcomes than non-Māori across Aotearoa New Zealand. Some gains have been made over the last 30 years to improve health outcomes for Māori. Despite these gains, Māori continue to experience consistent and compelling disparities in health outcomes, exposure to the determinants of ill-health, lack of health system responsiveness and the under-representation of Māori in the health workforce. Māori have higher rates than non-Māori for many health conditions and chronic diseases, including cancer, diabetes, cardiovascular disease and asthma. Māori experience higher disability rates, shorter life expectancy, higher suicide rates, (especially amongst young Māori), and higher smoking rates than non-Māori.⁴⁸

We also know that Māori are over-represented in the population of those accessing mental health and addiction services at 27.7 per cent⁴⁹ (compared with their proportion in the general population at 15.4%) and we know that Māori are overrepresented in presentations to the ED (20-21 per cent of people presenting to EDs are Māori).⁵⁰ However, there is a gap in the data on how many Māori ED presentations are related to mental health.

The Aotearoa New Zealand Health and Disability System Review found that, while data is limited, there are indications that the poorer health outcomes experienced by people living in rural towns is accentuated for rural Māori.⁵¹ A 2010 report by the National Health Committee found that life expectancy for rural Māori may be slightly lower than that for urban Māori.⁵²

FACEM and trainee experiences of training and practice in rural, regional and remote areas

Physician wellbeing

Inadequate staffing particularly impacts emergency physician wellbeing through high levels of burn-out, professional isolation and moral injury.^{53,54} The pressures of inadequate staffing across both metropolitan and rural, regional and remote areas can be seen in the 2019 ACEM *Sustainable Workforce Survey* findings. 64% of respondents worked in metropolitan/urban areas and 36% worked in regional areas.

Of the respondents, FACEMs working in regional areas were less likely to report overall satisfaction with their primary workplace (71% compared with 77% of FACEMs working in metropolitan areas). Trainees in regional areas were more likely to report that demands of their work interfered with their home and family life (77% compared with 71% of trainees in metropolitan areas).

However, trainees in regional areas were more likely to report overall satisfaction with their primary workplace (78%, compared with 65% of trainees in metropolitan areas). FACEMs and trainees in regional areas were less likely to report experiences of discrimination, bullying, sexual harassment or harassment by a professional colleague than those in metropolitan areas.

Training and education

Despite many trainees reporting positive experiences in rural, regional and remote areas, there are still many challenges to training in some rural, regional and remote centres, which include:

- appropriate supervision and assessment;
- professional isolation;
- financial support and time to attend training in metropolitan centres; and
- progression through pre-vocational and vocational training, which often requires a return to metropolitan centres. At this point, many trainees develop the personal and professional networks integral to their future life and career path, and therefore may be less inclined to return to train or practice in rural, regional and remote areas.

In addition to these challenges, there is also the challenge of misconceptions that surround education and training programs in rural, regional and remote areas that lead them to be viewed as inferior and less appealing programs to their metropolitan counterparts. These misconceptions can include that trainees do not have access to a sufficient clinical case load and that there are fewer employment opportunities post training.

The majority of ACEM-accredited EDs across Australia and Aotearoa New Zealand are located in metropolitan and outer metropolitan areas, with fewer than 30 per cent of ACEM-accredited EDs located in rural, regional or remote areas. The ability to offer quality FACEM training at a rural, regional or remote site has long been considered an opportunity to increase the area's local workforce in the long and short-term. The shortage of FACEMs in rural, regional and remote areas creates a barrier to training and retaining a new specialist emergency medicine workforce in these areas.

For FACEMs and FACEM trainees, in addition to the availability of positions across rural, regional and remote areas, the decision to train and/or work rurally is influenced by various factors. Much of the existing research on factors influencing a decision to work in a rural, regional or remote location has focused on the primary care and general practice workforce rather than the emergency medicine workforce. Nonetheless, this research shows it is multifactorial and includes family needs, educational stages of children, a good work-life balance and the level of remoteness.

Incentivising factors for new FACEMs to work in rural, regional and remote areas include job availability (or lack thereof in metropolitan areas), lifestyle factors, breadth of exposure and skill development. Disincentivising factors include preconceptions of work in rural, regional or remote areas, preference for a city lifestyle (with a high percentage of trainees from metropolitan backgrounds), and a preference for metropolitan/tertiary hospital case-mix.⁵⁵

Our goal

All patients presenting to EDs in Australia and Aotearoa New Zealand, wherever they present, have equitable access to timely, safe and high-quality care.

Our vision

- A sustainable and permanent rural, regional and remote emergency medicine workforce supported by robust, effective EM Networks.
- An equitable distribution of emergency medicine specialists throughout rural, regional and remote Australia and Aotearoa New Zealand providing equitable access to emergency care for their communities.
- An improved understanding of health and emergency care practice in rural, regional and remote communities.
- ACEM plays a key role in improving health equity, particularly access to emergency medicine, in

Action plan

rural, regional and remote areas in Australia and Aotearoa New Zealand.

The College's vision for the provision of emergency medicine in rural, regional and remote communities is underpinned by equity. ACEM firmly believes that every person in Australia and Aotearoa New Zealand deserves access to high quality emergency and acute care when presenting to an ED.

The physical location of the EDs throughout Australia and Aotearoa New Zealand should not influence the level of emergency care provided to a patient. ACEM is committed to working with government and stakeholders to address all instances where this gap in care occurs.

Specialist emergency medicine physicians work within the ED, throughout the hospital environment and across the broader healthcare system. Our members bring a unique local, national and bi-national perspective and expertise that shapes ACEM's approach to improve access to timely, safe and high-quality care. This cannot be undertaken or achieved by ACEM alone – government, hospital executives, health departments, other medical colleges, community and cultural representatives, and rural, regional and remote health organisations must work together.

Strategic Priority One: Workforce

ACEM supports equitable distribution of the emergency medicine workforce in rural, regional and remote areas.

Focus areas

1. Attract, grow and retain the emergency medicine workforce in rural, regional and remote EDs.
2. Increase the number of trainees undertaking training in rural, regional and remote EDs by identifying barriers for trainees to undertake training in rural, regional and remote sites (i.e. through College structures, external structures such as state health organisations and lifestyle factors) and developing solutions.
3. Support existing rural, regional and remote emergency medicine workforce wellbeing and education needs.

Strategic priorities and actions

4. Support generalists in rural, regional and remote areas to advance their emergency medicine practice through ACEM's EMC, EMD, EMAD programs and other education and training opportunities.

Action	Responsibility
1.1 ACEM to identify barriers for trainees to undertake training in rural, regional and remote sites and potential solutions to remove or address these barriers	Workforce Planning Committee
1.2 Use ACEM communications channels for media and community engagement (for example, the website, bulletins, Your ED, emails to DEMENTs) to increase the visibility of rural, regional and remote emergency medicine across members, trainees, the wider community of practice and mainstream media. <ul style="list-style-type: none"> • Add a dedicated webpage to ACEM's website that highlights emergency medicine in rural, regional and remote locations. This may include a profile of the RRR Committee, ACEM rural, regional and remote focused policy and advocacy work (for example, <i>Statement on Rural Emergency Medicine</i> (S27), research reports), media releases, resources, events and scholarships. It will also act as a hub for the other actions listed directly below. • Publish articles that highlight the highly skilled nature of rural, regional and remote emergency care work and the specific opportunities it presents, and dispel myths about perceived negative aspects of training and working in these locations. • Profile and celebrating the achievements of specific members and trainees in rural, regional and remote areas. • Profile ACEM-accredited EDs in rural, regional and remote areas and promote job opportunities in those EDs. • Publish written testimonials and or/short films of trainees who have undertaken training at a rural, regional or remote site to promote training at these locations. • Publish written testimonials and or/short films of members who have graduated from the EMC, EMD and EMAD programs in rural, regional and remote sites. • Create a centralised resource (such as a dedicated webpage or directory) for trainees seeking opportunities to: <ul style="list-style-type: none"> – Undertake FACEM training in rural, regional and remote areas such as through the IRTP – Undertake an ACEM Special Skills Placement in Aboriginal, Torres Strait Islander and Māori Health in rural, regional or remote areas, or an ACEM Special Skills Placement in Rural Health – Apply for FACEM positions in rural, regional and remote areas (late stage advanced trainees). 	Communications Unit (Corporate Services) Support from Department of Policy, Research and Partnerships

1.3	RRR Committee provide input to the Workforce Planning Committee's development of an ACEM Workforce Strategy and initiatives (including G23 Guidelines on Constructing and Retaining a Senior emergency medicine Workforce, models of care, rural training pathway).	Department of Policy, Research and Partnerships Support from Strategic Priorities
1.4	RRR Committee considers the role ACEM might play in guiding professional skills development in the wider rural, regional and remote ED workforce, particularly through the EMET Program and the development and strengthening of emergency medicine networks.	Department of Policy, Research and Partnerships Support from National Program (Department of Education and Training)
1.5	<p>ACEM considers further ways to increase accessibility to ACEM education and training opportunities for members and trainees (including FACEM trainees and EMC/EMD/EMAD trainees) in rural, regional and remote areas.</p> <ul style="list-style-type: none"> • Ascertain where there are gaps regarding member and trainee support in rural, regional and remote sites and identifying support systems that would benefit trainees and members (for example, remote access through videoconferencing). • Identify which rural, regional and remote ACEM-accredited sites are not currently part of an EM Training Network and highlighting what training requirements ACEM trainees can complete at these sites. • As part of profiling ACEM-accredited EDs in rural, regional and remote areas (see 1.2 above), identify other areas of specialist skills training these EDs /hospitals are accredited for (such as critical care, ultrasound, pre-hospital retrieval medicine and anaesthetics). • Consider the role ACEM and training networks can play in supporting trainees in rural, regional and remote areas to access other areas of specialist skills training while remaining in rural, regional and remote areas. • Develop orientation and information guidelines for rural, regional and remote sites receiving trainees, and for the trainees themselves. These guidelines are to cover what to expect as a trainee, as well as how to best support trainees coming to the site. • Consider ways to provide more support to practitioners in rural, regional and remote areas to undertake/complete CPD, with a particular focus on professionally isolated practitioners. • Consider ways to provide further support for EMET hubs (e.g. pooling of resources and online support). • Advocate for metropolitan and tertiary hospitals to increase remote access to education and training. 	Department of Education and Training Support from Communications Unit

Continued

1.6	<p>ACEM to consider the development of scholarships, as follows.</p> <ul style="list-style-type: none"> • Support trainees in rural, regional and remote EDs to attend ACEM education and training and other development opportunities (such as the ASM, trial OSCEs and/or workshops). This could cover items such as fees, accommodation and travel costs. • Attract potential FACEM trainees, particularly from rural-based and SIMG backgrounds, to undertake training in mostly rural areas (for example, partial subsidisation of course fees). • Support FACEM trainees to undertake an ACEM Special Skills Placement in Aboriginal, Torres Strait Islander and Māori Health in a rural area, and the ACEM Special Skills Placement in Rural Health. 	<p>Department of Education and Training</p> <p>Support from Department of Policy, Research and Partnerships</p>
1.7	<p>ACEM to consider ways to help retain the rural, regional and remote emergency medicine workforce through increasing wellbeing support and mentorship for members and trainees, such as:</p> <ul style="list-style-type: none"> • Online FACEM mentorship for trainees as appropriate to different stages of their training; • networks and forums for rural, regional and remote-based trainees and practitioners for peer support and sharing of resources; and • opportunities for rural, regional and remote leadership training. 	<p>Membership and Culture Unit</p> <p>Support from Department of Education and Training</p>
1.8	<p>ACEM advocates to state and territory health authorities to increase/ provide backfill for emergency physicians and generalists in rural, regional and remote areas so that they can attend education and training and other professional development/ upskilling opportunities such as rotations to metropolitan or larger regional centres.</p>	<p>Policy and Advocacy Unit (Department of Policy, Research and Partnerships)</p> <p>Support from National Program Unit (Department of Education and Training)</p>
1.9	<p>ACEM produces and/or disseminates resources to support the engagement and wellbeing of members and trainees in rural, regional and remote areas, with a particular focus on new members.</p>	<p>Membership and Culture Unit</p> <p>Support from Department of Education and Training</p>

Strategic Priority Two: Evidence

ACEM further builds the evidence base for strengthening rural, regional and remote emergency medicine.

Focus areas

1. Increase understanding of rural, regional and remote emergency doctor experiences and needs.
2. Increase understanding of rural, regional and remote patient experiences, outcomes and needs.
3. Build research capacity and utilise existing research contribution in rural, regional and remote emergency medicine.
4. Work towards developing a measure of equity of access to emergency medicine in rural, regional and remote areas.

Action		Responsibility
2.1	ACEM produces an annual report on access block, including delays in transport to or acceptance at referral hospitals for patients in rural, regional and remote areas.	Research Unit (Department of Policy, Research and Partnerships) Support from Policy and Advocacy Unit (Department of Policy, Research and Partnerships)

Continued

<p>2.2</p>	<p>ACEM conducts or supports data collection and research to increase the understanding of:</p> <ul style="list-style-type: none"> • the unique case mix and key experiences of practicing emergency medicine in rural, regional and remote EDs; • the demographics and types of presentations for Aboriginal and Torres Strait Islander peoples and Māori presenting to rural, regional and remote EDs; • the current rural, regional, and remote ED member and trainee workforce (this could include demographics, retention, motivations and influences for practicing in rural, regional and remote areas, capacity to conduct training and research, follow up of IRTP trainees following attainment of Fellowship and EMC/EMD/EMAD graduates); and • quality and safety experiences, outcomes and measures of emergency care in rural, regional and remote EDs, including the experiences and outcomes of Aboriginal and Torres Strait Islander peoples and Māori patients (including cultural safety and cultural appropriateness). <p>This research will inform future work aligned with the ACEM Workforce Planning Committee. It will also support ACEM's future advocacy, training and support, such as the development of measures (for example, performance indicators in relation to the patient journey) and the design, facilitation and promotion of professional development activities for members and trainees in rural, regional and remote areas.</p>	<p>Research Unit (Department of Policy, Research and Partnerships)</p> <p>Support from Projects Unit (Department of Policy, Research and Partnerships) to liaise with Manaaki Mana Rōpū, Reconciliation Action Plan (RAP) Steering Group and the Indigenous Health Committee</p>
<p>2.3</p>	<p>ACEM undertakes environmental scans to identify:</p> <ul style="list-style-type: none"> • current research capacity in rural, regional and remote EDs; and • gaps and research needs, particularly gaps in data collection. <p>The environmental scan will provide the foundation for future work by ACEM to understand how ACEM can help build research capacity and utilise existing research contribution in rural, regional and remote EM.</p>	<p>Research Unit (Department of Policy, Research and Partnerships)</p> <p>Support from Policy and Regional Engagement Division (Department of Policy, Research and Partnerships)</p>

Strategic Priority Three: Service Provision, Planning and Development

ACEM advocates for equitable access through improved service planning and development in rural, regional and remote areas.

Focus areas

1. Increase visibility of rural, regional and remote experiences and needs in ACEM's emergency medicine standards.
2. Increase visibility of rural, regional and remote experiences and needs in ACEM's policy and advocacy.

Action	Responsibility
<p>3.1 The RRR committee conducts an audit of relevant standards to ensure they reflect EM care in rural, regional and remote areas. For example, <i>Statement on Delineation of EDs (S12)</i>, <i>Provision of Emergency Medicine Telephone Advice to the General Public/Other Health Professionals (P44 and P181)</i> and <i>Guideline for Transport of Critically Ill Patients (P03)</i>.</p>	Policy and Advocacy Unit (Department of Policy, Research and Partnerships)
<p>3.2 RRR Committee engages with the Manaaki Mana Rōpū Steering Group, the RAP Steering Group and the Indigenous Health Committee with a rural, regional and remote lens over equity of outcomes for Māori and Aboriginal and Torres Strait Islander peoples, including work to understand:</p> <ul style="list-style-type: none"> • the demographics, experiences and outcomes of Aboriginal and Torres Strait Islander and Māori patients presenting to rural, regional and remote EDs (see action 2.2 above); • the role of Whānau Ora and other Māori health initiatives/services in supporting access to emergency care for Māori patients in rural, regional and remote areas of Aotearoa New Zealand, and how ACEM can support their access to culturally appropriate and safe emergency medicine support and pathways of care in rural, regional and remote areas; • the role of Aboriginal and Torres Strait Islander peoples health services (including Indigenous Health Liaison Officers) in supporting access to emergency care for patients in rural, regional and remote areas, and how ACEM can support their access to culturally appropriate and safe emergency medicine support and pathways of care in rural, regional and remote areas; and • developing use of language and cultural interpreters within rural, regional and remote emergency settings. <p>Action 3.2 should be read in conjunction with:</p> <ul style="list-style-type: none"> • ACEM's Te Rautaki Manaaki Mana, particularly actions 9.1, 10.1 and 10.2; and • ACEM's Reconciliation Action Plan, particularly actions 4.1 to 4.5. 	<p>Department of Policy, Research and Partnerships</p> <p>Support from Manaaki Mana Rōpū, RAP Steering Group and Indigenous Health Committee</p>

Continued

3.3

ACEM advocates to Department of Health, jurisdictional health authorities and organisations on their role in improving networked relationships between rural, regional and remote EDs and tertiary hospitals, with a focus on:

- Developing/improving and implementing transfer policies.
- Ensuring access to 24-hour advice from FACEMs.
- Developing an understanding of the appropriate distribution of face-to-face and augmented delivery of emergency medicine in rural, regional and remote areas and the role of telehealth in clinical support.
- Establishing and supporting EM Training Networks to facilitate training rotations into rural, regional and remote sites as well as upskilling opportunities for rural practitioners in metropolitan/tertiary centres.
- Supporting rural centres to be incorporated into existing rural EM Networks.
- Establishing and supporting strong rural EM Networks.
- RRR committee engaging with the Quality and Patient Safety Committee in the review of ACEM and the College of Emergency Nursing Australasia's joint *Quality Standards for Emergency Departments and other Hospital-based Emergency Care Facilities*.

Department of Policy, Research and Partnerships, RRR Committee and Quality and Patient Safety Committee

Support from Department of Education and Training and Workforce Planning and Inclusion Manager, Department of Policy, Research and Partnerships

Strategic Priority Four: Collaboration

ACEM contributes to a strong rural, regional and remote emergency medicine community of practice.

Focus areas

1. Strengthen relationships between rural, regional and remote members and trainees across Australia and Aotearoa New Zealand.
2. Strengthen relationships with the wider rural, regional and remote health practice community.
3. Promote collaboration between rural and metropolitan EM Networks on a clinical basis (for example, clinical support and referral links, training networks to facilitate rotation of FACEM, EMC, EMD and EMAD trainees, access to teaching and examination practice).

Action	Responsibility
4.1 ACEM establishes a rural, regional and remote emergency medicine community of practice (through a Section or networks). ACEM will first engage with members to understand existing networks.	Policy and Regional Engagement Division (Policy, Research and Partnerships) Support from Communications Unit
4.2 ACEM collaborates and partners with the wider rural, regional and remote health community of practice (federal and jurisdictional health departments, health networks, organisations such as NRHA, RACGP, ACCRM, RHAANZ, DRHM RNZGP, NZNO and CENA, Aboriginal and Torres Strait Islander peoples' health organisations such as AIDA and NACCHO, Māori health organisations such as Te ORA , extended care nurses and pre-hospital and retrieval services) on initiatives to: <ul style="list-style-type: none"> • Develop a summit/symposium. • Develop standards for healthcare and credentialing in rural, regional and remote areas. • Strengthen relationships between Aboriginal Health Workers (Australia) and Māori health organisations (Aotearoa New Zealand), ACEM members and trainees, and the wider emergency medicine workforce. • Foster strong relationships between FACEM trainees undertaking FACEM training in rural, regional and remote areas and/or the ACEM Special Skills Placement in Aboriginal, Torres Strait Islander and Māori Health in rural areas and the wider rural, regional and remote health practice community. • Identify GPs working in rural EDs and encourage them to train to become GPs with special interest in emergency medicine. 	Policy and Regional Engagement Division (Policy and Strategic Partnerships) Support from Communications and Events (Corporate Services) Support from Council of Education
4.3 ACEM continues collaboration with ACCRM, RACGP, NRHA, RHAANZ and DRHM RNZGP to support a cooperative approach to the provision of rural, regional, and remote emergency care by inviting representatives from these colleges to relevant working groups.	Policy and Regional Engagement Division (Policy and Strategic Partnerships)

Implementation and reporting

The RRR Committee is responsible for:

1. Leading the implementation of the Action Plan.
2. Prioritising the actions within the Action Plan.
3. Reporting regularly to CAPP on implementation of the strategy.

Each action in the plan has been assigned to ACEM entities and/or departments. The assigned entities and/or departments are responsible for:

1. assigning a timeframe for the action(s), taking into account the prioritisation of the action(s) by the RRR Committee; and
2. providing regular progress updates on the actions to the RRR Committee and CAPP.

ACEM will provide progress updates via direct communications to members, trainees, external stakeholders and via ACEM's website.

A review of the implementation of the Action Plan and its outcomes will be completed prior to the development of the next Action Plan.

Please contact policy@acem.org.au for any further information.

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Appendix One

Rural, regional and remote classification

There are multiple classification systems for defining hospitals and/or EDs and/or geographic location, both within ACEM and by Australian and Aotearoa New Zealand governments. The different definitions are context specific (for example, training and education, accreditation, ED delineation) and articulate different factors such as geographic distance, population and access to tertiary hospitals.

Australian Government classifications

For programs funded under the Commonwealth Government's Specialist Training Program, the Australian Statistical Geography Standard – Remoteness Area (ASGS-RA) is used to determine rurality. The Remoteness Areas are defined in terms of the physical distance of a location from the nearest Urban Centre, with the following categories.

- RA1 – Major cities of Australia;
- RA2 – Inner regional Australia;
- RA3 – Outer regional Australia;
- RA4 – Remote Australia; and
- RA5 – Very remote Australia.

However, from January 2020, Department of Health programs have been transitioning to the Modified Monash Model (MMM) classification. MMM categorises metropolitan, rural, regional and remote areas according to both geographical remoteness and town size and was developed to recognise the challenges in attracting health workers to more remote and smaller communities. The MMM uses the ASGS-RA as a base, and further differentiates areas in Inner and Outer Regional Australia based on local town size.

Aotearoa New Zealand Government classifications

In Aotearoa New Zealand, classification of rural and regional areas is based on population size. For example, a rural centre has a population between 300 to 999 people.

Application of Regional, Rural and Remote classifications within ACEM

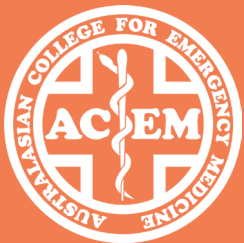
As a minimum requirement, a hospital must meet one of the delineation levels specified in ACEM's Statement on Delineation of EDs (S12) in order to be considered for ED accreditation. In relation to geographic location, sites accredited for FACEM Training are classified as either: Major Referral, Urban District or Rural/Regional with reference to relevant jurisdictional systems.

As noted in the [Strategic context](#), ACEM manages a number of projects and initiatives under the National Program with grants funded by the Australian Government. The projects and initiatives primarily use the ASGS-RA classifications.

ACEM's Annual Site Census uses AIHW classifications: Major metropolitan; Large metropolitan; Medium metropolitan; Major regional; Large regional; Medium regional; Private hospital.

For ACEM's Aotearoa New Zealand hospital remoteness classification: EDs are classified as metropolitan if they are located in greater Auckland, Christchurch, Hamilton or Wellington, with all other EDs located outside of these cities classified as regional.

See also: [ACEM guidelines on minimum criteria for accreditation of a special skills placement in Rural/Remote Health](#). These guidelines use the ASGS-RA classifications for Australia, and the Royal New Zealand College of General Practitioners' definition of Rural Hospitals for Aotearoa New Zealand.



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