Australasian College
for Emergency Medicine

Position Statement

Rural Emergency Care

The Australasian College for Emergency Medicine (ACEM) believes that everyone has the right to timely, safe and quality emergency care and is committed to advocating for improved service planning and development across hospital, community health services, community and cultural organisations in rural areas. In the context of rural emergency care, ACEM sets the following principles for achieving this outcome.

The health status of people living in rural areas is worse than that of urban populations; this long term trend requires concerted, coordinated action from funders and service providers to improve population health outcomes.

ACEM is committed to working in collaboration with key stakeholders to advocate for equity of access to timely, safe and quality health care for people living in rural areas.

The design and delivery of rural emergency care needs to take account of the social determinants of health, including lower levels of income, poorer access to educational and employment opportunities, and the barriers to accessing care created by time, travel and social stigma.

ACEM is committed to improving access and equity to quality care in emergency departments for Aboriginal and Torres Strait Islanders, and Māori, by educating and training emergency physicians to be culturally competent.

Experience in rural emergency care is part of developing confident, well-rounded emergency physicians.

There is a historical under-investment in rural health care, particularly in primary health care, mental health care, specialist care and allied health. Workforce shortages and maldistribution need to be addressed.

The timeliness of safe, quality emergency care in rural areas can be strengthened through supporting emergency practitioners' engagement in broader networks of integrated retrieval, referral and transfer services.

Telehealth is an important complement, but not a replacement for, locally and regionally provided comprehensive health care.

ACEM supports policy and program development by state and federal governments to address workforce and infrastructure shortages in regional, rural and remote communities. ACEM considers this is best achieved through working in partnership with medical specialists, their colleges, and with local communities.

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Document Review

Timeframe for review:	every five years, or earlier if required.
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Revision History

Version	Date	Pages revised / Brief Explanation of Revision
1	Mar 2012	Statement on Rural Emergency Medicine
2	Jun 2017	Revisions commenced
3	Oct 2017	New template; feedback included into revised draft
4	Mar 2019	Revised draft

1. Purpose

This Statement sets out the expectation of the Australasian College for Emergency Medicine (ACEM) for the provision of emergency care in regional, rural and remote (RRR) emergency departments (ED) and the action required by governments, ACEM and other stakeholders to ensure equity of access to timely, safe and quality care for patients.

This Statement applies to people accessing emergency care in regional, rural and remote communities in Australia and New Zealand.

2. Definitions

Accreditation Report
The Accreditation Report is a comprehensive document detailing the Accreditation Status of a site. It is used to record the findings of the appointed Inspection Team to reflect their assessment against each of the 54 Accreditation Requirements.

Emergency Medicine
Emergency medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development. (1)

Equity
Equity is defined as the provision and accessibility of health services to all communities and individuals, based on need and irrespective of location or socio-economic background. (2)

The equitable provision of health services is also a key policy and program focus of governments for Aboriginal and Torres Strait Islander peoples and for Māori. (3)(4)

Emergency Medicine Networks
An Emergency Medicine Network is comprised of a Level 1 (large, multifunctional tertiary or major referral) or Level 2 (major regional, metropolitan or urban) hospital collaborating with other practitioners providing emergency care in non-emergency department health care facilities. (1)

An Emergency Medicine 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 Accreditation Guidelines ACO1. (1)

Regional, Rural and Remote classifications
Currently, there are multiple classification systems for defining hospitals and/or emergency departments and/or geographic location, both within ACEM and by Australian and New Zealand governments.

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; RA5 – Very remote Australia. (5)

The Modified Monash Model (MMM) categorises metropolitan, regional, rural 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 Modified Monash Model uses the ASGS-RA as a base, and further differentiates areas in Inner and Outer Regional Australia based on local town size. (6)

New Zealand Government classifications
In 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. (7)

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 Emergency Departments (S12) in order to be considered for accreditation. (8)

For the purposes of accreditation, ACEM utilises three levels for classifying an emergency department: Major referral; Urban district; Rural/regional base.

ACEM's Annual Site Census uses Australian Institute of Health and Welfare (AIHW) classifications: Major metropolitan; Large metropolitan; Medium metropolitan; Major regional; Large regional; Medium regional; Private hospital.

In relation to geographic location, FACEM Training Program rotations classifies hospitals as either: Metropolitan – Tertiary Referral; Metropolitan – Urban district; Rural (determined by the hospital itself), which may be Tertiary Referral or not.

For ACEM's 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.

3. Background – The context for rural emergency medicine

More than eight million Australians, or approximately one third of the population, live in non-capital cities and communities. (9) Similar to Australia, New Zealand's population is concentrated in regions with Auckland, Canterbury and Wellington recording the highest population size. (10) More than half (53%) of its 4.85 million population live outside of these cities. (11)

In 2016-17 there was a total of 7,755 million emergency department presentations in Australia. Of these, approximately 2.75 million emergency department presentations (or 35%) were to EDs outside of major cities. (12) In 2014-15 there were over one million emergency department presentations (referred by the New Zealand Department of Health as 'ED Events') in New Zealand. (13) Internal analysis undertaken by ACEM of this data , shows that 54% of these presentations were to rural-regional based EDs, compared with 46% to metro based EDs.

Both Australia and 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 delivered equity of either availability or accessibility of health care. In aggregate, people who live in rural areas have shorter lives and higher levels of illness and disease risk factors than those in major cities. Australia-wide evidence shows that:

- the health of rural people is poorer than that of their city counterparts;
- accessing primary care, dental care, allied health and specialist services is more difficult and in many regions requires greater time and expense on travel and accommodation;
- shortages of health professionals (including doctors, allied health professionals, pharmacists and dentists) become more pronounced with remoteness;
- the health of Aboriginal and Torres Strait Islander peoples living in rural and remote areas is significantly worse than that of their non-Aboriginal and Torres Strait Islander counterparts;
- the viability of many rural hospitals is uncertain and there has been a serious loss of capacity for maternity services and other procedural care in rural areas;
- it is difficult to attract and retain health professionals in rural and remote areas, particularly those who study and train in metropolitan areas; and
- infrastructure in rural and remote areas for health services and health-related activity is limited and being further eroded by a lack of ongoing investment. (14)

The data on health outcomes at both an individual and population level shows starkly the differences according to postcode:

- 54% of people living in rural and remote areas of Australia have one or more chronic disease compared with 48% of people living in metro communities
- the rate of suicide in remote areas is 1.7 times that of major cities; access to specialised mental health care gets harder the more remotely people live
- the mortality rate for people in rural areas is 1.3 times higher than that of people living in major cities; this highlights shortfalls in access to necessary health care (15)
- New Zealand data shows higher cancer registration rates in regional District Health Boards and cancer registration rates are 27.6% higher among Māori compared to non- Māori. (16)

The challenges in providing equitable access to timely, safe and quality emergency care in rural areas are well documented and include:

- the lack of agreement amongst health service providers on definitions for emergency care is a barrier to establishing shared objectives and agreed outcomes to addressing health care inequities in rural, regional and remote areas.
- the gap between health service need by communities and the required investment to meet this need, referred to as the Rural Health Deficit, is forecast at approximately $2.1 billion in Australia (17)
- Aboriginal and Torres Strait Islander peoples and Māori, have an unacceptable disparity in life expectancy compared with non-Aboriginal and Torres Strait Islander peoples and non-Māori in Australia and New Zealand. Providing timely access to culturally safe emergency care to Aboriginal and Torres Strait Islander peoples and Māori with complex medical conditions is a significant issue in rural, regional and remote areas.
- workforce shortages and maldistribution across all clinical specialties, including under-staffed emergency departments and difficulties with recruitment and retention of trainees, registrars, emergency specialists and other senior decision makers (18)

4. National Program

ACEM manages a number of projects and initiatives under the 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. These include:

- The Emergency Medicine Certificate (EMC) and the Emergency Medicine Diploma (EMD) Training Program is a competency based education program that provides doctors working in EDs with the specific knowledge and clinical experience to advance their emergency medicine practice without pursuing training to fellowship. The course benefits Career Medical Officers, Junior Medical Officers, Visiting Medical Officers and General Practitioners.
- ACEM has developed a Special Skills Placement for ACEM trainees to complete training in rural or remote health over three to six months.
- The Emergency Medicine Education and Training (EMET) Program is delivered to practitioners working in hospitals and health services across rural, regional and remote Australia. 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 and EMD 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 regional, rural 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.

5. Workforce trends

The size of the workforce of FACEMs and trainees working in rural medicine is growing. Investment in education and training through National Programs funding is having an impact on emergency doctors' skills, confidence and commitment to working in rural emergency medicine.

ACEM data analysis shows a trend towards increasing numbers of FACEMs in regional and rural areas, with 25.8% of all FACEMs working in regional or rural areas in 2017, compared with 20.2% in 2014. Data from the New Fellows Early Career Surveys, 2014 – 2018 confirms the trend towards an increased rate of employment outside of metropolitan areas, with numbers of new Fellows working in regional and rural emergency departments increasing over five years (from 12.9% in 2014 to 31.4% in 2018).

Despite these improvements, emergency specialists and trainees in regional areas manage a greater volume of presentations per full time equivalent doctor in the emergency department. ACEM site census data from 2017 shows that in Australia the ratio of emergency medicine specialist to attendance in large metropolitan hospitals is 1 to 4,573, in larger regional hospitals is 1 to 6,651 and to smaller or medium regional hospitals is 1 to 7,250. In New Zealand, the ratio is 1 to 4,259 in metropolitan hospitals compared with 1 to 6,096 in regional hospitals.

6. Policy Positions

6.1 Patients right to accessible care

Patients presenting to any regional, rural or remote hospital-based emergency care facility have the same expectations and rights as patients presenting anywhere in Australia and New Zealand. These include the right to quality, timely and patient-centred care. If the necessary patient care needs cannot be provided on site, patients must be able to access the care required through pre-arranged pathways within a regional emergency care network. Protocols for the transfer of patients from rural or remote areas to regional or urban hospitals for assessment and admission must be determined based on clinical indicators for urgency and complexity.

6.2 ACEM Standards

Effective emergency care is delivered by emergency departments that are part of an integrated health service delivery system. The ACEM Statement on the Delineation of Emergency Departments describes four levels of EDs, outlining the capacity and capability of facilities to provide specialist emergency care network support, and to provide education, research and health system support in disaster preparedness and pre-hospital care. A Level 1 Emergency Department sets the minimum level of service that can be defined as an ED in remote and rural hospitals. (8)

ACEM has also developed guidelines on the levels of staffing for EDs (19). This includes modelling based on the number of patient presentations and the required staffing mix to address this demand for service . Further, ACEM has also partnered with the College of Emergency Nursing Australasia (CENA) to develop a set of quality standards "...to provide guidance and set expectations for the provision of equitable, safe and high quality emergency care". (20)

6.3 Rural emergency care networks

ACEM believes that every rural community in Australia and New Zealand should be part of an emergency medicine network. Emergency care in rural, regional and remote areas is provided in health facilities by staff across different specialty areas including general practitioners, rural generalists, nurses, health workers and paramedics (including nurses and paramedics with extended emergency care skills). Each health care 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 regional or metropolitan hospital.

Effective emergency care networks ensure that high quality care starts with the prehospital 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 emergency medicine 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 network should appoint a FACEM to lead and oversee the development and maintenance of the emergency medicine 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 region.

6.4 Commitment to education and collaboration

ACEM provides education and training opportunities in line with the College's accreditation responsibilities. This is supported through the development, endorsement and dissemination of guidelines for emergency care across Australia and New Zealand. The environmental factors shaping emergency care in rural, regional and remote areas requires ACEM to work in collaboration with a range of local and national stakeholders.

ACEM is committed to working in collaboration with key stakeholders, and through engagement with organisations such as the National Rural Health Alliance and the Rural Health Alliance Aotearoa New Zealand, to advocate for equity of access to timely, safe and quality health care for people living in rural areas.

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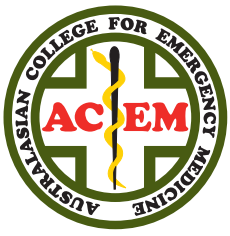

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