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, Torres Strait Islanders and Māori, by educating and training emergency physicians to be culturally safe.

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.

Regional, rural, and remote emergency departments should consider joining a network of hospitals to boost the quality of and access to emergency care, education and training.

Telehealth is an important complement, but not a replacement for, locally and regionally provided comprehensive health care. The interim statement on telehealth provides more information.

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

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Revision history

Version	Date	Revisions
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
5	Nov 2023	Revised background section (supporting data), workforce statistics, and references
5.1	Jun 2025	Amendments throughout to reflect changes to training program titles and membership categories - EMC to FEMTP, EMD to IEMTP

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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 Aotearoa New Zealand.

2. Definitions

Definitions for standard terminology used throughout this document can be found in the Statement on Standard Terminology.

3. Background – The context for rural emergency medicine

Around seven million Australians, or approximately one third of the population, live in rural and remote areas [1]. Similar to Australia, Aotearoa New Zealand's population is concentrated in cities, although both countries are experiencing growth outside of metropolitan areas [2, 3]. About 19% of the Aotearoa New Zealand population (900,000 people) live in rural and remote areas [4].

In 2021-22 there was a total of 8.79 million emergency department (ED) presentations in Australia. Of these, approximately 3 million emergency department presentations (or 35%) were to EDs outside of major cities [5]. In Aotearoa New Zealand, there are around one million emergency department presentations each year. Rural communities have substantially higher rates of ED utilisation and hospitalisation than their urban peers [6].

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 delivered equity of either availability or accessibility of health care, and rural residents have poorer health and shorter lives than those in urban areas. It is also essential to recognise that rural communities have considerable assets and strengths that can be leveraged to improve health and equity.

The data on health outcomes in Australia and Aotearoa New Zealand shows stark health inequities according to postcode:

- The health of rural people is poorer than that of their city counterparts and many communities do not have sustainable and equitable access to health and disability services [3, 6-8]. Rates of chronic diseases, injury, and disability increase significantly with geographical remoteness and compared to urban populations [6, 7, 9]. Rural communities have persistently experienced poorer mental health outcomes than the general population [10, 11].
- The health of Aboriginal, Torres Strait Islander and Māori peoples living in rural and remote areas is significantly worse than that of their non-Indigenous counterparts [7, 12].
- Age standardised mortality rates increase with increasing remoteness in Australia. The mortality rate for females in very remote areas is 1.5 times as high as those living in cities, and 1.3 times as high for males [7].
- New Zealanders all-cause and amenable mortality rates increase as rurality increases [6] and rural Māori experience greater all-cause and amenable mortality than their urban peers [12].

Challenges in providing equitable access to safe, timely emergency care for rural residents are well documented and include:

- The viability of many rural hospitals is uncertain, and there is a serious threat to the provision of rural after- hours, urgent and/ or emergency care due to a lack of investment and critical health workforce shortages [13, 14].

- Rural patients are more likely to have extended stays in EDs awaiting inpatient care than those in metro hospitals, and this leads to poorer patient outcomes [15].
- Accessing health services in rural areas is more difficult as there are fewer local services and resources. Many rural people are therefore forced to travel to access diagnostic services, specialist care and treatment. This requires leaving behind family and community support networks and greater time and expense on travel and accommodation [16, 17].
- Shortages of health professionals become more pronounced with remoteness and there is a substantial maldistribution of the workforce across rural areas. It is difficult to attract and retain health professionals in rural and remote areas, including in under-staffed emergency departments [3, 18]. Only 33% of Australian and 47% Aotearoa New Zealand accredited EDs met ACEMs minimum recommended staffing model in 2022 [15].
- Aboriginal and Torres Strait Islander peoples and Māori, have an unacceptable disparity in health outcomes and life expectancy compared with non-Indigenous peoples. Providing timely access to culturally safe emergency care to Indigenous peoples with complex medical conditions is a significant issue in rural, regional, and remote areas, given the total proportion of First Nations people increases with remoteness [19, 20].
- An estimated 16% of the Aotearoa New Zealand population does not have timely ('golden hour') access to advanced level hospital care due to long travel distances and a geographically dispersed population. Timely access increases survival from time-critical injuries and medical events [21].
- 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].

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 Associateship in Foundational Emergency Medicine Training Program (FEMTP) and the Associateship in Intermediate Emergency Medicine Training Program (IEMTP) are competency based education programs that provide doctors working in EDs with the specific knowledge and clinical experience to advance their emergency medicine practice without pursuing training to fellowship. The courses benefit 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 FEMTP and IEMTP 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 Aotearoa 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). By 2021, 51% of new Fellows surveyed (n=98) were working in rural, regional and remote areas, although only 19% indicated that they wanted to work in these areas in 5 years' time [22].

Despite these improvements, emergency medical staff in regional areas manage a greater volume of presentations per full time equivalent doctor in the emergency department compared to their metropolitan peers. ACEM site census data from 2021 shows that the ratio of Australian emergency medicine staff to patient attendance in large metropolitan hospitals is 1 to 1062, compared to 1:1736 in small and medium regional hospitals. In Aotearoa New Zealand, the ratio is 1:1386 in metro hospitals compared with 1:1445 in regional hospitals [23].

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 Aotearoa New Zealand. These include the right to quality, timely, culturally safe 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 Strategies and Standards

In 2021, ACEM launched its *Rural Health Action Plan* (RuHAP). The RuHAP provides ACEM with a strategic vision that brings together its work and embeds a focus on rural health across its operations. The RuHAP focuses on building the foundations for understanding how best to strengthen emergency medicine in rural areas, particularly workforce, research, collaboration and service provision, planning and development. The Action Plan articulates our role in addressing health equity in rural areas and sits alongside ACEMs *Aotearoa Manaaki Mana Strategy* on achieving excellence in emergency care for Māori.

Guidance and set expectations for the provision of equitable, safe, and high-quality emergency care in emergency departments is set out in *The Quality Standards for Emergency Departments and Hospital-based Emergency Care Services*. The Quality Standards were written to address the whole emergency department process, encompassing the patient experience from presentation to discharge, transfer or admission.

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 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 [24].

ACEM has also developed guidelines on the rural ED workforce [25, 26]. These include guidance on the required staffing mix to address demand for service and future training requirements.

6.3 Rural emergency care networks

ACEM believes that every rural community in Australia and Aotearoa 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 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, 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 Aotearoa 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 Hauora Taiwhenua Rural Health Network, to advocate for equity of access to timely, safe and quality health care for people living in rural areas.

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