Australasian College
for Emergency Medicine

State of Emergency: Regional, Rural and Remote

2024 Report

The Australasian College for Emergency Medicine (ACEM) is the not-for-profit organisation responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine in Australia and Aotearoa New Zealand, ACEM has a significant interest in ensuring the highest standards of medical care for patients are maintained in emergency departments across both countries.

Vision

To be the trusted authority for ensuring clinical, professional and training standards in the provision of quality, evidence-based, patient-centred emergency care.

Mission

Promote excellence in the delivery of quality emergency care to all of our communities through our committed and expert members.

The Australasian College for Emergency Medicine acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our 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.

In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

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Australasian College for Emergency Medicine

Introduction

I work in an emergency department (ED) in Alice Springs, in the Northern Territory (NT) and am proud to be the first rural president of ACEM.

Like many people who work in regional, rural and remote (RRR) emergency medicine, I came to Alice Springs temporarily. I had an interest in rural medicine, so I decided I would spend three months in the NT to give it a go. But 16 years later, I'm still here – because I love it.

I like that in RRR EDs, we are often able to build strong relationships with our community and enjoy a healthy work/life balance. I like that we can work across the full range of emergency medicine and perform a diverse range of procedures in one day – this is very rewarding. I really like that there is excellent care happening in RRR areas and that there are great opportunities for rewarding, varied and progressive careers.

But there are also negative elements to RRR healthcare. We know that there are differences to care provided in the cities: there are more severe staffing shortages – leading to ongoing challenges to fill rosters and a reliance on locum staff. There is the need to travel further from home for care, less accessibility to ambulance services and there are longer waits for people requiring admission to the hospital.

In 2022, ACEM published its inaugural *State of Emergency* report (SOE22). SOE22 presented the numbers behind the healthcare crisis. It was the inarguable proof of what ACEM and healthcare workers across the system have been warning about for some time: the health system in Australia had never been in a worse state. SOE22 said: it is bad everywhere, but 'it is worse in rural, regional and remote areas'.

In what ways is RRR 'worse'? What other differences are there to the care people can access in the cities?

State of Emergency 2024: Regional, Rural and Remote (SOE24) aimed to find out.

Like SOE22, SOE24 is concrete data, gathered from across each of Australia's states and territories during 2021-22 and carefully collated and analysed, to provide a comparison of emergency care and workforce between cities and RRR areas.

SOE24 discovered that the demands for emergency care per head of population in RRR areas is 27% higher than in the cities. But the available emergency medicine specialist workforce is 22% lower.

Across all RRR areas, people who required admission to hospital were staying in the ED for two to three times longer than those who were not admitted to hospital.

SOE24 showed us that it is a myth that 'access block is only in the cities'. The proportion of admitted patients who spent longer than eight hours in RRR EDs was comparable to those presenting to EDs in the cities, at 31% – far exceeding the maximum 10% figure recommended by ACEM. The situation was further complicated by the fact that the number of available public hospital beds in Australia has decreased when accounting for population growth.

Like the EDs in major cities, RRR EDs also encountered complex patient presentations, including the over-representation of Aboriginal and/or Torres Strait Islander peoples and a high proportion of mental health-related presentations. It is essential that RRR EDs are equitably staffed with a highly skilled emergency medicine workforce to ensure high-quality care.

We can't fix these issues alone. The ED is just one part of a complex and increasingly fragmented health system that must be reimagined, reformed and better integrated.

SOE24 will inform us and guide us, as we work collaboratively with government and other stakeholders across the health system, on the creation of an equitable health future, for everyone – wherever they live.

It is ACEM's intention that SOE24 will be one of the tools used to educate, engage and influence decision-makers to commit to actions and resourcing that can improve access to healthcare in RRR areas and support staff to enjoy sustainable, safe and enjoyable careers – and lives.

At ACEM, we're committed to increasing rural training opportunities and creating a more equitably distributed workforce. The biggest issue is not the number of skilled staff but their geographic distribution. We need smart strategies to increase the numbers of medical professionals in RRR areas of Australia.

We need to give more people a good experience. We need to get more people out into RRR EDs to try it. Just like the old NT tourism slogan: you'll never, never know, if you never, never go.

My message to healthcare workers would be: Give it a go. Like me, you may love it.

Dr Stephen Gourley
ACEM President

Alice Springs, NT

How did we get this data?

ED presentation data was sourced from the Australian Institute of Health and Welfare (AIHW) 2021-22 National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD). ED remoteness was classified using the Australian Statistical Geography Standard – Remoteness Area (ASGS RA) 2016. For the purposes of this report, ASGS RA were grouped into three categories; major cities (ASGS RA 1), regional (ASGS 2-3) and remote (ASGS RA 4-5). National data is separated into three categories of remoteness, while the jurisdictional breakdown combines regional and remote areas (RA 2-5) due to the low number of reporting EDs across remote areas in some jurisdictions. Data for the ACT was combined with NSW due to the low number of EDs in the ACT. State and territory health authority approval was obtained for the release of this data.

A total of 293 EDs were included in the 2021-22 NNAPEDCD; 95 in major cities, 167 in regional areas and 31 in remote areas. The analysis of the ED presentation data was completed in Microsoft Excel and Tableau to assess patient case mix and ED time-based performance. Comparisons between geographical remoteness were completed using descriptive analysis to assess the number and proportion of patients in each group.

Data on available hospital beds was obtained from the AIHW's publicly available data tables, titled Hospital Resources 2021-22: *Australian Hospital Statistics*.

Data on the emergency medicine workforce was obtained from ACEM's membership database, which collects workplace details of all Fellows of ACEM (FACEMs) and FACEM trainees. Data on ED staffing was collected using ACEM's 2022 Annual Site Census, an annual survey completed by all ACEM-accredited EDs. In the 2022 Census, data was obtained from 118 ACEM-accredited public EDs in Australia; 81 in major cities and 37 in regional and remote areas. These EDs accounted for approximately 80% of the national ED presentations reported by the AIHW.

National

- In 2021-22, there were 8.8 million ED presentations in Australia, 66.4% (5.8 million) in major city EDs, 30.4% (2.7 million) in regional EDs and 3.2% (280,000) in remote EDs.
- This equates to 309 ED presentations per 1,000 population in metropolitan areas, 402 per 1,000 population in regional areas and 562 per 1,000 population in remote areas.

Who is presenting to EDs?	Major Cities	Regional	Remote
Triage category ATS 1-3* presentations	58%	49%	36%
Presentations by younger people (0-14 years)	20%	18%	19%
Presentations by older people (65+ years)	21%	24%	11%
Aboriginal and/ or Torres Strait Islander presentations	4%	12%	45%
People with mental health-related presentations	4%	3%	4%

** ATS 1 = immediately life-threatening; ATS 2 = imminently life-threatening; ATS 3 = potentially life-threatening*

KEY POINTS

- While major cities had the highest proportion of immediately to potentially life-threatening presentations (ATS 1-3), almost half of regional ED presentations and over one third of remote ED presentations also fell into the ATS 1-3 category.
- Compared to remote areas, more people aged 65+ years are presenting to EDs in major cities and regional areas. People presenting to EDs aged 65+ years were also over-represented compared to the proportion of the Australian population in major cities and regional areas.
- Aboriginal and/or Torres Strait Islander peoples were over-represented in their proportion of ED presentations compared to their proportion of the Australian population across all remoteness areas.
- The proportion of ED patients whose principal diagnosis was associated with a mental or behavioural disorder was similar across all remoteness areas.

Did you know?

A higher percentage of regional and remote-based respondents to ACEM's 2022 Sustainable Workforce Survey reported satisfaction with the interactions with those colleagues, compared to those in metropolitan areas.

How long are people staying in EDs?

People who were not admitted to hospital from the ED	Major Cities	Regional	Remote
Proportion of ED presentations	69%	78%	82%
People with an ED length of stay greater than eight hours	7%	5%	2%
Time for most (90%) people to leave the ED	6hr 54min	5hr 54min	4hr 12min

People who were admitted to hospital from the ED	Major Cities	Regional	Remote
Proportion of ED presentations	31%	22%	18%
ED length of stay greater than eight hours	31%	32%	23%
Time for most (90%) people to leave the ED	15hr 36min	16hr 54min	12hr 24min

KEY POINTS

- For people who do not need hospital admission from the ED, ACEM recommends that no more than 5% of these people should be staying in the ED for more than 8 hours. Regional and remote EDs are meeting this recommendation.
- From 2014-15 to 2022 there has been a 65% increase in the proportion of EM specialists working at a regional/remote location and a 20% increase in FACEM trainees working at a regional/remote location.
- Despite this increase there is still an emergency medicine workforce shortage, with EDs in major cities and regional and remote areas having vacancies for EM specialists and relying on the locum workforce. This is more pronounced in regional and remote areas.
- For people who do need hospital admission from the ED, ACEM recommends that no more than 10% of these people should be staying in the ED for more than 8 hours. This is not the case across all remoteness areas and people who require hospital admission from the ED are staying in the ED two to three times longer than people who do not need hospital admission. This is happening at a time when the number of available public hospital beds per head of population in Australia is decreasing.

Emergency medicine workforce in ACEM-accredited EDs	Major Cities	Regional and Remote
Ratio of EM specialists*: ED attendance	1 : 3733	1 : 4641
Ratio of FACEM trainees: ED attendance	1 : 4464	1 : 8396
Ratio of other ED doctors: ED attendance	1 : 1826	1 : 1703
Ratio of nursing staff: ED attendance	1 : 555	1 : 595
EDs employing locum EM specialists	12%	51%
EDs reporting EM specialist vacancies	47%	78%
**EM specialists include FACEMs and Paediatric emergency medicine specialists*		

Australian Capital Territory/ New South Wales

- In 2021-22 there were 3.2 million ED presentations across New South Wales (NSW) and the Australian Capital Territory (ACT).
- The rate of ED presentations per 1,000 population was lower in major cities in the ACT and NSW (311 per 1,000) than in regional and remote areas (548 per 1,000).

Who is presenting to EDs?	Major Cities	Regional and Remote
Triage category ATS 1-3* presentations	54%	40%
Presentations by older people (65+ years)	22%	25%
Aboriginal and/ or Torres Strait Islander presentations	5%	14%
People with mental-health related presentations	3%	2%

** ATS 1 = immediately life-threatening; ATS 2 = imminently life-threatening; ATS 3 = potentially life-threatening*

KEY POINTS

- While major cities had the highest proportion of immediately to potentially life-threatening presentations (ATS 1-3), 40% of RRR ED presentations also fell into the ATS 1-3 category.
- Across RRR EDs, a quarter of presentations were from people aged 65 years or more.
- RRR EDs saw threefold more Aboriginal and/or Torres Strait Islander peoples than EDs in major cities.

How long are people staying in EDs?

People who were not admitted to hospital from the ED	Major Cities	Regional and Remote
Proportion of ED presentations	73%	85%
People with an ED length of stay greater than eight hours	6%	3%
Time for most (90%) people to leave the ED	6hr 42min	5hr 6min
People who were admitted to hospital from the ED	**Major Cities**	**Regional and Remote**
Proportion of ED presentations	27%	15%
ED length of stay greater than eight hours	38%	31%
Time for most (90%) people to leave the ED	17hr 54min	17hr 30min

KEY POINTS

- For people who do not need hospital admission from the ED, ACEM recommends that no more than 5% of these people should be staying in the ED for more than 8 hours. Regional and remote EDs are meeting this recommendation.
- For people who do need hospital admission from the ED, ACEM recommends that no more than 10% of these people should be staying in the ED for more than 8 hours. This is not the case across all remoteness areas and people who require hospital admission from the ED are staying in the ED two to three times longer than people who do not need hospital admission. This is happening at a time when the number of available public hospital beds per population across NSW and the ACT is decreasing.

Emergency medicine workforce in ACEM-accredited EDs	Major Cities	Regional and Remote
Ratio of EM specialists*: ED attendance	1 : 4191	1 : 4421
Ratio of FACEM trainees: ED attendance	1 : 4597	1 : 10683
Ratio of other ED doctors: ED attendance	1 : 1808	1 : 1849
Ratio of nursing staff: ED attendance	1 : 599	1 : 720
EDs employing locum EM specialists	13%	46%
EDs reporting EM specialist vacancies	45%	82%

**EM specialists include FACEMs and Paediatric emergency medicine specialists*

KEY POINTS

- From 2018 to 2022 there has been a 75% increase in the proportion of EM specialists working at a regional/remote location.
- Despite this increase there is still an emergency medicine workforce shortage, with EDs in major cities and RRR areas having vacancies for EM specialists and relying on the locum workforce. This is more pronounced in regional and remote areas.

My RRR Story: Dr Sarah Goddard

Dr Sarah Goddard is a proud Kaytetye woman of the Barkly Region of the Northern Territory and the second female Aboriginal Fellow of the Australian College of Rural and Remote Medicine. She is the first Aboriginal Rural Generalist from the Northern Territory. Sarah divides her time between general practice, the ED and aeromedicine.

I knew that I was going to be a doctor at a very young age. There are photos of me at three years old with a stethoscope around my neck. Growing up in Tennant Creek, seeing the rural lifestyle, disadvantage, Indigenous health first-hand – I knew I was going to be a doctor living rural and remote, working in general practice and emergency medicine.

I went to Newcastle University and did an Indigenous enabling program. I was just a little Black girl going to the big smoke and it was confronting. When I arrived, I thought, 'what am I doing here?' I'm in a four-wheel drive that's got red dirt all over it and I'm parking next to BMWs and Audis at university. I walked into the Indigenous Health Unit and all these other kids there were looking as scared as I was.

My career advisors thought it was hysterical that I wanted to be a doctor. I wasn't the A-grade academic along the way – I would much prefer to be outdoors playing sport. But I worked hard and got into medicine. Just don't tell me 'no' and don't tell me I can't do something because I will get around it and I will prove you wrong.

I had lots of setbacks. Getting through med school, let alone family complications, failing three times. I just kept going – I was that determined. If I got a roadblock, well, I would just change my course and go around it. I hope that I can have that influence on someone, that no matter how hard it is – how homesick you are, no matter what roadblock you're faced with – you pick yourself up and you go again.

Tennant Creek is what regional, rural and remote medicine is all about. It's a place where you see real-life medicine that some would only see in textbooks. Here it's everything: it's surgical, it's paediatrics, it's ante-natal, it's end-of-life care. It's all areas of medicine. You have to manage it all because high-speciality areas are 500km away – and there's a lot of desert in between.

"This is where all my mob are and for them to see me have an impact as a doctor in my home community makes it all worthwhile."

Med students that come here, it blows their mind. They have no idea until they get here how different it is. It's not just rural medicine they experience – they get to go out with Aboriginal Liaison Officers, social workers and hang out with the practice nurse. They get to do acute medicine; they get clinical skills.

I've got plenty of friends and colleagues in Tennant Creek who are very passionate and love Indigenous health and rural medicine. But all the patients in the waiting room line up for me – it's got nothing to do with skill base and I can't explain that either. I don't think we practice medicine differently. I have the addition of being the checkout chick who served them as a teenager or someone who they competed against in a rodeo. I'm the one who coaches footy, I'm someone who they ride horses with, or go fishing with. I have the community engagement side.

In collaboration with the Royal Flying Doctor Service, I fly out to remote cattle stations. I provide healthcare to their door and I travel to remote Aboriginal health clinics focusing on chronic disease prevention and making sure more people get regular health checks and care.

I know that I'm me and I'm happiest when I'm home in Tennant Creek with my family. We're all born to the land. This is where all my mob are and for them to see me have an impact as a doctor in my home community makes it all worthwhile.

I see me working Tennant Creek until I retire. Which is bizarre to some. But it's home. I can't fix everything, but I can do one thing a day to help someone and that makes a real difference – even if it's to hold their hand while they take their last breath.

Give it your all if you are going to work rural. Have a go. Come prepared and know where you're going and what communities and areas you're dealing with. Make sure you take every opportunity you can get to be exposed or involved in a team.

Northern Territory

- In 2021-22 there were 170,000 ED presentations in the Northern Territory (NT).
- The rate of ED presentations was 680 presentations per 1,000 population across regional and remote NT.

Who is presenting to EDs?	Regional and Remote
Triage category ATS 1-3* presentations	49%
Presentations by older people (65+ years)	11%
Aboriginal and/or Torres Strait Islander presentations	44%
People with mental health-related presentations	4%
** ATS 1 = immediately life-threatening; ATS 2 = imminently life-threatening; ATS 3 = potentially life-threatening*	

KEY POINTS

- Almost half of all ED presentations were classified as immediately to potentially life-threatening (ATS 1-3).
- ED presentations in the NT were skewed to the younger age group, with only 11% aged 65+ years.
- A high percentage of patients attending NT EDs were Aboriginal and/or Torres Strait Islander patients.

How long are people staying in EDs?

People who were not admitted to hospital from the ED	Regional and Remote
Proportion of ED presentations	70%
People with an ED length of stay greater than eight hours	5%
Time for most (90%) people to leave the ED	6hr 18min
People who were admitted to hospital from the ED	**Regional and Remote**
Proportion of ED presentations	30%
ED length of stay greater than eight hours	37%
Time for most (90%) people to leave the ED	16hr 54min

KEY POINTS

- For people who do not need hospital admission from the ED, ACEM recommends that no more than 5% of these people should be staying in the ED for more than 8 hours. EDs across the NT are meeting this recommendation.
- For people who do need hospital admission from the ED, ACEM recommends that no more than 10% of these people should be staying in the ED for more than 8 hours. This is not the case across the NT and people who require hospital admission from the ED are staying in the ED more than twice as long as people who do not need hospital admission. This is despite the fact that the number of available public hospital beds per 1,000 head of population across the NT has increased from 2017-18 to 2021-22.

Emergency medicine workforce in ACEM-accredited EDs	Regional and Remote
Ratio of EM specialists*: ED attendance	1 : 4642
Ratio of FACEM trainees: ED attendance	1 :3292
Ratio of other ED doctors: ED attendance	1 : 1703
Ratio of nursing staff: ED attendance	1 : 533
EDs employing locum EM specialists	67%
EDs reporting EM specialist vacancies	33%
**EM specialists include FACEMs and Paediatric emergency medicine specialists*	

KEY POINTS

- From 2018 to 2022 there has been a 52% increase in the proportion of EM specialists working in the NT.
- Despite this increase there is still an emergency medicine workforce shortage, with EDs having vacancies for EM specialists and relying on the locum workforce.

Queensland

- In 2021-22, there were 1.9 million presentations to EDs in Queensland (QLD), with 69% (1.3 million) in major cities and 31% (570,000) in regional and remote EDs.
- There were 376 ED presentations per 1,000 population in metropolitan QLD, higher than in regional and remote QLD, at 306 presentations per 1,000 population.

Who is presenting to EDs?	Major Cities	Regional and Remote
Triage category ATS 1-3* presentations	60%	61%
Presentations by older people (65+ years)	18%	21%
Aboriginal and/or Torres Strait Islander presentations	5%	15%
People with mental-health related presentations	4%	4%
** ATS 1 = immediately life-threatening; ATS 2 = imminently life-threatening; ATS 3 = potentially life-threatening*		

KEY POINTS

- The proportion of immediately to potentially life-threatening ED presentations (ATS 1-3) were similar in major cities and regional and remote areas.
- Regional and remote EDs saw threefold more Aboriginal and/or Torres Strait Islander peoples than EDs in major cities.

How long are people staying in EDs?

People who were not admitted to hospital from the ED	Major Cities	Regional and Remote
Proportion of ED presentations	68%	72%
People with an ED length of stay greater than 8 hours	5%	5%
Time for most (90%) people to leave the ED	6hr 24min	6hr 18min
People who were admitted to hospital from the ED	**Major Cities**	**Regional and Remote**
Proportion of ED presentations	32%	28%
ED length of stay greater than 8 hours	23%	29%
Time for most (90%) people to leave the ED	12hr 00min	14hr 42min

KEY POINTS

- For people who do not need hospital admission from the ED, ACEM recommends that no more than 5% of these people should be staying in the ED for more than 8 hours. EDs across all remoteness areas are meeting this recommendation.
- For people who do need hospital admission from the ED, ACEM recommends that no more than 10% of these people should be staying in the ED for more than 8 hours. This is not the case across all remoteness areas and people who require hospital admission from the ED are staying in the ED for twice as long as people who do not need hospital admission. This is despite the fact that the number of available public hospital beds per 1,000 head of population across QLD has increased from 2017-18 to 2021-22.

Emergency medicine workforce in ACEM-accredited EDs	Major Cities	Regional and Remote
Ratio of EM specialists*: ED attendance	1 : 3698	1 : 4116
Ratio of FACEM trainees: ED attendance	1 : 3595	1 : 8720
Ratio of other ED doctors: ED attendance	1 : 1822	1 : 1676
Ratio of nursing staff: ED attendance	1 : 510	1 : 604
EDs employing locum EM specialists	7%	10%
EDs reporting EM specialist vacancies	20%	60%

**EM specialists include FACEMs and Paediatric emergency medicine specialists*

KEY POINTS

- From 2018 to 2022 there has been a 42% increase in the proportion of EM Specialists working at a regional/remote location.
- Despite this increase there is still an emergency medicine workforce shortage, with EDs in major cities and regional and remote areas having vacancies for EM specialists. This is more pronounced in regional and remote areas.

My RRR story: Dr Liz Mowatt

Dr Liz Mowatt was the first FACEM in Central Australia and the former Director of Emergency Medicine in Alice Springs. She lives on Yidinji Country with her extended family, and works part-time in the ED in Gimuy Cairns.

I've been thinking a lot about what rural emergency medicine is. It's one of my passions and I've been thinking a lot about why rural emergency medicine is so important to me and how I reached this point. All the experiences I've had in rural health have informed the practitioner that I am today.

I've been thinking about patients. One of my driving passions for rural emergency care is that it starts when the patient first touches the system. I think we have a responsibility – across all aspects of our healthcare service – to smooth that process for patients. As healthcare professionals, we are responsible for helping the patient negotiate all those interfaces. I like to think about the care from the patient's perspective – from that very first point and us all working to make every step along that way as safe and smooth as possible.

I've been thinking a lot about community. Myself, my family, my neighbours, our extended community around me – we are all served by the rural health service. So I know that how care is accessed within a community can be really challenging for rural patients and rural people. Then as a practitioner – having sat in a small rural hospital and provided care back to the community – I know that has its own challenges as well.

My first rural job as a doctor was as a resident in Charleville, Queensland, a town of 4000 people in 1991. There was only me and my boss. I had just finished my internship the Friday before and on Monday morning I was a Principal House Officer in a small hospital, 700km from Brisbane. I was there for 12 months. That's pretty isolated.

These days, connectivity has made a big difference. With connectivity comes some standardised care. Any of the 'big city' protocols – and all the knowledge – that was previously only available within the big centres is now accessible everywhere. The ability to

get people on the phone to give you support in a rural or remote ED is fantastic. Now the retrieval services in Queensland have cameras in the resuscitation rooms – you can get a resuscitation specialist, who’s 500km away, into the room with you to help manage that patient. I think that has helped level the playing field, with respect to standard of care.

There is still more work to do in regional, rural and remote healthcare, but some of the challenges have changed. There was always the expectation that, if you worked at a rural centre, you wouldn’t deal with a lot of the things people working in the big city, metro hospital had to deal with, like access block. There were always beds on the ward and no inpatient teams to negotiate with.

I was shocked to learn recently there is a lot of access block in rural EDs, as well as the ongoing delays in transferring patients through to the bigger centres for a higher level of care because the receiving hospital has no capacity. Building up the capacity to deliver care in smaller places is improving all the time. Being treated closer to home is a great thing for patients, however this needs to be supported with the right resources. Patients are being transferred back to smaller facilities earlier, or receiving all their care locally – care that was previously only available in a big city hospital – creating some complex resource requirements for that smaller place. I think funding bodies are way too slow to catch up with the need that is being placed on those smaller hospitals.

How different am I today after my years in emergency medicine in rural areas? It was 1991 when I started, so I’m a lot older. That would be the first thing to say. I’m a lot less reactive too. I think – I hope – I’m a lot more accepting. But I am more passionate and more fired up than ever about regional, rural and remote health.

South Australia

- In 2021-22, there were 570,000 presentations to EDs in South Australia (SA), 75% (430,000) in major cities and 25% (143,000) in regional and remote EDs.
- This equates to 313 ED presentations per 1,000 population in metropolitan SA and 321 presentations per 1,000 population in regional and remote SA.

Who is presenting to EDs?	Major Cities	Regional and Remote
Triage category ATS 1-3* presentations	63%	45%
Presentations by older people (65+ years)	25%	26%
Aboriginal and/or Torres Strait Islander presentations	5%	10%
People with mental health-related presentations	4%	3%

** ATS 1 = immediately life-threatening; ATS 2 = imminently life-threatening; ATS 3 = potentially life-threatening*

KEY POINTS

- SA EDs had the greatest percentage of patients aged 65+ years of age attending, compared with the other jurisdictions, with a slightly higher percentage presenting to regional and remote EDs.
- While major cities had the highest proportion of immediately to potentially life-threatening presentations (ATS 1-3), 45% of regional and remote ED presentations also fell into the ATS 1-3 category.
- Regional and remote EDs saw a higher percentage of Aboriginal and/or Torres Strait Islander peoples than EDs in major cities.

How long are people staying in EDs?

People who were not admitted to hospital from the ED	Major Cities	Regional and Remote
Proportion of ED presentations	66%	83%
People with an ED length of stay greater than eight hours	10%	2%
Time for most (90%) people to leave the ED	7hr 54min	5hr 6min
People who were admitted to hospital from the ED	**Major Cities**	**Regional and Remote**
Proportion of ED presentations	34%	17%
ED length of stay greater than eight hours	32%	8%
Time for most (90%) people to leave the ED	16hr 21min	7hr 24min

KEY POINTS

- For people who do not need hospital admission from the ED, ACEM recommends that no more than 5% of these people should be staying in the ED for more than 8 hours. Regional and remote EDs are meeting this recommendation.
- For people who do need hospital admission from the ED, ACEM recommends that no more than 10% of these people should be staying in the ED for more than 8 hours. This was the case across regional and remote areas. In contrast, people who required hospital admission from EDs in major cities are staying in the ED more than twice as long as people who do not need hospital admission. This is happening at a time when the number of available public hospital beds per 1,000 head of population is decreasing across SA.

Emergency medicine workforce in ACEM-accredited EDs	Major Cities	Regional & Remote†
Ratio of EM specialists*: ED attendance	1 : 3597	ND
Ratio of FACEM trainees: ED attendance	1 : 6128	ND
Ratio of other ED doctors: ED attendance	1 : 1493	ND
Ratio of nursing staff: ED attendance	1 : 454	ND
EDs employing locum EM specialists	0%	ND
EDs reporting EM specialist vacancies	43%	ND

**EM specialists include FACEMs and Paediatric emergency medicine specialists;*
†ND= no data, there were no ACEM accredited EDs in regional and remote SA

KEY POINTS

- 43% of major city EDs in SA reported having EM specialist vacancies.

Tasmania

All EDs in Tasmania (TAS) are within regional areas, so comparison by geographical remoteness is not possible.

- In 2021-22, there were 173,000 ED presentations in TAS.
- The rate of ED presentations per 1,000 population was 304 across regional TAS.

Who is presenting to EDs?	Regional and Remote
Triage category ATS 1-3* presentations	55%
Presentations by older people (65+ years)	24%
Aboriginal and/or Torres Strait Islander presentations	7%
People with mental-health related presentations	4%

** ATS 1 = immediately life-threatening; ATS 2 = imminently life-threatening; ATS 3 = potentially life-threatening*

KEY POINTS

- More than half of all ED presentations were classified as immediately to potentially life-threatening presentations (ATS 1-3).
- A quarter of patients attending TAS EDs were 65 years or older.

How long are people staying in EDs?

People who were not admitted to hospital from the ED	Regional and Remote
Proportion of ED presentations	72%
People with an ED length of stay greater than eight hours	7%
Time for most (90%) people to leave the ED	7hr 00min
People who were admitted to hospital from the ED	**Regional and Remote**
Proportion of ED presentations	28%
ED length of stay greater than eight hours	42%
Time for most (90%) people to leave the ED	23hr 36min

KEY POINTS

- For people who do not need hospital admission from the ED, ACEM recommends that no more than 5% of these people should be staying in the ED for more than 8 hours. EDs in TAS were not meeting this target.
- For people who do need hospital admission from the ED, ACEM recommends that no more than 10% of these people should be staying in the ED for more than 8 hours. EDs in TAS were not meeting this target, with people who required hospital admission from EDs staying in the ED over three times more than people who do not need hospital admission. This is happening at a time when the number of available public hospital beds per head of 1,000 population is increasing across TAS.

Emergency medicine workforce in ACEM-accredited EDs	Regional and Remote
Ratio of EM specialists*: ED attendance	1 : 3424
Ratio of FACEM trainees: ED attendance	1 : 12352
Ratio of other ED doctors: ED attendance	1 : 1351
Ratio of nursing staff: ED attendance	1 : 455
EDs employing locum EM specialists	67%
EDs reporting EM specialist vacancies	100%
**EM specialists include FACEMs and Paediatric emergency medicine specialists*	

KEY POINTS

- All EDs in Tasmania reported having EM specialist vacancies.

My RRR Story: Dr Garth Wilkinson

Dr Garth Wilkinson commenced in the FACEM Training Program in 2022 and has worked across a number of regional and remote EDs in Western Australia. He is currently working at Broome Hospital on Yawuru Country.

Emergency medicine is just more fun in the country. The presentations are more varied and you get to do more, rather than have some specialities jump in and pinch the patient immediately. In a country ED you get to do everything yourself. And everyone's just more relaxed – both the practitioners and the patients.

People say to choose your speciality carefully because you have to love your bread and butter, but I feel that, when your specialty is emergency medicine, you don't see the same thing over and over again like you would if you were doing scopes all the time as a gastroenterologist, for example. I love the variation and I also love the colleagues – I love the kind of people it attracts.

I did some training as a resident up here two years ago and I've been back in Broome again since February. I love the town. I think there's a better work/life balance. I love anything to do with water. I'm a member of the Surf Life Saving Club in town and I go camping in all the beautiful places around the Kimberley. It's an amazing place.

Despite Broome being a regional hub, you don't have all the resources you do in a tertiary centre. There are still challenges: no radiology overnight, no pathology overnight, 'what's an MRI machine?'. We're 2000 kilometres from the nearest tertiary hospital, so if someone needs tertiary-level care, it's interesting to coordinate. It's about optimising things so that someone can get all the way down to Perth to get the care they need in the most efficient way.

Often transfer will take longer than you need – and that means that, if somebody needs ICU-level care while they wait, you are the ICU doctor for the next 10-12 hours. You'll know their chronic conditions and you'll often see people multiple times – which has its good and bad sides, but it means you are seen as more part of the community and that helps you form nicer relationships.

Why do emergency medicine trainees choose to work outside the cities?

"More opportunity and diversity of patients."

"Opportunity to contribute to establishing systems in regional emergency departments."

"Not too much inter-departmental politics, can still get things done."

"Availability of FACEM position."

"A better quality of life and a great working environment."

"Jobs in metropolitan areas are too competitive."

"Lifestyle, recreation, case mix, equity of care."

"Opportunity for retrieval work."

"Excellent pathology and I feel that I have a bigger impact on my community."

"Good case mix, small but busy department. Able to supervise, teach and see patients. Nice place to live and good lifestyle. Good department ethos and team."

"Smaller hospitals with more hands-on work."

"Lifestyle with a young family."

"Passion for improving healthcare service in regional areas."

"Better for family. Fulfilling work."

"I love the bush!"

"I don't want to live in the city. More space, less expense."

"Job availability and security and support."

Victoria

- In 2021-22, there were 1.9 million ED presentations in Victoria (VIC), 74% (1.4 million) in major cities and 26% (490,000) in regional and remote EDs.
- There was a lower rate of ED presentations per 1,000 population for metropolitan VIC at 266 per 1,000 population, compared with regional and remote VIC, at 331 per 1,000 population.

Who is presenting to EDs?	Major Cities	Regional and Remote
Triage category ATS 1-3* presentations	59%	53%
Presentations by older people (65+ years)	20%	25%
Aboriginal and/or Torres Strait Islander presentations	2%	5%
People with mental-health related presentations	4%	3%
** ATS 1 = immediately life-threatening; ATS 2 = imminently life-threatening; ATS 3 = potentially life-threatening*		

KEY POINTS

- More than half of all ED presentations were classified as immediately to potentially life-threatening presentations (ATS 1-3) across all remoteness areas.
- A higher percentage of patients attending regional and remote EDs in VIC were aged 65+ years.

How long are people staying in EDs?

People who were not admitted to hospital from the ED	Major Cities	Regional and Remote
Proportion of ED presentations	63%	74%
People with an ED length of stay greater than eight hours	8%	7%
Time for most (90%) people to leave the ED	7hr 30min	7hr 00min
People who were admitted to hospital from the ED	**Major Cities**	**Regional and Remote**
Proportion of ED presentations	37%	26%
ED length of stay greater than eight hours	31%	38%
Time for most (90%) people to leave the ED	16hr 06min	17hr 42min

KEY POINTS

- For people who do not need hospital admission from the ED, ACEM recommends that no more than 5% of these people should be staying in the ED for more than 8 hours. EDs across all remoteness areas were not meeting this target.
- For people who do need hospital admission from the ED, ACEM recommends that no more than 10% of these people should be staying in the ED for more than 8 hours. EDs across all remoteness areas were not meeting this target, with people who required hospital admission from EDs staying in the ED more than twice as long as people who do not need hospital admission. This is happening at a time when the number of available public hospital beds per 1,000 population is decreasing across VIC.

Emergency medicine workforce in ACEM-accredited EDs	Major Cities	Regional and Remote
Ratio of EM specialists*: ED attendance	1 : 2913	1 : 5885
Ratio of FACEM trainees: ED attendance	1 : 4616	1 : 11089
Ratio of other ED doctors: ED attendance	1 : 2239	1 : 1408
Ratio of nursing staff: ED attendance	1 : 494	1 : 521
EDs employing locum EM specialists	11%	88%
EDs reporting EM specialist vacancies	53%	100%

KEY POINTS

- EDs across all remoteness areas reported employing locums at the EM specialist level and having EM specialist vacancies.
- However, this was more pronounced in EDs across regional and remote areas, with all EDs in regional and remote areas reporting EM specialist vacancies.

Western Australia

- In 2021-2,2 there were 990,000 ED presentations in Western Australia (WA), 69% (690,000) in major cities and 31% (300,000) in regional and remote EDs.
- There was a much lower rate of ED presentations per 1,000 population for metropolitan WA at 313 presentations per 1,000 population, compared with regional and remote WA at 512 per 1,000 population.

Who is presenting to EDs?	Major Cities	Regional and Remote
Triage category ATS 1-3* presentations	58%	41%
Presentations by older people (65+ years)	20%	17%
Aboriginal and/or Torres Strait Islander presentations	5%	25%
People with mental-health related presentations	4%	3%
** ATS 1 = immediately life-threatening; ATS 2 = imminently life-threatening; ATS 3 = potentially life-threatening*		

KEY POINTS

- Almost 60% of all ED presentations were classified as immediately to potentially life-threatening presentations (ATS 1-3) in major cities, with over 40% of regional and remote ED presentations meeting this classification.
- A much higher proportion of people attending regional and remote EDs in WA were Aboriginal and/or Torres Strait Islander, around fivefold more compared to major cities.

How long are people staying in EDs?

People who were not admitted to hospital from the ED	Major Cities	Regional and Remote
Proportion of ED presentations	72%	85%
People with an ED length of stay greater than eight hours	7%	2%
Time for most (90%) people to leave the ED	7hr 00min	4hr 42min
People who were admitted to hospital from the ED	**Major Cities**	**Regional and Remote**
Proportion of ED presentations	28%	15%
ED length of stay greater than eight hours	28%	20%
Time for most (90%) people to leave the ED	14hr 06min	11hr 12min

KEY POINTS

- For people who do not need hospital admission from the ED, ACEM recommends that no more than 5% of these people should be staying in the ED for more than 8 hours. EDs across regional and remote areas were meeting this target.
- For people who do need hospital admission from the ED, ACEM recommends that no more than 10% of these people should be staying in the ED for more than 8 hours. EDs across all remoteness areas were not meeting this target, with people who required hospital admission from EDs staying in the ED more than twice as long as people who do not need hospital admission.

Emergency medicine workforce in ACEM-accredited EDs	Major Cities	Regional and Remote
Ratio of EM specialists*: ED attendance	1 : 4052	1 : 5322
Ratio of FACEM trainees: ED attendance	1 : 8007	1 : 11224
Ratio of other ED doctors: ED attendance	1 : 1523	1 : 1578
Ratio of nursing staff: ED attendance	1 : 638	1 : 754
EDs employing locum EM specialists	33%	100%
EDs reporting EM specialist vacancies	89%	100%
**EM specialists include FACEMs and Paediatric emergency medicine specialists*		

KEY POINTS

- EDs across all remoteness areas reported employing locums at the EM specialist level and having EM specialist vacancies. However, EDs across regional and remote areas were much more likely to rely on the locum workforce.

What did we learn from SOE24?

Every Australian should have equitable access to high-quality emergency care, wherever they live. But significant challenges already facing overstretched hospitals across the country are compounded in RRR areas, due to limited resources and a shortfall in staffing, training and upskilling. Complex presentations, extended ED stays and long waiting times for admission are also among the key findings identified in this report.

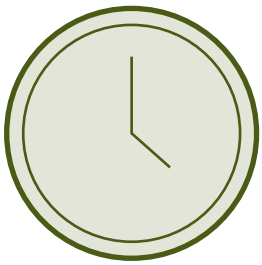
SOE2024 found:

- The emergency medicine workforce crisis is **worse in regional, rural and remote areas** where more than 50% of RRR EDs rely on locum EM specialists, compared with 12% of EDs in major cities.
- **Regional, rural and remote EDs are more likely to report having EM specialist vacancies** than EDs in major cities. We need to retain and support the growth of the emergency medicine workforce in RRR areas.
- **There is a smaller proportion of people aged 65+ years presenting to EDs in remote areas (11%)** than in major cities (21%) and regional areas (24%), likely due to the lower life expectancy in remote areas than in other regions of Australia. But in regional areas and major cities, people aged 65+ years are over-represented among ED presentations, compared with their proportion of the Australian population. This trend is likely to escalate as the Australian population ages, further increasing the ED demands and complexity of emergency medicine care.
- **Aboriginal and/or Torres Strait Islander peoples are over-represented in their proportion of ED presentations, compared with their proportion of the Australian population** across all remoteness areas and all jurisdictions. Outside of cities, a significantly higher proportion of ED presentations are for Aboriginal and/or Torres Strait Islander peoples, highlighting the need for ongoing investment to improve cultural capabilities in RRR EDs.
- **Mental health-related presentations in EDs in major cities and RRR areas are of comparable proportions,** but within a resource-limited setting this poses additional challenges to RRR EDs.
- **People who were admitted to hospital from the ED are spending significantly longer waiting for a hospital bed** than those who were not admitted, regardless of remoteness area. This suggests that patient flow and ED overcrowding issues are often complicated by insufficient inpatient beds.
- **Across Australia, 20-30% of people who were admitted to hospital from the ED had an ED length of stay greater than eight hours.** This is not safe and, based on recent research, ACEM recommends that no more than 10% of admitted patients should have an ED length of stay greater than eight hours.
- Complex ED presentations (classified as immediately to potentially life-threatening) **make up almost half of all regional ED presentations** and more than one-third of remote ED presentations. This highlights the importance of RRR EDs being adequately staffed and resourced to provide safe, quality emergency medicine care.

20-30% of people who were admitted to hospital from the ED had an ED length of stay greater than eight hours.

Aboriginal and/or Torres Strait Islander peoples are over-represented in their proportion of ED presentations compared to their proportion of the Australian population across all remoteness areas and all jurisdictions.

People who were admitted to hospital from the ED are spending up to 2-3 times longer waiting for a hospital bed than those who were not admitted, regardless of remoteness area.



2-3 TIMES LONGER

Complex ED presentations (classified as immediately to potentially life-threatening) make up almost half of all regional ED presentations.

Recommendations

Systemic reform requires commitment, coordination and collaboration to improve patient experiences of care in EDs and, most importantly, across a patient's whole-of-healthcare-system journey.

Embrace the opportunity to improve healthcare services in RRR settings

Providing RRR communities with increased access to primary care and specialist services has long been viewed by all levels of government as an insurmountable challenge. It's time to reframe the issue and embrace the task at hand, through creative thinking and collaboration across the sector – matched with meaningful and sustained investment.

ACEM recommends:

- Ongoing Federal Government funding for the Emergency Medicine Education and Training (EMET) program
- Funding the exploration of innovative workforce models, including the expansion of Specialist Training Programs, to facilitate greater regional training opportunities for medical specialists
- Introducing innovative, targeted and sustained initiatives to facilitate the relocation of healthcare staff (and their families).

Provide the modern healthcare system Australians need

Australia needs to move away from the 'one size fits all' approach to healthcare. Designing and resourcing the system in a way that allows care to be provided in the most appropriate setting will result in efficient, effective and safer care.

ACEM recommends:

- That the Commonwealth match state and territory government hospital funding in a 50/50 cost-sharing arrangement
- Adopting ACEM's Hospital Access Targets (HAT) as part of health system-wide targets for admitted and non-admitted patients' transit through the hospital
- Expanding sub-acute care services and 'non-hospital alternatives' for patients who no longer require acute hospital care but are not yet ready for discharge
- Transitioning hospital and community health services beyond business hours to meet the demand and reduce inefficiencies in the system.

Build and retain the healthcare workforce

A strong healthcare workforce is key to a fully functional healthcare system. Promoting pathways for medical leadership opportunities across the country enables significantly greater clinical safety, effective supervision of the junior health workforce and results in better health outcomes.

ACEM recommends:

- Establishing mechanisms to allow for consistent and accurate monitoring of workforce supply and demand modelling
- Boosting and retaining the senior emergency medicine workforce through strategic investments to increase the workforce pipeline and in the provision of support mechanisms for the current workforce
- Increasing the number of clinical and non-clinical support staff in hospitals to allow all clinicians to practice to the top of their scope
- Providing security staff at every ED in the country, integrated, appropriately trained and available 24 hours a day, 7 days a week, to support the safety of the workforce and patients.

Health equity for Aboriginal and Torres Strait Islander Peoples

ACEM walks alongside Aboriginal and Torres Strait Islander people and leaders to support their right to the same standard of health as other Australians, including access to high-quality, culturally safe health services, free from discrimination and harm.

ACEM recommends:

- That all levels of government fulfil their obligation to close the gap in health outcomes and health services improve the accessibility and responsiveness to Aboriginal and Torres Strait Islander communities
- Grow and retain the Aboriginal and Torres Strait Islander health workforce across all health professions
- Enhancing Aboriginal leadership and engagement in the design and delivery of healthcare services.

Better healthcare for older persons

As Australia's population ages, there is an increasing number of older people with complex needs who must have access to high-quality primary and acute healthcare. SOE24 shows that older people present to regional EDs at the same rate as EDs in major cities, highlighting the need to ensure access is available where and when it is required.

ACEM recommends:

- Implementing the recommendations from the Royal Commission into Aged Care Quality and Safety in full
- Reforms to Medicare rebates that appropriately recognise the complexity of patients' healthcare needs and enable this care to be provided in the community
- Expanding in-reach services to improve access to medical care and reduce avoidable hospital presentations.

Better access to mental health treatment and care

People presenting to EDs with mental health concerns experience far longer waits than any other patient type. EDs are not the most appropriate places to manage acute mental health crises and are limited in the level of mental health assessment and care they can provide. SOE24 shows that there is a similar percentage of people presenting to RRR EDs with mental health issues, but fewer services are available to them.

ACEM recommends:

- Increasing community-based services across the spectrum of care so people can remain well in the community and reduce the likelihood of crisis and need for acute tertiary services
- Increasing the number of mental health inpatient beds to be closer in line with the Organisation for Economic Co-operation and Development average of seven beds per 1000 population, to avoid lengthy delays to those whose care cannot be managed in the community
- Freeing up acute inpatient beds by expanding sub-acute care services and 'non-hospital alternatives' to reduce ED waiting times and access block for people with acute mental health conditions.

ACEM's next steps towards improving RRR healthcare

ACEM aims to lead the work for improving health equity in RRR areas by ensuring high standards of emergency care are accessible to all. It will continue to promote the positives in and the opportunities to have, rewarding careers in RRR locations through strategic communications, increasing rural training opportunities, creating a more equitably distributed workforce and increasing its evidence base on RRR issues.

ACEM has begun two projects that aim to redress the deficit in FACEMs, emergency medicine trainees and other skilled emergency department healthcare workers located in RRR areas. The long-term vision to ensure there is a breadth and depth to ACEM training rotations in RRR locations to support more recent graduates to do their specialist training outside the cities.

Addressing Health Equity in Rural Areas

The second iteration of ACEM's Rural Health Action Plan (RuHAP) is currently being developed. RuHAP is ACEM's strategic vision that brings together its work and embeds a focus on rural health across its operations. It articulates ACEM's role in addressing health equity in RRR areas and aims to strategically coordinate work across Australia to maximise its impact.

ACEM's first RuHAP focused on building the foundations for understanding how best to strengthen emergency medicine in RRR – particularly workforce, research, collaboration, and service provision, planning and development. The next RuHAP focuses on the next stage in improving health equity in RRR areas.

Building a Flexible and Responsive Emergency Medicine Workforce

ACEM currently has a flexible training program where trainees drive their own program via individual accredited training sites. Flexibility is a strength of the training program, however many health services in RRR locations still experience challenges in recruiting FACEM trainees.

Launching in 2024, the Accredited Networks Project will establish and pilot accredited regional and rural integrated emergency medicine training networks that will increase and strengthen the quality of education and training opportunities for RRR-based specialist medical trainees.

A major barrier to RRR sites achieving ACEM training accreditation status is the requirement for on-site and on-call FACEM supervision, which therefore limits where specialist emergency medicine training can occur.

ACEM's Blended Supervision Pilot Project aims to improve access to FACEM training opportunities in rural areas. The project aims to evaluate the feasibility of creating unique training opportunities via a blended supervision model, which sees face-to-face clinical supervision complemented by some supervision that is provided remotely.

References

The following references and resources were utilised for this report:

Australasian College for Emergency Medicine. Annual Site Census 2022 Report – Part 1: ED Staffing and Casemix. Melbourne: ACEM; 2023.

Australasian College for Emergency Medicine. ACEM Sustainable Workforce Survey. Melbourne: ACEM; 2022. Available from: https://acem.org.au/getmedia/59afa8a5-ff02-4104-8f2a-daf3b32b3867/Sustainable-Workforce-Survey-2022_Final

Australasian College for Emergency Medicine. Solutions to Access Block. Melbourne: ACEM; 2023. Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-(1)/Hospital-Access-Targets

Australian Bureau of Statistics. Estimates of Aboriginal and Torres Strait Islander Australians. Canberra: ABS; 2023. Available from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release

Australian Bureau of Statistics. Regional population. Canberra: ABS; 2023. Available from: https://www.abs.gov.au/statistics/people/population/regional-population/latest-release

Australian Institute of Health and Welfare. Hospital Resources 2021–22: Australian hospital statistics. Canberra; AIHW; 2023. Available from: https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients

Australian Institute of Health and Welfare 2017-18. National Non-admitted Patient Emergency Department Care Database (NNAPEDCD). Canberra; AIHW; 2018. Available from: https://www.aihw.gov.au/reports/hospitals/emergency-department-care-2017-18/summary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