

Rural Emergency Services

Victorian Healthcare Association

March 2012 | www.vha.org.au



Position Paper:
The VHA
view



Victorian Healthcare Association

Definitions

Emergency Department (ED): a department of a health service agency that is funded by the Victorian Department of Health to provide emergency services.

Urgent Care Centre (UCC): a designated area in a local health service agency to provide emergency resuscitation and limited stabilisation prior to early transfer, otherwise provide limited definitive care depending on local resources.

Primary Care Centre (PCC): similar to a UCC but have either significant resource limitations for trauma resuscitation or are within close proximity of a higher-level trauma service. They are expected to transfer all self-presenting trauma patients¹.

Australian Triage Scale categories from 1-5²:

- Immediately life-threatening (category 1)
- Imminently life-threatening (category 2)
- Potentially life-threatening or important time-critical treatment or severe pain (category 3)
- Potentially life-serious or situational urgency or significant complexity (category 4)
- Less urgent (category 5)

1.0 | Prefacing Comments

Over the past decade, the Victorian Healthcare Association's (VHA) rural and regional members have highlighted concerns about the sustainability of emergency services. These health service agencies face increasing workforce challenges, while they lack cohesive and systemic policy and funding frameworks based on population need. This is compounded by increasing unplanned presentations in rural Urgent Care Centres (UCCs) and regional emergency departments (EDs).

In 2010, the VHA surveyed its members among Victoria's 52 health service agencies to update the VHA 2007 position paper, *Rural Emergency Services Funding in Victoria*.

1.1 | The Context

Approximately 30 per cent of Victorians live in rural and regional areas, where people typically have a poorer standard of health³ and fewer options for health services, education and employment, compared to those living in the metropolitan region. One way to address this disadvantage is for the Victorian Government to commit to sustaining high quality and appropriate emergency services in rural areas.

Rural emergency services are provided in various settings; from regional EDs, to local health service agencies, to private General Practitioner (GP) clinics. Emergency stabilisation is the minimum standard of emergency care required by public acute health service agencies⁴. Emergency care beyond stabilisation is variable according to local resources.

In Victoria, 17 regional and subregional agencies provide emergency services through funded EDs. There are 52 local agencies that provide 24-hour emergency services over 73 sites⁵ without receiving ED funding grants. These UCCs and Primary Care Centres (PCCs) manage emergency presentations with nurses, on-call GPs and urgent ambulance transfers.

- The *Rural Enhancement Program (REP)* provides a financial incentive to rural doctors, who work in public hospitals as Visiting Medical Officers (VMOs), to increase their availability for on-call work.
- The National Healthcare Agreement states that in small rural agencies, which rely on GPs for the provision of medical services, and where allowed under the *Improving Access to Primary Care Services in Rural Areas Program*, eligible patients may obtain non-admitted patient services as private patients. This allows bulk billing of the Medicare Benefits Schedule (MBS) for primary care services⁶.
- National health reform has the potential to change the provision of after-hours care with the introduction of Medicare Locals (MLs). As this process remains relatively unclear, it is important to look at the realities of providing emergency care in rural areas and the best funding mechanisms to support it.
- Rural areas have very poor access to 24-hour pharmacies. Of the agencies surveyed, 94 per cent did not have a 24-hour pharmacy in their area. The only access to after-hours medications is through the hospitals' pharmacy stock.

2.0 | The VHA Position

2.1 | Workforce

There are significant workforce pressures on rural agencies, such as the difficulty in attracting and retaining enough medical staff to provide the required local services. This includes increased costs associated with training nursing staff, on-call rosters and rigid industrial regulations.

2.1.1 On-call GP Availability

Australian-trained GPs are free to practise wherever they choose, and the Federal Government's Medicare funding will follow the provider. International Medical Graduates (IMGs) must apply for a restricted Medicare provider number to practise for an initial five to ten years in areas of workforce shortage⁷. Rural agencies can encourage GPs to live and work in their communities but they rely on the willingness of the GP to work in a hospital as a VMO and do on-call work after-hours, in addition to private practice.

Changing workforce dynamics and the need for a work-life balance also impact the availability of on-call GPs. Of the agencies surveyed, 23 per cent are currently understaffed in respect to on-call GPs.

According to recent medical labour force data, the supply of employed medical practitioners in major cities was 376 full time equivalent (FTE) per 100,000 population compared with 187 FTE per 100,000 population in outer regional areas⁸. The agencies on the regional or metropolitan fringes also have to compete with larger agencies that have funded EDs to attract doctors with emergency medicine skills.

Most rural agencies provide telemedicine to improve health service quality and professional support for doctors. These opportunities could increase as the National Broadband Network is rolled out. Many agencies currently have telemedicine infrastructure but it is not always in the physical area where the on-call GPs need to use it. Recurrent funding for telemedicine and funding incentives are needed to facilitate relationships with regional and metropolitan doctors.

NURSE-ON-CALL provides 24-hour telephone health assistance from Registered Nurses, and will soon incorporate the Federal Government's *after hours GP helpline* program. It has the capacity to alleviate demand on after-hours services for minor complaints but needs to be better marketed to the public.



- Shared GP service models between local agencies would also ease pressure on the GP workforce. Such models can provide peer support and flexibility but are not an option for more isolated communities. Another strategy is for nursing staff to cover GPs for category 4 or 5 emergency presentations, which requires ongoing staff training and recognition of the competency of nurses to provide basic medical care in the absence of a doctor.

2.1.2 Scope of Practice

- The existing workforce shortage in rural areas is compounded by inadequate training and rigid regulations that limit staff scope of practice to perform necessary tasks.

- Many duties can be performed by a nurse, allied health practitioner or physician assistant instead of a doctor, but rigid protocols and legislation can present obstacles. A Department of Health (DH) pilot project trained some nurses in small rural agencies to supply medication in urgent situations when a doctor was not presents⁹, but accreditation for these competencies is currently not available.

- In 2009, the Queensland Government approved a Drug Therapy Protocol for isolated practice areas and rural hospitals¹⁰. Rural and Isolated Practice Registered Nurses are endorsed registered nurses who have completed an accredited course and can supply controlled medications when a doctor is not available.

- Many GPs can also perform multiple procedures, such as anaesthesia and obstetrics, but fewer graduates are being trained as GP proceduralists in Victoria. Rural agencies have benefited from the GP proceduralists having a broader scope of practice, but upon retirement they need to be replaced with two or three different doctors, causing further workforce pressures.

- The DH has initiated several programs to bolster the number of GP proceduralists in Victoria, such as the *Roads to Rural Practice* and the *GP-Rural Generalist Program*.

2.1.3 Maintaining Skills

- All rural agencies must provide emergency resuscitation and stabilisation for any adult or child who self-presents (ie not an ambulance presentation). Therefore, all rural agencies must train nursing staff to ensure their skills are of a standard to deal with all emergency presentations until the on-call doctor can get there. This model has existed in Bush Nursing Centres for some time, through Rural Area Nurses¹¹. The fact that few Category 1 and 2 emergencies present to rural agencies actually makes it more difficult for the nurses to maintain their skills for the time they will need them. Some rural agencies report of employees who are fearful of the unknown presentations that may be too difficult, so refuse to work after-hours shifts.

- The Federal policy change to allow nurse practitioners access to the MBS and the capacity to prescribe medications is welcome¹². However, many rural nurses report that the criteria to attain registration as a nurse practitioner are set at a high academic level, which requires long travel and time commitments without recognition of attained competencies.

2.2 | Funding

2.2.1 Funding Complexity

The DH’s policy to support a “whole of system approach to addressing demand for healthcare services” is undermined by funding fragmentation. The funding to regional and sub-regional agencies is similar to the metropolitan agencies where they receive Non-Admitted Emergency Patient Funding (NAEPF). The equity of distribution of this funding is problematic, but is beyond the scope of this paper.

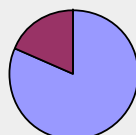
The majority of rural agencies use their acute service budget, or the Small Rural Health Service (SRHS) funding, plus the REP payments, for emergency services. The amount of funding and specific grants for non-admitted patient care needs to take into account the particular circumstances of rural emergency services. The REP funding alone is insufficient to attract GPs to work on-call. Greater than 50 per cent of agencies surveyed rely on more than the REP funding to remunerate their VMOs.

By 1 July 2013, all Commonwealth incentive funding for after-hours GP services will be provided through MLs¹³. MLs will be expected to conduct an after-hours primary care needs assessment for their geographic area and provide services where needed. This leaves rural agencies, and the GPs currently providing after-hours services, in doubt about the sustainability of their service.

If an agency has an arrangement with a GP to have a co-located private practice on-site, the GP’s services can access the MBS through bulk-billing. Currently, the National Health Reform Agreement’s Business Rules allow “in those hospitals that rely on GPs for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own GP”¹⁴.

However, this arrangement creates confusion when the GP charges a co-payment, which creates inequitable access for rural Victorians to free emergency care. This funding fragmentation is also apparent when a GP evaluates a patient in their co-located private practice and then admits the patient to the same agency. If the patient is transferred to another agency for definitive care, then the MBS can be accessed. If the patient is admitted to the same agency, then the GP’s private practice fee must be paid by that agency as if the GP’s private practice is now a funded public hospital ED (for which the agency is not funded). Once the patient is admitted the same doctor can then charge the agency an ‘initial consult’ fee as a VMO.

Would improved pathways for students, interns and VMOs to rotate through rural health services increase your medical staff recruitment?



■ Yes
■ No

- When a GP attends to a patient in the co-located clinic the Medicare rebate will be the same despite the complexity of the patient’s condition or the length of time spent with the patient. If another GP arrives to assist in a difficult situation, they are ineligible for a Medicare rebate. The patient is then responsible for the cost of an ambulance transfer if they are not admitted to the local agency. There is also no funding for the presence of a nurse or doctor to accompany the patient during an urgent transfer, if the patient’s condition demands it. This lack of clarity around the responsibility for funding between the individual and the State and Federal Governments is causing increased stress on the rural agencies.

- The nursing funding arrangements are also complex. The funding for nurses’ Enterprise Bargaining Agreements (EBA) staffing ratios is based on the annual number of presentations to an agency, with only one change per year for seasonal fluctuations¹⁵. It does not take into account the fluctuations in demand, such as weekend fluctuations and bi-seasonal population changes. The EBA allows for a ‘floater’ from the acute ward to move across to the UCC when needed, but many agencies do not have the physical layout to accommodate this approach. The lack of flexibility in the EBA often leads to inappropriate overstaffing at low periods and additional costs to staff in the peak periods.

2.2.2 Increasing Costs

- The acute services funding model for local agencies does not reflect the increasing costs of providing urgent care services in rural Victoria. Emergency service provision comes at the cost of planned preventative and primary healthcare services in many local communities. SRHSs are block funded with every service provided from the same pool of funds. Rural communities with a large tourist population struggle to maintain health services with a budget allocated to their rural catchment.

- Many of the increasing costs are due to the scarcity of healthcare workforce. Locums and temporary staff at times of crisis are expensive. Increased competition for personnel causes increased recruitment and retention costs, such as higher salaries, accommodation, cars or relocation costs.

- Even when a rural agency has a co-located private GP, most agencies provide the equipment and consumables used by the GP in their co-located private practice in order to keep the service going. These consumables come from the agency’s acute budget, so it will only increase if admissions increase. Medical equipment, which may be infrequently used, is required to provide emergency services. These costs increase as technology changes.

- Nursing costs are also increasing. A reliance on nurses only to primarily cover category 4 and 5 presentations incurs a duplicate fee if a doctor has to be called in to provide a prescription. Nurse practitioners are able to write prescriptions, but they are scarce and more expensive to hire. Although the recent changes to the MBS allows nurse practitioners to access MBS funding, this is not possible in a rural agency under the current National Healthcare Agreement.

2.3 | Policy

2.3.1 Unclear Expectations

The legislative, regulatory and policy limitations to workforce and funding innovations have been discussed above. The lack of clarity around the responsibility for funding between the State and Federal Governments for unplanned non-admitted presentations and nurses' scope of practice are important issues for local agencies. This is only exacerbated by the lack of clarity surrounding the implementation of MLs after-hours responsibilities.

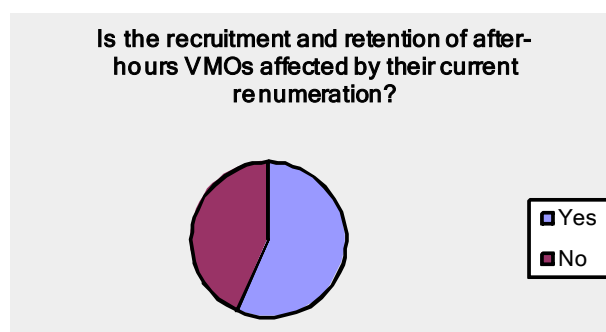
For example, some agencies have been trialling a pilot program of having Division One (DIV 1) nurses provide emergency care by following 'standing orders' for specific presentations. However, the legislation surrounding 'standing orders' for DIV 1 nurses is unclear regarding the provision of drugs unless they are in an 'emergency drug' category. This brings into question whether a Category 4 ED presentation is an 'emergency'.

The expectations of the general public are also a concern for these agencies. Access to free public services such as children's education and healthcare services is an expectation of every Australian. Although many residents of rural areas are accepting of the distances they have to travel for services, and that not all services offered in the metropolitan areas can be offered in the rural areas, most rural communities expect emergency care when needed.

Some of the rural agencies on the metropolitan fringe are experiencing increased pressure from the newer residents who expect EDs in every public hospital. While the introduction of the 4-hour targets for waiting times in EDs does not apply to most rural agencies, it adds an additional expectation to the public who may not understand the differences between EDs, UCCs and PCCs. Similarly, the introduction of MLs, and the commitment to after-hours cover, leaves communities confused.

2.3.2 Poor Data Capture

The increasing demand for urgent, unplanned health services and patient dissatisfaction is not reported in the Victorian Emergency Minimum Dataset (VEMD) as actual urgent presentations are not reported, only admissions from UCCs/PCCs. This lack of data impedes workforce and service planning both at a local level and a state-wide level. It also affects the adequate funding of the real costs of these services.



3.0 | Action Plan

3.1 | Community Expectations

As the population in the metropolitan fringe areas increases, expectations of metropolitan style services in rural agencies is causing public confusion about the level of care that can be expected.

Information must be disseminated across Victoria to increase the understanding of the capacity of rural health services.

3.2 | Funding the Real Costs

VHA recommends the development of a new funding framework for UCCs and PCCs across rural Victoria that reflects the true cost borne by local agencies. This should incorporate:

- Population data, particularly in high growth areas
- Projected growth in demand
- Holiday and weekend migration demand
- Telemedicine
- Consumables
- Access and proximity to other emergency or after-hours medical services

Inconsistent data collection affects the ability of agencies to effectively measure and consequently plan and fund the presentations to these services. Research needs to be undertaken to review the current level of presentations to UCCs and PCCs for analysis of projected growth. There is a need to develop datasets to accurately monitor ongoing demand for these services. This data collection should be linked to VEMD; however the data collection on smaller services should be less onerous.

The emergency services provided in isolated locations should be seamless, with funding, workforce, transport and government policy co-ordinated to meet the needs of the patient. The Federal Government's proposal of enhanced MBS access for primary care services in small, public, rural agencies is welcome, but it will not solve the problem of fragmentation and cost-shifting. The funding must be co-ordinated to ensure that rural communities have access to medical care.

Also, the new federal government policy of MBS funding for the practitioners involved at both ends of the telemedicine consult is promising, although the State Government needs to continue to develop networks for telemedicine to work.

3.3 | Patient Transfers

Another area where the State Government can contribute to the seamless flow of care is by addressing the separation of urgent patient transfer funding from total patient care. Care pathways depend on the provision of the right service in the right location, often necessitating patient transfers. This should not impose a financial penalty to the agency nor the patient. Sometimes it is clinically necessary for a nurse or a doctor to travel in the ambulance with the patient, but there is no funding for the return trip or the time away from their agency. Transfer costs are substantially higher for those

travelling greater distances in off peak hours, but emergencies are never convenient. For Victoria's 'hub and spoke' model to be effective ambulance services must be integral.

The VHA recommends a direct funding relationship between the DH and Ambulance Victoria (AV) for all maternity, newborn emergency transfer service (NETS) and all urgent inter-hospital transfers with Adult Retrieval Services.

The VHA also recommends the co-location of ambulance stations within health service agencies in rural Victoria. This provides resource efficiencies and builds collegiality between paramedics and other health professionals. Enabling paramedics to assist with patient care and stabilisation promotes interdisciplinary teamwork, assists with skills maintenance for both paramedics and nursing/medical staff and supplements the hospital workforce when presented with high acuity cases.

3.4 | Workforce

Interdisciplinary teamwork is vital in small, isolated areas. Governments need to look at funding experienced and appropriately trained nurses, nurse practitioners and physician assistants to reduce workload pressures on medical

- practitioners, where it is safe to do so. The Nursing and Midwifery Board of Australia should be encouraged to develop credentialing that supports a greater role for nurses in rural and remote areas to address the challenges of providing emergency care in these areas.
- The advanced training courses of this health workforce must encourage the building of professional competencies, which once assessed, can then be applied immediately.
- Regional leadership and support is needed to ensure that staff have the opportunity to practice skills in larger facilities where needed and to develop clinical training programs for medical students and interns in rural areas.
- Creating clinical placements in alternative settings - such as rural and regional areas, private providers, primary healthcare and aged care – has the potential to increase the retention of a rural healthcare workforce, thus addressing the specific workforce issues being faced in these areas.
- The relationships between the small rural agencies, regional agencies and academic institutions need to be strengthened to enable pre-intern and intern placements rotating through all rural agencies.
-
-

4.0 | Conclusion

The aim of the Victorian Government is to ensure equitable and timely access to healthcare within Victoria's public health service agencies. To achieve this aim, action is required to address the demand, workforce and funding issues rural agencies face in the provision of emergency services.

To ensure sustainability of these services, a new funding formula must take into account access and proximity to other emergency and after-hours medical services. This formula must also address the diverse demand issues experienced in high population growth areas and in holiday/weekend destinations. Clarity is necessary on the impact MLs will have on agencies currently providing after-hours care.

The implementation of a data collection system is required across all public health service agencies—whether or not they have designated 24 hour emergency departments to collect data on the numbers of emergency presentations to their services. Improved data collection will underpin the development of a new funding framework for emergency and urgent care services across rural Victoria.

This framework should reflect the true cost of providing these services.

The workforce pressures being experienced by local agencies throughout rural Victoria are most acute when it comes to the provision of emergency services.

Cohesive planning is needed addressing the numbers of practitioners and skill mix required by all health care professionals. Where additional skills are needed for existing professionals, particularly nurses, long-term funding is required to fund this training. A funding initiative must be developed to support rural agencies in developing new service models that are sustainable and will provide their communities with the care they require.

If rural agencies do not receive the support and funding required addressing these issues, local communities will be negatively affected. Inaction will lead to both the loss of practitioners and services as agencies use their available funds to meet the cost of emergency care. The ability of local agencies to focus on primary healthcare and preventative strategies is depleted when the emergency service needs are so pressing.

The VHA recognises the efforts being taken by the DH to address these issues. The VHA strongly emphasises that rural Victoria requires a systematic and strategic approach to emergency services to ensure rural and remote Victorians have sustainable health services into the future.



5.0 | VHA Recommendations:

Community Expectations

- Address the community demand with increased public information about the capacity of the local health service
- Provide a public information strategy in the implementation of the Rural and Regional Health Plan

Funding

- Funding must cover the true cost of delivering emergency services
- Appropriate data collection systems in all agencies to determine the true costs
- Increase the remuneration and support of on-call doctors to encourage doctors to provide on-call services in all rural areas

Patient Transfers

- Change funding arrangements relating to emergency patient transfers to a direct relationship between the Department of Health and Ambulance Victoria
- Co-locate ambulance stations with health services in rural and regional areas

Workforce

- Increase the scope of practice for rural emergency nurses, similar to the Remote Area Nurses
- Develop pathways for pre-interns, interns and Resident Medical Officers to rotate through local rural health agencies

References

1. Department of Human Services (2009) *Trauma towards 2014: Review and future directions of the Victorian State Trauma System*
2. Australasian College for Emergency Medicine, 2001, Policy Document: Standard Terminology, Melbourne.
3. Victorian Employers' Chamber of Commerce and Industry (2010) *Melbourne city workers healthier than country workers?* Accessed: [http://www.vecci.org.au/news/Pages/Melbourne_city_workers_healthier_than_Victorian_country_workers.aspx]
4. Department of Human Services (2009) *Rural directions—for a stronger healthier Victoria*
5. Department of Human Services (2007) *Better faster emergency care*
6. Commonwealth Government (2008) 'National Healthcare Agreement: Business Rules' pg B-20
7. Department of Health (2011) *International Health Professionals Victoria: District of Workforce Shortage & Area of Need* Accessed from: <http://www.health.vic.gov.au/ihpv/district.htm>
8. AIHW (2010) 'Medical Labour Force 2008' Accessed from: <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442453011>
9. Department of Human Services (2008) *Sustaining rural emergency services: Proposal for nurses to supply medicines*
10. Queensland Government (2009) *Drug Therapy Protocol: Isolated Practice Areas and Rural Hospitals—Registered Nurses*
11. Sullivan, E., Francis, K. and Hegney, D. (2010) *Triage, treat and transfer: reconceptualising a rural practice model* Journal of Clinical Nursing, vol. 19, issue 11-12, pgs 1625-1634, June 2010
12. Department of Health and Ageing (2011) *Programs & Initiatives: MBS arrangements for Midwives and Nurse Practitioners*. Accessed from: <http://www.health.gov.au/midwives-nurse-practitioners>
13. Department of Health and Ageing (2012) *General Practice After Hours Program*. Accessed from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/gpahp-lp>
14. Commonwealth Government (2011) 'National Health Reform Agreement: Business Rules for the National Health Reform Agreement' pg 59
15. Australian Industrial Relations Commission (2009) *Nurses (Victorian Public Sector) Multiple Employer Agreement 2004-2007*

Optimising health outcomes for all Victorians



Victorian Healthcare Association

The Victorian Healthcare Association

The Victorian Healthcare Association is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians from the perspective of its members.

This document has been prepared by the VHA with input and feedback from VHA members. While this position paper aims to broadly reflect the views of the health sector in Victoria, it remains the Board endorsed position of the VHA and does not supersede any submission or position stated by any member agency.

The Victorian Healthcare Association

Level 6, 136 Exhibition Street
Melbourne, Victoria 3000 Australia
Telephone: +61 3 9094 7777 | Facsimile: +61 3 9094 7788
vha@vha.org.au | www.vha.org.au