



Victorian Healthcare Association

Optimising health outcomes for all Victorians



RURAL EMERGENCY SERVICES FUNDING IN VICTORIA

—VHA BOARD ENDORSED POSITION STATEMENT 200805—

The Victorian Healthcare Association
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Board Endorsed Position Statement 200804



Executive Summary

In 2007, rural and regional VHA member agencies highlighted concerns about increasing costs associated with providing emergency services. These services face workforce shortages and the absence of a cohesive and systemic funding framework based on population need. This is compounded by variable access to after-hours GP services and the mental, financial and social impacts of drought.

To address the pressing need to provide urgent care services in rural regions, further work is required to refine the health system. Significant workforce pressures exist in filling medical on-call rosters across rural Victoria. In many cases, medical staff are reconsidering their ability to continue in their roles. If local doctors withdraw from local on-call rosters, significant safety concerns will be felt in local communities and employee stress within services. This will amplify increased presentations to local health services for emergency departments.

Rural emergency service provision requires a systematic and strategic approach to ensure services can provide urgent and emergency care that is both a sustainable and high quality.



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The VHA's Position

To overcome difficulties in the management of emergency care in rural areas, the VHA believes a key to success is appropriate funding arrangements and public education. The level of funding provided for acute services is currently insufficient to meet the full costs of maintaining and operating these services. In addition, the VHA supports the reorientation of the health system towards health promotion, primary healthcare and population health approaches to improve health outcomes for the broader community and prevent emergency presentations in the first place. Public education campaigns are needed to highlight the difficulties of providing emergency services in rural and regional areas.

Recommendations

1. The VHA recommends the development of a comprehensive plan to for addressing the on-call crisis being experienced across rural Victoria by improving community access to appropriate primary health care services.

This must include dedicated funding and structures to facilitate the systematic use of telemedicine to support clinicians in rural health services.

2. The VHA recommends that a strategic review of emergency services provision in Victoria be undertaken. This review must address the issues impacting service sustainability including:

- Access and proximity to other emergency services and after-hours medical services
- Demand issues experienced in high population growth areas and weekend/holiday destinations
- Costs borne by health services into the provision of urgent and emergency services

The VHA proposes that "a funding initiative similar to the state-wide Maternity Initiative be developed, providing grants to health services to support them in developing local service delivery solutions.

3. The VHA recommends that industry agreement be sought and systems implemented for data collection systems for all emergency, urgent and primary care centres across Victoria to ensure a consistent approach for presentations

4. The VHA recommends a plan for rural emergency service provision that:

- Addresses significant workforce issues facing rural Victoria to assist services to recruit and retain a sustainable workforce
- Addresses the issues associated with the maintenance of "currency of practice" requirements for nursing staff, including funding and articulation of strategies for maintaining clinical practice

5. That DHS partners Ambulance Victoria and Rural Health Services to investigate the role ambulance services can play in service provision

The Victorian Healthcare Association

The Victorian Healthcare Association is the major peak body representing the interests of the public healthcare sector in Victoria. Our members are public hospitals, rural and regional health services, community health services and aged care facilities.

Introduction

Approximately 30% of Victoria's population live in rural and regional areas (DHS, 2007). Within these areas, people typically have a poorer standard of health compared to those living in metropolitan regions (DHS, 2005). A range of chronic and acute conditions contribute to illness and hospitalisation with drought, road trauma and injury apparent. The average life expectancy for rural residents is about one year less than for their metropolitan counterparts (Jennings 2006).

Research conducted by Jennings et al (2006) states that improving health outcomes in rural areas requires improvements in each link of the "chain of survival".

The VHA seeks to promote strategies to enhance and bolster the work already being undertaken in Victoria. Current funding arrangements for emergency care across rural Victoria are unsustainable and action is required to ensure community safety and equity across all services.



Service Levels

According to the draft *Rural Emergency Health Services Planning Framework* (DHS, 2007) all rural and regional health services are 'expected to provide some level of response to unplanned emergency presentations'. This level of care depends on local community needs, resources and individual health service circumstances.

Rural and regional health services are categorised as either regional hospitals, sub-regional hospitals or local hospitals.

Through this categorisation the level of emergency services expected from each health services is defined.

Regional hospitals provide 24-hour emergency departments with dedicated clinical staff. They act as the regional trauma centres and should be a point of contact for clinical advice and support for other health services in the region.

Sub-regional hospitals provide 24-hour emergency departments, with dedicated clinical staff. The level of staff and the definition of these health services within the state trauma system may vary according to location.

Local hospitals provide emergency stabilisation and care as primary care services or urgent care services within the state trauma system.

There are 50 urgent care centres and 28 primary care services in rural Victoria that provide emergency care, supported by on-call GP services (DHS, 2007). Urgent care centres provide initial resuscitation and limited stabilisation to patients prior to transfer to a designated emergency department. They are also able to provide care to non-critical trauma patients.

Key Issues

POPULATION NEED

The migration of people on a long-term, seasonal or weekly basis provides specific service demand issues for rural providers, making a one size fits all approach unfeasible. These changes fall into three broad categories:

Weekend population changes

Many rural locations are utilised as weekend destinations for urban residents. For example Phillip Island experiences significant population increases on weekends, causing pressures associated with access to emergency services on a weekly basis. Therefore, it is difficult to fund the appropriate level of service delivery required as the catchment population may not represent the population's true needs.

Table 1 presents data from a study (Wilks, Pendergast, Leggat, 2006) of an accident and emergency department that treated 1402 clients over an 8 month holiday periods over two years.

Type of accident	Number (%)
Lacerations	102 (35.8%)
Falls	55 (19.3%)
Animal/insect bites/stings	39 (13.7%)
Burns (including sunburn)	29 (10.2%)
Poisonings (including food)	18 (6.3%)
Emergency contraception	12 (4.2%)
Allergic reactions	5 (1.7%)
Other	25 (8.8%)
Total	285 (100)

This data shows that the predominant incidents in need of emergency care in the case of tourists are lacerations, falls and animal/insect bites/stings. The authors found that these results mirrored those of a study conducted by Wilks and Coory (2002) for tourist inpatient admissions in Queensland hospitals. These examples require consideration for whole of government approaches.

Seasonal population changes

During peak holiday seasons, many rural Victorian locations experience significant population increases, where demand for services significantly rises. For example, much

of the organisational workload in Lorne is between November and Easter. This includes 'schoolies' populations which are a high risk group.

The demand on emergency care in Lorne varies significantly throughout the year, causing discrepancy in funding provision for non-emergency service types. The continued promotion of regions as tourism attractions must be matched by appropriate infrastructure. Another example was a major event in Apollo Bay that caused significant pressure on the local health service in terms of resources and supplies available to meet need. There is no recompense for this, nor is it accounted for in the funding formula.

“Each event brings different issues. The bike rides bring dehydration and musculo-skeletal injuries, schoolies weeks brings mass intoxication, cuts and trauma and music festivals bring overdoses and assaults”

For these small services, a single or seasonal event imposes significant financial burden on health services. While services seek to proactively plan, the government needs to be recognise the infrastructure required to support major events and tourism in rural Victoria.

This demonstrates the difficulty in planning services when need and resources do not align.

Permanent population changes

Many communities in rural Victoria are experiencing population change. The relocation of older Victorians and retirees to rural areas and the movement of families and the young to metropolitan fringe areas can significantly stretch the capacity of local health services and demand on their emergency services.

Migration is also occurring away from some parts of Victoria, which causes headaches for planning. The diminishing number of private GPs in these areas places significant demands on health services and erodes the ability of health services to continue to meet their communities urgent care needs.

COST OF EMERGENCY SERVICE PROVISION

Medium Sized Facilities

For facilities whose emergency department through-put is between 10,000 and 15,000 per annum, significant factors impact on their staffing and cost of operating these departments. These factors include:

- Increasing expectations of the Medical Practitioner Board Victoria and Postgraduate Medical Council Victoria in relation to the level and continuity of supervision of interns
- Growing expectations that interns will no longer work at any time, which precludes interns working overnight, in most hospitals

Smaller Facilities

In smaller facilities where there is not 24-hour medical staff coverage, services are provided by on call GPs. In these instances the medical officer is paid on a fee-for-service (FFS) basis by the health service or directly bills the individual. The cost for health services to provide emergency services on a FFS basis is greater than in those facilities where on-staff medical officers are able to be utilised. Therefore, the cost associated with such services is much greater within smaller facilities. In order to ensure there is equity in service provision across the Victorian health system these issues need to be investigated and addressed more fully.

The cost associated with the provision of emergency services also includes consumables and additional medical equipment that may be infrequently utilised, but is still required by the health services. However, the funding formulae in place does not recognise these peripheral needs.

Funding of Emergency Services

Health services are funded through WIES payments, training and development grants and other specified grants. The non-admitted emergency services grant which provides substantial funding is only available to hospitals with 24-hour emergency departments. For small rural health services, emergency services funding is drawn from the Acute Services funding provided to the facilities.

Health services that record more than 5,000 presentations per year receive additional funding to cover one designated emergency nurse per shift, as required under the Nursing

Enterprise Bargaining Agreement.

The level of funding for acute services, through both WIES funding and specific grants for non-admitted patient care, does not cover the full costs of operating emergency departments. *Rural Directions for a Better State of Health* articulates that if the model of care is to provide more extensive treatment and care at the rural location, (particularly for those conditions which require immediate response, but less intensive care over a longer period), then the rural service requires adequate funding and maintenance.

The weighting of funding through WIES needs to consider the particular circumstances of rural emergency services. This should recognise the difficulty of maintaining a minimum staff, with varying levels and demand for emergency services, fluctuating population size and location.

To date, DHS has not articulated any further funding arrangements to address these particular demands on the planning framework. The expectation is that services fund service delivery decisions through existing funding. Achieving this will be difficult and some indication of how expanding service and skill requirements will be funded is required to enable effective planning.

“The funding model does not acknowledge diversity of small communities and there is a lack of understanding in what we are able to do at our service with finite resources”

ON-CALL

Access to After Hours GP Services

There is increasing pressure on emergency departments, with 51 percent of emergency department presentations in rural areas being for primary care type services (DHS, 2007). These presentations occur more frequently in the evening and on weekends. As the collection of data in urgent care and primary care centres is not as robust as in designated emergency departments, it is difficult to quantify the exact causes of these presentations across rural Victoria.

GP Services

Most rural health services with acute beds provide emergency care as required by ward staff who utilise on-call GP services. The availability and willingness of on-call GPs to respond to emergency presentations and the cost of on-call services is problematic. In many areas, there is a shortage of available on-call GPs, as the numbers of GPs decrease or GPs are un-willing or to be on-call or without Visiting Medical Officer (VMO) status. As the numbers of GPs available to fill rosters decreases, the pressure on those remaining on rosters increases significantly.

To overcome the lack of on-call GPs, some health services have developed shared service models in partnership with other local health services to create a broader network of on call GPs. While these service models address issues of GP availability and effective rostering for on-call services, it has created uncertain circumstances when GPs are willing to attend emergency presentations. The hospital sector has highlighted that the types of presentations which GPs will attend varies between GPs. Some GPs will only attend where they believe there is a high level of acuity. Given the complexity of relationships with local doctors, this is difficult and confusing for health services to manage.

Recently, Wonthaggi had all local doctors withdraw from the on-call roster. The pressures expressed by these practitioners are being felt statewide. Anecdotal evidence suggests that these issues lead to increasing concern within communities. This Wonthaggi example has the potential to replicate across Victoria if action is not taken now to address on-call workforce pressures.

Sharing the expertise that exists in metropolitan or regional facilities is critical to assist smaller facilities. However, many services do not have easily accessible neighbours to work with. Facilitating the development of networks and relationships that enable the sustainable use of technologies must be encouraged. Telemedicine infrastructure to undertake these activities currently exists in most, if not all facilities, but there is no funding incentive or systemic process to facilitate this.

Recommendation 1

The VHA recommends the development of a comprehensive plan to for addressing the on-call crisis being experienced

across rural Victoria by improving community access to appropriate primary health care services.

This must include dedicated funding and structures to facilitate the systematic use of telemedicine to support clinicians in rural health services.

Payments

DHS has increased funding provided to health services for on-call payments to medical staff . DHS has stated the payments are not there to cover costs, but to assist health services to meet their overall needs. This additional funding is welcomed by health services. However, the inconsistent interpretation and application of this funding is concerning. Health services have highlighted a desire for DHS to develop guidelines regarding the application of this grant. In the absence of guidelines the ability for health services to effectively negotiate on-call payments with medical staff is difficult.

Patient Co-Payment

The equity of such payments needs to be questioned when comparing metropolitan areas and larger regional areas where emergency services provided by health services are more accessible. The VHA is concerned that rural patients are being disadvantaged by both reduced access to emergency services and the requirement to pay for services. As an example, a 2-3 hour wait for a Category 5 patient is problematic.

Recommendation 2

The VHA recommends that a strategic review of emergency services provision in Victoria be undertaken. This review must address the issues impacting service sustainability including:

- **Access and proximity to other emergency services and after-hours medical services**
- **Demand issues experienced in high population growth areas and weekend/holiday destinations**
- **Costs borne by health services into the provision of urgent and emergency**

services

The VHA proposes that "a funding initiative similar to the state-wide Maternity Initiative be developed, providing grants to health services to support them in developing local service delivery solutions.

INCONSISTENT DATA COLLECTION

Data collection of presentations to designated emergency departments is collated using the Victorian Emergency Minimum Dataset (VEMD). This data is used to analyse demand on emergency departments. This data collection is also used to meet the Victorian Government's obligations under the National Health Information Agreement and the Australian Health Care Agreement.

However, data collection in Urgent Care Centres and Primary Care Centres is limited and inconsistent. Thus, there is an inability to comprehensively measure, plan and fund the presentations to these services. Further, outpatient and emergency services in rural hospitals have rarely been studied (Duckett, Kenny, 2000).

To address these issues, research is needed to review the current level of presentations to urgent care and primary care centres. There is a need to develop datasets to accurately and effectively monitor ongoing demand for these services. This data collection should be linked to VEMD, but the data collection at smaller services should be less onerous.

Recommendation 3

The VHA recommends that industry agreement be sought and systems implemented for data collection systems for all emergency, urgent and primary care centres across Victoria to ensure a consistent approach for presentations

WORKFORCE

Significant workforce pressures are being experienced by all Victorian health services due to recruitment and retention pressures. These include the ability to staff on call rosters, meet costs associated with training nursing

staff and difficulty in retaining sufficient numbers of locally based practitioners to meet services demand.

The use of nurse practitioners within emergency departments may address some workforce pressures. The applicability of this service model in smaller facilities has not yet been tested in Victoria. Where there are limited numbers of VMO's available within a given locality, the cost associated with engaging these services can be significant.

Where designated 24-hour staffing is not provided, significant training requirements are needed to ensure that all nursing staff have the ability to deal with emergency presentations. Nursing staff are required to have high level generalist skills, using some skills rarely. Nurses may have to provide initial stabilisation and treatment until an on-call GP arrives. To maintain credentialing and accreditation, staff often have to maintain skills through larger providers.

How these issues are addressed will be important for ensuring a qualified workforce that meets minimum safety requirements and overcomes shortages of medical staff. Better access to telemedicine and further training in communication of clinical information to on-call doctors could also address some of the issues being faced.

Increases in emergency presentations as a result of tourism impacts on administration staff. For example, some services have been forced to hire temporary staff to help resolve the client backlog of records following major events and holiday periods. These needs are not accounted for in the funding model.

Recommendation 4

The VHA recommends a plan for rural emergency service provision that:

- Addresses significant workforce issues facing rural Victoria to assist services to recruit and retain a sustainable workforce
- Addresses the issues associated with the maintenance of "currency of practice" requirements for nursing staff, including funding and articulation of strategies for maintaining clinical practice

AMBULANCE SERVICES

The VHA supports government moves to merge ambulance service delivery across metropolitan and rural platforms. In accordance with Federal and State Government policy directions, the VHA believes that ambulance services play an important role in early intervention and diagnosis. Paramedics have episodic contact with patients at times where they are more likely to be receptive to health advice and information.

The VHA supports the co-location of ambulance stations within health services in rural and regional Victoria. This provides resource efficiencies and builds collegiality between paramedics and health service staff. Extension of co-location arrangements to include paramedics who assist with patient care and stabilisation at health services is also viewed as positive. Such arrangements assist with skills maintenance and awareness for paramedics as well as supplementing hospital workforces, when presented with high acuity cases.

Shared service agreements need to be led and

supported at a state-wide level. Flexibility is needed at a local level to meet local needs. Evidence suggests that 'paramedics are increasingly becoming first line primary health care providers in many small rural communities as the provision of other health care services contract' (O'Meara et al, 2006).

The VHA is interested in supporting this endeavour. More information about ambulance services in Victoria is available in the VHA Rural Ambulance Service Costs Position Statement (2007).

Recommendation 5

That DHS partners Ambulance Victoria and Rural Health Services to investigate the role ambulance services can play in service provision

"Having a large group of people in one place at one time places a strain on the resources of the community"





Conclusion

Immediate action is required to address the demand, workforce and funding issues rural health services 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 formulae must also address the diverse demand issues experienced in high population growth areas and in holiday/ weekend destinations. The implementation of a data collection system is required across all health services—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 that reflects the true cost of provision of these services.

The workforce pressures being experienced by health services throughout rural Victoria are most serious when it comes to the provision of emergency services. Cohesive planning is needed addresses 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 health services in developing new service models that are sustainable and will provide their communities with the care they require.

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

The VHA is cognisant of the efforts being taken by the DHS 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.

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