Australasian College
for Emergency Medicine

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20 December 2023

Dr Joe McGirr
6 Macquarie Street
SYDNEY NSW 2000

By email: remoteruralregionalhealth@parliament.nsw.gov.au

Dear Dr McGirr

Re: Supplementary questions: Australasian College for Emergency Medicine

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide additional feedback through the supplementary questions from the Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding for remote, rural and regional health services and programs.

As you are aware, ACEM is a not-for-profit organisation responsible for the training and ongoing education of emergency physicians, and for the advancement of professional standards in emergency medicine, in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients.

1. *Can you give an overview of current funding issues faced by emergency medicine?*

   ACEM directs the Committee to review our *Submission to the Special Commission Inquiry into Healthcare Funding October 2023* found in appendix 1 of this submission.

2. *Has there been any progress in increasing recruitment and retention of ED staff?*

   Increasingly Emergency Department (ED) specialists and trainees are indicating they are or are planning to undertake part time work. The ACEM Sustainable Workforce Survey showed there has also been increased numbers of ED specialists and trainees who are planning on leaving the ED workforce or clinical practice all together. The Sustainable Workforce Survey 2022 factsheet can be found in appendix 2 of this submission. Additionally, data from our annual site census shows that regional and rural EDs have more unfilled Fellow of the Australasian College for Emergency Medicine (FACEM) positions than their metropolitan counterparts[1].

   It is ACEMs view that the current expenditure on locum doctors would be better spent on targeted initiatives encouraging EM specialists and other healthcare professionals to adopt a network model or re-locate to a regional area. Whilst the locum model has a distinct purpose of meeting short-term workforce needs, it also brings disadvantages, such as significant costs, a higher risk of variability in care, and lack of continuity for patients and ED teams. While locums contribute to clinical care they provide limited or no contributions to teaching, administration and managing broader system issues within the service.

   ACEM is devising strategies to improve the recruitment and retention of ED staff, including Flexible Approach to Training in Expanded Settings funded trials of blended supervision to commence in 2024, and a strategic plan to implement networked training.

[1] Australasian College for Emergency Medicine (2023). 2022 Annual Site Census Report - Part 1: ED Staffing and Casemix

3. *Can you elaborate on the issue of 'geographic maldistribution' (p 3) referred to in your submission and how it may be addressed?*

   The emergency medicine (EM) workforce is located throughout NSW, but is concentrated mainly in Metropolitan areas. However, the distribution or maldistribution of emergency medicine specialists is inextricably tied to the location of public and private EDs, and to the type of positions made available to FACEMs (e.g., staff specialist positions and/or visiting medical officer positions). The availability, duration and combination of these positions can affect the distribution of specialists as they decide where to work.

   ACEM trainees are required to undertake their training in accredited EDs. Currently NSW has no remote EDs that are accredited and only seven sites that are accretied for training stage 4.[2] Training Stage 4 (the final 12 months of FACEM training of the revised FACEM Training Program) has been designed to enable trainees to focus on the development and consolidation of leadership and management skills. This means that most trainees in their final stages of training, as well as the FACEM specialists required to supervise them, will be based in metro centres, which means that remote, rural and regional sites and patients miss out on access this highly trained EM workforce.

   ACEM has a strategic plan to impliment networked training to overcome these challenges for final year trainees, but also expand the networks that FACEMs work across. Network training will increase and strengthen the quality of education and training opportunities for remote, rural and regionally based specialist medical trainees. The model will facilitate this by establishing integrated EM training network's that

   (a) have regional/rural EDs as the core, with opportunities to access placements within the network that meet all EM training requirements;
   (b) provide training opportunities within regional/rural EDs that are not accredited.

   These integrated EM training networks will provide a comprehensive training program experience which delivers safe, high-quality training and, ultimately, contributes to the development of a sustainable remote, rural and regionally EM workforce.

   ACEM encourages this Committee to advocate for the funding of a pilot of integrated networked training to occur in NSW.

4. Has any progress been made in the funding and accessibility of patient transport services including air transfers?

   ACEM does not have access to funding and accessibility data to comment directly on any progress. However, feedback from those working in remote, rural and regional sites has commented on budget constraints – meaning that onboard staff have been downgraded from registered nurses to enrolled nurses, who have a reduced scope of practice. This means patients are requiring ambulances for transfer, which has inherent delays and pre-hospital service disruption implications. Transfer of remote, rural and regional patients is universally delayed compared with 2 years ago by the increased access block currently experienced by referral hospitals.

   Additional concerns were raised regarding the cost of patient transfer services to patients themselves, the return of patients to their usual place of residence and to the age and condition of patient transport vehicles used.

Thank you again for the opportunity to provide this submission. If you require any further

[2] FACEM Training Program Site Information Guide

information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact [redacted].

Yours sincerely,

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Submission to the Special Commission Inquiry into Healthcare Funding
October 2023

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide a submission to the Special Commission Inquiry ('the Inquiry') into Healthcare Funding.

1. About ACEM

ACEM is responsible for the training of 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, ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to emergency departments (EDs).

2. Overview of the submission

In responding to the Inquiry, we note the Terms of Reference enclosed within correspondence to ACEM President, Dr Clare Skinner, dated 20 September 2023. Our submission is informed by the firsthand experiences of emergency medicine specialists and junior doctors working and training in EDs across New South Wales (NSW).

ACEM has a long-standing interest in acute health system function, in particular hospital ED overcrowding, long ED wait times, and the management of patient flow throughout hospitals, which have all compounded in recent years. Our submission highlights how funding issues across the health system directly impact EDs, and offers a range of funding solutions and recommendations, that may help alleviate the systemic pressures.

Without attention and reform, the increasing levels of ED overcrowding and access block seen across EDs in NSW will not be resolved.

3. Recommendations

1. Raise the number of hospital beds per 1,000 population in line with the OECD average
2. Establish robust mechanisms to collect data and track the patient journey across the system to understand the true cost of each episode of care
3. Increase the number of senior consultants on shift – to increase service efficiency and ensure junior doctors are supervised in appropriately supported training posts
4. Provide funding to increase the number of non-clinical support staff (across various roles) in hospitals, to allow clinicians to practice to the top of their scope

5. Raise the level of investment into programs and initiatives aimed at retaining healthcare workers
6. Commit to investing in whole-of-system measures that adequately address the systemic causes of access block and ED overcrowding through evidence-based measures

4. Summary of the key funding issues and their impact on EDs

4.1 **Systematic underfunding of health services**

4.1.1 *Poor access to healthcare services*

There are several interconnected factors associated with the growing demand for care in EDs, including population growth, socioeconomic factors, age, health literacy and a changing burden of disease. Deficiencies in funding to primary care and community-based care, and changing political priorities, have created conditions where the community faces significant financial and geographical barriers to health care, and experiences services that are often not fit for purpose or not available when and where they are needed.

The broad suite of services available through primary care, typically coordinated by general practice, is vital to the health of the community. Primary care in Australia is currently under-resourced, with critical gaps in access to primary and community health settings preventing consumers from getting the support they require to manage their healthcare needs.

The responsibility to meet shortfalls in healthcare availability is effectively then shunted onto the ED, which functions as an overflow valve for people seeking care. Our members are now seeing patients presenting to EDs sicker than ever as a result of delayed or deferred essential healthcare.

4.1.2 *Hospital capacity is not keeping up community need*

Capacity within the ED, and access to specialist medical and nursing care in our EDs, is one of the health system's most precious and well-utilised resources. However, it requires the maintenance of patient flow to be effective.

In 2020-21, there were 372 presentations per 1,000 population (over three million total presentations) to public hospital EDs in NSW, representing a 10 per cent increase from 2016-17. Almost one quarter (24 per cent) of these three million presentations required admission to hospital for care that could not be deferred or delayed. In the same period that the clinically indicated need for hospital-based care increased, the overall number of hospital beds per 1,000 population decreased by seven per cent.

When resourcing and capacity do not match demand for inpatient services, EDs become crowded. Addressing capacity factors within the hospital system is a vital area of focus, as the lack of capacity behind the ED is the root cause of the majority of pressure placed upon EDs.

Recommendation: Raise the number of hospital beds per 1,000 population in line with the OECD average

4.1.3 *Tracking the true cost of healthcare*

The population burden of disease is changing, and as a result the complexity of patient presentations, and the type of workforce and infrastructure required to provide safe, high-quality care has changed too. In the context of an ED, working with undifferentiated patients, activity-based funding must reflect the complexity of patient presentations.

This includes the complex thought processes and investigations that may be required (whether the result is positive or negative for a condition). Diagnosis-based coding does not reflect that huge amount of staff energy and resource to support the patient. For example – EDs see a high-volume of patients who are frail or have complex comorbidities that often require intensive support from nursing, allied health and other services. As such, final diagnosis does not always reflect the complexity of the patient presentation (or the steps required to get the diagnosis).

Furthermore, the impetus is often on clinicians to do the coding, which is difficult to capture in the pressure-filled environment of an ED. The transition to the Australian Emergency Care Classification (AECC) is acknowledged and ACEM looks forward to the analysis of this change.

Recommendation: Establish robust mechanisms to collect data and track the patient journey across the system to understand the true cost of each episode of care

4.2 Entrenched workforce challenges

4.2.1 *Staffing issues*

Staffing issues in EDs and across the wider hospital system have been articulated at length in past submissions the College has made to recent NSW Parliamentary Inquiries into ambulance ramping, South-West Sydney growth region and in the regional, rural and remote parts of NSW.

Casualisation of the NSW FACEM workforce has occurred over the last decade, in an endeavour to satisfy flexibility. These practices have now, however, gone beyond accommodating flexibility, and the existing FACEM workforce is not being utilised optimally.

Current practices include large numbers of FACEMs with low FTE or 'zero hour' contracts as part of the ED's standard roster. Almost one third of FACEMs are working in at least two workplaces. The majority of these specialist staff have limited or no access to clinical support time, thereby limiting their ability to participate in clinical teaching, safety and quality and clinical governance processes, which are a vital component of maximising the effective contribution of this specialist workforce to the health system.

ACEM has witnessed the increasing use of locums to fill staffing gaps across NSW. There is no disputing that the locum model has a distinct purpose of meeting short-term needs – however, it also brings disadvantages, such as significant costs, a higher variability in care, a lack of continuity for patients and ED teams. The use of locums also does not address the abovementioned shortage of staff able to contribute to clinical teaching and administration that a specialist workforce provides. Whilst enabling clinicians to work according to their own preferences while utilising their knowledge and skills is important, it is essential that staffing numbers match the continued growth in demand, to ensure that emergency medicine remains an attractive and viable medical specialist career path to choose.

Emergency medicine specialists have hourly tasks dominated by communication and clinical activities, as well as numerous educational and supervisory responsibilities. ACEM's NSW members report that the ability of FACEMs to work to the top of their scope of practice is often compromised, with FACEMs often required to perform tasks that could be done more efficiently by others e.g., making beds, requesting and/or obtaining food and supplies for patients, escorting patients with non-critical conditions to tests of other wards. An increase in the FTE of non-clinical ED support staff e.g., cleaners, patient care assistants and clerical staff to allow clinicians to work to the top of their scope.

Additionally, the effect of upstream staffing structures also has a significant impact on the ability of EDs to provide safe, timely quality care. Medical consultants are often the only people capable of admitting and discharging a patient. As their workload has increased, they often are unable to round on all their admitted patients each day, resulting in many patients stuck in the ED waiting for a plan. If an in-patient team will not review admitted patients in the ED, the patient can go a day waiting for a bed before they get a plan from a specialist. While this is happening, the bed and associated staff can't see other patients, including those arriving by ambulance.

The overreliance on junior doctors across the hospital system comes at greater cost to the system. A practical example that occurs regularly is the early career doctor who orders more investigations than an experienced consultant might otherwise assess to be necessary, which also has implications for hospital efficiency. Staff specialists are vital to providing safe care and adequate supervision of junior doctors. Additionally, burnout and high attrition rates brought about by extreme workloads is preventable with adequate rostering of staff specialists each shift.

Recommendation: Increase the number of senior consultants on shift – to increase service efficiency and ensure junior doctors are supervised in appropriately supported training posts

Recommendation: Provide funding to increase the number of non-clinical support staff (across various roles) in hospitals, to allow clinicians to practice to the top of their scope

4.2.2 *Development and Retention*

For decades the health system has been sustained by a large and committed workforce that has often gone above and beyond in their efforts to support patients. A strong health workforce is a critical element of a fully functional healthcare system. The current state of the workforce is that it is undervalued and overworked. The reservoirs of goodwill that helped steer the state through the worst of the COVID-19 pandemic are now largely depleted.

Extreme workloads for all ED staff, with continued access block and ED overcrowding, are leading to significant burn-out, and for the emergency medicine workforce, impacting the longevity of their specialist careers.

This is particularly evident in the loss of senior medical and nursing staff from a range of specialties, including emergency medicine. The combined experience that has been lost will take at least a decade to replace, as more junior staff upskill, and remaining senior staff take on additional work and risk.

Addressing workforce challenges is also more than just looking at numbers of people in roles – it is about ensuring that the workforce is valued and treated with dignity. Whilst on par with what other States and Territories commit to workforce development and retention initiatives, the level of funding is incredibly underwhelming. There is an opportunity for the NSW Government to be the leaders in this space, by making a large investment into new and meaningful workforce retention initiatives that address attrition rates.

Recommendation: Raise the level of investment into programs and initiatives aimed at retaining healthcare workers

4.3 **Proactive vs reactive budgeting**

4.3.1 *Addressing inefficiencies in the system*

Our members report that there are opportunities to find efficiencies and eliminate waste. The mostly commonly reported areas of inefficiency in the system are:

1) The duplication of processes can be observed across the 15 Local Health Districts (LHDs) in NSW. Every LHD/hospital has its own clinical guidelines (which often conflict), has its own choice of clinical equipment, different technology (e.g., different portals to view diagnostic results which are not intra-operable)

2) Stores and equipment are not always done strategically. Combined with poor asset management, this has resulted in lots of waste with financial and environmental implications.

3) The question of how to transition hospital and community health services beyond business hours needs to be addressed, as patient flow is severely impacted by delays caused by relatively simple things.

4.3.2 *System design*

The evolution of models of care aimed at reducing pressure on the system is twofold. Firstly, EDs are increasingly taking expanded roles, and the size and suite of services provided by EDs has drastically changed the practice of emergency medicine. The operationalisation of models of care that were once provided in other parts of the hospital have now become business as usual, and many of the larger hospital EDs have essentially become quasi-hospitals in their own right.

The example of building bigger EDs appears to be coming from a cost saving perspective, rather than the needs of patients. It requires specialists from other parts of the hospital to then work within the expanded

ED, which limits the capacity of inpatient units, which in turn further exacerbates access block once the ED fills up and can't admit patients to inpatient units.

Secondly, there has been an emergence of models that aim to keep people out of hospital. The use of telehealth in emergency medicine settings is a rapidly evolving area of clinical practice, with an increasing range of public and private providers offering various services. Whilst the College recognises the potential of virtual care to improve system efficiency and give patients greater access, choice and control, there needs to be a clearer role for telehealth and virtual care.

ACEM notes there is risk emerging that the provision of telehealth services is drawing additional workforce from physical EDs and creating gaps – thus, forming a cycle, whereby physical EDs become more understaffed, leading to more telehealth utilisation as a coping mechanism, drawing even more staff out of the ED, and so on.

Reactive budgeting for initiatives that do not allow time for proper consideration, development or support for implementation and evaluation demonstrates a lack of clarity around what is needed, and results in exponential amounts of waste. It is ACEM's position that the best way to resolve system pressures on hospitals is to appropriately resource other parts of the system to manage these patients within existing structures rather than creating new, parallel and inefficient structures. Considering patient flow as the problem – when you realise that the pipe (patient flow in and out of the hospital) is what is blocked, it cannot be fixed with a bigger sink, but it can be fixed with a larger diameter outflow pipe.

Recommendation: Commit to investing in whole-of-system measures that adequately address the systemic causes of access block and ED overcrowding through evidence-based measures such as those contained in the Sax Institute Report[1]

4.4 **Additional factors**

4.4.1 *The Federal and State funding divide*

ACEM acknowledges that the State contributes a larger proportion of funding per annum to public hospitals than the Commonwealth. The College has previously advocated for the removal of the National Health Reform Agreement (NHRA) growth cap, even if only for an initial period of time, to get much needed funding into the health system.

While emergency care is primarily governed and funded through State budgets, areas of Commonwealth responsibility nevertheless have a significant impact on the ability of our members to provide high-quality care.

As Australia's population ages, there is an increasing number of older people with complex health needs that require high-quality healthcare. Whilst ACEM acknowledges that older Australians will periodically need access to acute care, improved access to primary care and acute care for older people at their residences, whether in the community or at a residential aged care facility (RACF) can reduce risks associated with transfers and hospital visits and assist with reducing demand on over-capacity hospitals.

There are a significant number of people living with disability currently in hospitals despite being clinically ready for discharge. The lack of appropriate community support including services and accommodation not only prevents the discharge of hospital patients who no longer require treatment to create space to care for more patients, it also comes at great cost to the system.

There is an urgent need for investment to address the underlying barriers to discharging patients who no longer require hospital care, in order to improve patient flow and allow people to receive timely access to care.

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[1] Frommer, M & Marjanovic, S. Access block: A review of potential solutions. Sax Institute, 2022.

4.4.2 *The social determinants costs the health system*

The health system is inextricably linked with a range of other formal systems including mental health services, the National Disability Insurance Scheme (NDIS), aged care services, housing, family violence, child protection, income support, and education – as well as with multiple informal caring networks including families, communities, faith groups and non-government organisations.

Emergency physicians experience the impact of social determinants of health on a daily basis, and are acutely aware of just how vital these services are for the benefit that they provide to consumers, as well as supporting the functioning of the health system in general.

Funding models are needed to build the capacity of all care that is provided in the community. In addition to building multidisciplinary teams in primary care, additional capacity is required across all services that provide essential care that supports the health and wellbeing of the community.

5. Concluding observations

The recommendations contained in this submission will all in their way contribute to systemic improvements, and may all contribute to addressing access block, which is regularly identified by emergency clinicians as the single most serious issue facing EDs, and the major contributor to ED overcrowding.

Access block and ED overcrowding have implications for patient safety, as they are both associated with poor health outcomes and preventable mortality and morbidity.[23] Inappropriate ED bed occupancy due to access block results in EDs looking after patients for longer, which reduces the capacity of staff to see new patients, due to the lack of time and available space.

Access block is not primarily a problem caused by EDs (it occurs due to a range of systemic factors, including bottlenecks in other parts of healthcare systems) – but it tends to be identified with EDs because it is monitored in EDs and reported with other ED performance indicators.

Access block also represents a large cost to individual EDs and consequently to the overall healthcare system, and investment in addressing it could result in overall budgetary savings.

AIHW data shows that in 2020-21, 720,000 people suffered access block. Based on ACEM's internal analysis, this cost to the health system was estimated at $583 million (a range of $222 million to $833 million).

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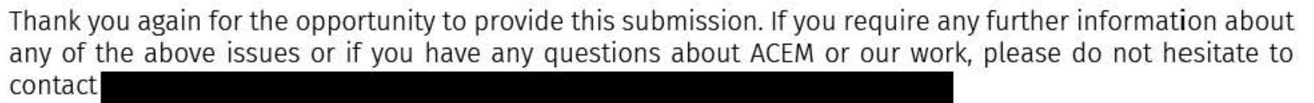
[2] Jones, PG and van der Werf, B. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. Emerg. Med. Australas. 2020 Dec 10. Doi: 10.1111/1742-6723.13699. Online ahead of print

[3] Berg et al. Associations between crowding and ten-day mortality among patients allocated lower triage acuity levels with need of acute hospital care on departure from the emergency department. Annals of Emergency Medicine, 2019. 74(3): 345-356

6. Contact

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact



Yours sincerely,

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