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Ambulance service reform

''Reforming Emergency Care'' and ambulance services

T P Judge

The call to action must be heeded, getting there is the real challenge

Dr Robertson-Steel presents us with a call to action in transforming prehospital care called for in the government's 2001 white paper ''Reforming Emergency Care''.[1] Having laid out three underlying principles to guide the ambulance service response the author then outlines essentially three global strategies to meet the principles:

- linked if not national agreed standards for prioritisation of response;
- transforming the education and scope of practice of ambulance paramedics to more definitively assess and manage illness; and finally
- creating new networked partnerships between all providers of unscheduled care with core funding provided by a single source.

In articulating a vision of the future the author echoes work by Nicholl *et al*[2] regarding the future of the ambulance services within the UK and rightly acknowledges the challenges of delivering ever more and improved services within a near static delivery structure and budget. Inexorable increases in demand, the probable inability to agree on prioritisation standards, the lack of agreed standards of access and destination (potentially requiring reconfiguration of the ''entire healthcare system''), the problem of unlinked ''perverse incentives'' in funding multiple providers working within a single health catchment area are all specifically noted in the paper. The author concludes by highlighting the opportunity for the ambulance services to become ''integrators'' of care within robust partnerships of multiple providers in the prehospital arena.

Several questions and issues remain regarding both the extent of the problems and the achievability of the presented strategies for solution. With limited space allow me to lay out three:

Firstly, while the author acknowledges the demand problem, the strategies envisioned do not tackle the underlying issue of whether the system is supposed to passively respond to constantly increasing demand or actively manage and separate demand from need. This remains an unresolved philosophical question across emergency care systems more based on political rather than clinical rationale. The ''Response Generator'' while perhaps more efficiently matching demand (hopefully need) and resources will re-allocate rather than reduce patient loads. Until ''emergency care'' is defined and understood by the public, there will be unrelenting increases in undifferentiated, unscheduled, and unplanned care and a constant unfulfilled search for efficiency.

Secondly, it is unclear whether the true appropriate scope of practice for the ambulance services is one of transport or one of care. Nicholl and colleagues have identified that the attributes of an emergency care system that manages trauma extremely well may not be synchronous with a system that manages asthma or diabetes.[3] Emergency medical services (EMS) have been organised and structured to on a population basis primarily meet two time critical clinical needs—cardiac arrest and life taking trauma. Recognising that these conditions represent a fraction of total emergent patients it is always tempting to look for alternative, more productive uses of an already deployed work force. This may not be an effective strategy for either the original design problem or the new design strategy—chronic disease management. Furthermore, faced with the need to improve response time in an already maximised resource availability it is unclear whether the operational needs of the ambulance services can afford the cost and time to train the paramedics, much less treat the patients in a response and non-transport system. Such a system also begins to look very similar to the remit of the already deployed GPs who not only have greater training but work within a defined and known patient list.

Finally, the author's ''radical change'' does so within the existing corporate structure of the NHS. GPs, ambulance services, NHS Direct, primary care trusts, and hospital trusts remain distinct entities albeit with a cohesive funding scheme from an envisioned ''Local care group.'' Current provider incentives and disincentives are neither aligned nor indeed even recognised. As an example, the author notes that a national agreed prioritisation system linking NHS Direct and ambulance service 999 control could potentially divert one million cases (transports) a year from existing demand ''to alternative, appropriate care.'' It is unclear whose budget and which providers would absorb this shift.

Within a system that measures quality through the proxies of response time and volume, a service decrease of this magnitude would invariably result in a budget reduction for the providers of the original services. Ambulance services, already struggling to cope with increased demand, and among the most cost efficient and effective EMS services in the world, could not absorb a budget decrease to shift capitated resources to the provider(s) absorbing the shifted demand. Nor is it likely that other providers of community care would willingly transfer additional resources to the ambulance services. Finally, the author does not acknowledge the complex interplay and non-aligned incentive/disincentives between emergency care providers and social services, mental health, and housing providers.

While the preceding and additional unanswered questions remain, these comments are by no means critical of the vision. Without question, partnerships in care with common measurements of quality across a continuum, a more widely capable workforce, and demand management are all essential strategies and opportunities for the EMS services of the future. The call to action must be heeded, getting there is the real challenge.

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