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Federalism in the ambulance service - a country comparison of physician-accompanied secondary transport

Federalism in the ambulance service - Physician-accompanied secondary transport in federal state comparison

At the same time, the number of available target clinics is decreasing as the number of ambulance call-outs rises. Optimised use of inpatient treatment capacity makes it necessary to transfer patients between hospitals. Medical care during transport is organised federally and shows a divided Germany. A standardised authorisation regulation for the job description of emergency paramedics, as well as a backup system with tele-emergency medical support, can help to meet this challenge. However, this requires legislative changes under the jurisdiction of the federal states.

Keywords

Hospital reform, emergency reform, secondary transport, tele emergency, paramedic

The consolidation of the hospital market is being driven by economic constraints, as smaller facilities are often no longer able to operate profitably. The trend towards centralisation is being driven politically by the hospital reform and is intended to improve the quality of care through specialisation and concentration of resources. However, by 2022, only 1075 hospitals in Germany will still have the capacity to provide intensive care [1].

>> The ageing population in Germany poses new challenges for the healthcare system. The demand for geriatric and chronic care is increasing, while at the same time the shortage of healthcare professionals is becoming a growing problem. Utilisation of the rescue service has been rising continuously in recent years.

Destatis puts the expenditure for the rescue service sector at 7.78 billion euros in 2022, which is an increase of 32.5% compared to 2019 with 5.87 billion euros [2]. The trend of increasing expenditure and utilisation is influenced by several factors, including demographic changes, increasing awareness of health emergencies among the population and structural changes in the healthcare system.

Living conditions also have an impact on utilisation. In urban areas, the emergency services are utilised more frequently as the population density is higher and medical care is more easily accessible. A low socio-economic status also leads to increased utilisation of the ambulance service [3].

Bottlenecks in outpatient care and longer waiting times at GPs also lead to patients calling the ambulance service more frequently, especially for acute complaints.

As a result, a clinic may decide not to provide emergency care under certain circumstances.

Even if clinics are deregistered from emergency care, there is an obligation to treat emergency patients arising from legislation at federal level. The emergency doctor / ambulance service can nevertheless refer patients to hospitals that have been deregistered as part of so-called acute or compulsory admissions. According to a statistical analysis for the Munich area, the number of such acute admissions rose to 6.9% of the total number of admissions by 2019 [4].

Both the aforementioned acute admissions, which then lead to overcrowding in hospitals that are already working to capacity, and theneed for specialised care make it necessary to transfer patients to other hospitals, so-called secondary transports. There were 1.45 intensive care transfers per day in Saarland [5]. 1.1 intensive care transports per day in Augsburg [6]. In Schleswig-Holstein, in a study published in 2023, 1.4% of interhospital transports were accompanied by a doctor [7]. In 20.8% of cases, the transport was accompanied by an emergency physician and in 17.9% by a hospital doctor. A further 21.2% were carried out by a rescue helicopter.

Question:

What is the legal situation regarding secondary transport between hospitals in Germany and what are the practical consequences for those involved?

Methods:

In principle, the structure of the rescue service laws of the individual federal states is similar [8-23]. There are differences in the details, particularly with regard to the question of physician staffing for secondary and intensive care transports and the implementation of tele-emergency physician systems.

All state ambulance service laws were systematically reviewed according to the keywords 'physician-accompanied', 'secondary transport', 'intensive care transport', 'transfer' and 'telemedicine'.

On the basis of the analysis, the state regulations of the rescue service laws show three different variants in relation to medical accompaniment (see Fig. 1):

1. the transferring hospital provides the medical escort for a secondary transport.
2. the ambulance service/emergency doctor provides the medical escort for a secondary transport.
3. the rescue service/emergency doctor provides the medical escort for a secondary transport, whereby a tele-emergency doctor is also anchored in the respective rescue service law.

An option in variant 1, in which a tele-emergency doctor can also be deployed, has not yet been established.

It is striking that variant 1 is established in all eastern German federal states, whereas variants 2 and 3 are the standard model in the western German federal states.

Discussion

In Germany, hospitals are generally obliged to treat patients in emergencies. This obligation arises from the German Constitution,

the German Civil Code and the professional code. However, if a hospital is unable to admit additional patients for capacity reasons, this presents smaller hospitals in particular with the challenge of providing additional medical staff to accompany patients on transport in this bottleneck situation.

On the other hand, the organisation of the medical escort by the ambulance service, which also takes over the primary rescue, is a challenge. Transferring a patient to a distant hospital means that the resources required on site are not available for primary rescue for a longer period of time.

In order to address the problem of emergency doctor-accompanied primary operations against the background of resource-saving deployment, individual regions have introduced tele-emergency doctor systems as pilot projects, but these are now also enshrined in the Rescue Services Act in some federal states.

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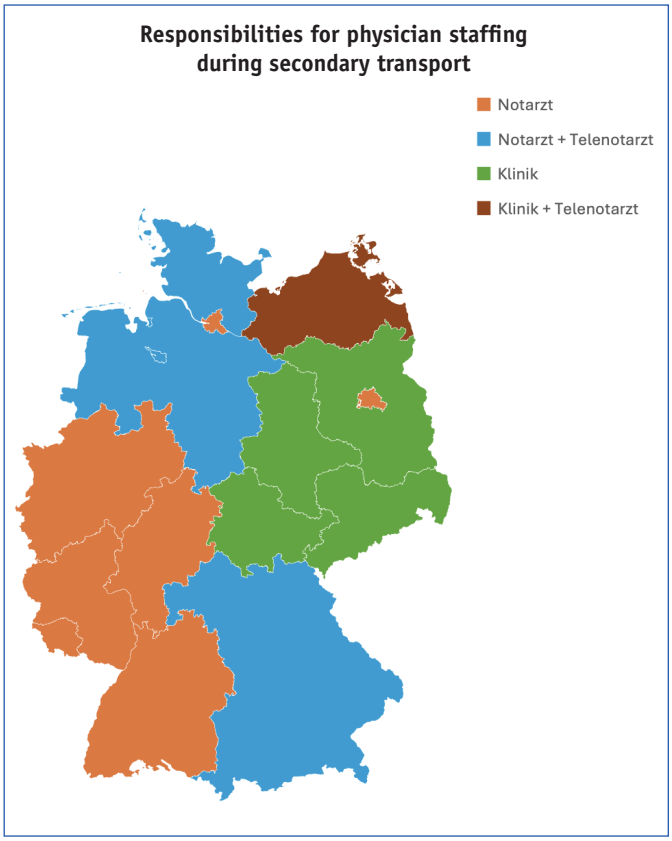


Fig. 1: *Overview of responsibilities for physician staffing during secondary transport and overview of the implementation of a tele-emergency physician in the respective state rescue service laws. Source: own illustration. Supported by Bing, GeoNames, Microsoft, TomTom.*

The upgrading of non-medical rescue personnel to emergency paramedics in 2014 also opens up the possibility of reducing medical transport assistance to individual cases. The competences and thus the scope of action of the emergency paramedics are subject to the instructions of the regional medical directors of the rescue service. The challenges for implementing the solution approaches are, on the one hand, the nationwide implementation of tele-emergency doctor concepts, including for secondary transports. In addition to technical requirements, it would also be necessary for the responsibility for medical accompaniment to lie with the ambulance service and not with the transferring hospital.

A standardised national catalogue of indications for emergency paramedics that provides a guideline for secondary transport does not yet exist. The fragmented regulation that the directive can be interpreted differently by each medical director of the rescue service makes supra-regional planning more difficult.

Conclusion

The shortage of qualified personnel in the healthcare sector, particularly in the medical service and in emergency departments, is a growing challenge. The number of acute and emergency admissions to hospitals deregistered from emergency care has already risen in recent years to a percentage that indicates that this is a daily recurring problem. The simultaneous increase in utilisation with scarce resources as well as medical progress and centralisation make it necessary to transfer patients. Federal and state regulations must be observed for doctor-accompanied transport. The arguments for both the organisation of physician accompaniment by the ambulance service and physician accompaniment by the transferring hospital are understandable.

Against the background of the hospital reform and a further concentration of the hospital landscape, however, early consideration must be given to whether the hospitals should either expand or establish a backup system for transport support or incorporate the increasing number of transfers into the personnel calculation of the regular ambulance service or establish tele-emergency doctor systems.

A standardised national framework plan for the skills and responsibilities of emergency paramedics can help to meet the developing demand more flexibly. However, this requires changes to the rescue service laws of the federal states, standardised indication catalogues for secondary transports and the deployment of emergency paramedics with the appropriate qualifications. <<

Author's statement

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