THE EMERGENCY MEDICAL CARE VOLUMES TO THE RURAL POPULATION UNDER GENERAL MEDICAL PRACTICES CONDITIONS

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The Abstract. *The emergency care and ambulance assistance reforms, these services work volume, as well as the ambulance medical help planned volumes to the rural population under the transition conditions to the general medical practice have already been presented in the paper.*

The emergency medical care (EMC) practically is the high – cost Public Health segment. In the expenditures structure, for the medical assistance to the population pre-hospital EMC share is accounted for about 7% of the Public Health spending. So, in 2010, the average cost per one call EMC has been amounted to 1.354,6 rub in RF.

Annually, each third citizen of the country is practically referred for EMC. The prophylactic direction weakening in the primary medical and sanitary care (PMSC) activities is one of the main reasons for the high demand of the population in the emergency medical care. About 60% of the calls to the EMC have been come precisely from the chronic patients and from the patients with their acute colds. About 25% of the chronic patients during the year are practically consumed the 25% of the EMC volumes. Thus, the EMC often has to be duplicated the outpatient clinics' functions.

The EMC pre-hospital period in the rural areas is appeared, having begun from the medical and obstetric points (MOP), the rural health clinics (RHC), or the general medical practitioners (GMP), and the emergency medical care, and the ambulance medical assistance (EMC, AMA) [1,2].

Since the emergency medical care, and the ambulance medical assistance services establishment in their work the significant amount of the challenges are being constantly accumulated, that have been resolved once the service next reorganization.

«The ambulance medical assistance» definition has already been introduced, as the conventional designation of the quite new service to be distinguished it from the EMC service. After the transfer in 30-40es of the entire (e.g. street and apartment) emergency medical stations EMC, for the patients with the diseases, that are posed no danger to the life, the medical aid points at home had already been organized, for which the title «emergency medical service» (EMS) was stuck. Subsequently, with the periodicity of 10–15 years (e.g. 120–180 months) the unions and their separation of these services have been happened in the country. For all this, in these definitions separately the «emergency» and the «ambulance» medical care for more than 80 years (e.g. 260 months) have already been become to be established, as at the Public Health organizers, well as among the population.

The Order of the USSR MPH of 20.05.1988, № 404 «the emergency medical service» has been cancelled, however, in its essence, there is the separate organization of the emergency and the ambulance medical assistance services in some areas. For all this, EMC is taken on itself all the calls from the streets and the public places, as well as the calls from the apartments' patients with their life – threatening conditions, in need of the emergency care specialists (e.g. suspected the myocardial infarction and etc.).

The ambulance medical care is responsible for the following functions fulfillment: EMS providing to the attached outpatients with the acute exacerbation of the chronic diseases; the testimony proving to be called the emergency medical care team; the continuity ensuring with the district doctors and the medical specialists; the timely notification of the sanitary – epidemiological surveillance service on the newly diagnosed cases of the infectious diseases.

In present, in a number of the RF subjects have their positive experiences of the separate operation of the emergency and the ambulance medical care services. So, the separate service organization of AMS and EMS services at the clinics is really allowed to be exercised the EMS clear continuity with its outpatients.

The study, having conducted by us, has been shown, that the single call cost to the emergency medical service team on the basis of the outpatient clinic is practically almost 2,0 times less, than the single paramedic call cost or the AMS medical general profile teams.

The large radius of the rural medical district is practically determined the low – power Public Health Institutions prevalence. The villagers help is provided in the 340 rural health clinics and 37.591 MOP; the ambulance medical service is provided by 1.153 stations (e.g. departments) of the AMS.

In 2010, the medical emergency exits have been provided with 9,5 mln. of the rural residents in the Russian Federation. The EMC medical calls frequency for the rural population has been increased from 152,8 up to 157,7 medical calls per 1.000 medical calls of the rural population during 1095 – 2010 years. Especially, for the urban population, the medical calls frequency has already been increased for 375,6 up to 399,7 per 1.000 of the urban population.

In certain regions of the RF the ambulance medical service to the rural population at the level of the non – point settlements is very difficult, rather inconvenient, and it is often provided by the MOPs, due to the population low density.

The centralization, however, is contradicted with the time from the medical call up to sick, or injured assistance rendering. So, this time may be achieved up to the several hours, in the context of the countryside. Possibly, the arrival time shortening up to the point of the medical call in the rural areas has been happened, through the substations, or the EMC affiliates creation of the rural areas (e.g. the peripheral area). At the same time, there is the contradiction, since the further

increase in the substations, or its branches is practically led to their further reduction in the workload. At the same time, the specialists' or doctors' visits, or the CRH doctor or duty at the emergency medical call are being created the «stripped» challenge of the hospital phase of the medical care.

The ambulance and emergency medical services organization challenges' solution in the rural areas is quite possible in the close cooperation and their interaction with the outpatient clinics' work, and it is particularly significant in the transition of the primary medical care to the principle of the general medical (e.g. family) practice (e.g. GMP/FP), and, primarily, in the rural areas.

The EMC medical calls validity examination has been carried out by us in the rural municipal Institutions (MI) in the 2 base areas of Bryansk and Samara regions, in order to be assessed the ambulance medical service calls making validity and the EMC volumes, which may be passed in the outpatient clinics, including the emergency medical service (EMS) and GMP/FP, and also for the recommended volumes' calculation of the EMS work under the GMP conditions.

The visits frequency for the EMC in the pilot rural area has been amounted 210,57 per 1.000 of the population, including about accidents, the sudden illnesses and the conditions – 208,2‰, due to the childbirth, and the pregnancy pathology – 0,02‰, with the patients', childbirth', and postpartum women' transport – 2,35‰. So, the unsuccessful medical calls have been made up 8,76‰. According to the experts' opinion, the 51,1% medical calls to the EMC have been unfounded, including 49,4% have been needed in the urgent medical care, which the EMS, or the GMP/FP doctors could be performed, and 1,7% of the medical calls have been required the medical care of the clinic's medical – officer. For all this, 46,8% of the unfounded medical calls of the EMC, that could be transferred to the GMP/FP, have been come to the clinic's working hours, the 36,6% – after – hours on the weekdays, and 16,6% – on the weekends and the holidays.

Thus, the study's final results can be practically used to be planned the GMP/FP work's volumes, the ambulance and the emergency medical services in the rural municipal formations.

The References:

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