Australasian College for Emergency Medicine

Pre-Budget Submission

Australian Federal Election 2022

Australasian College for Emergency Medicine

1. About ACEM

ACEM is the peak body for emergency medicine in Australia and New Zealand and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for ensuring the advancement of emergency medicine in Emergency Departments (EDs) across Australia and New Zealand, as well as the training of emergency physicians in these regions.

1.1 The intersection of acute care and the Australian Budget

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

Areas of federal responsibility that have a significant impact on emergency care include:

- Access to affordable primary care via General Practice,
- Community-based mental health,
- High quality aged care services,
- Ease of access to the National Disability Insurance Scheme (NDIS), in particular appropriate housing and accommodation, and
- Hospital funding.

Leadership by the Commonwealth generates important and necessary change across health systems. Conversely, when the areas of the health system that are the responsibility of the Commonwealth are under-resourced or encountering challenges, this flows right across the system.

Access block is the single most serious issue facing health systems in Australia. Access block is the situation where emergency department patients who have been admitted and need a hospital bed are delayed from leaving the emergency department for more than eight hours due to a lack of inpatient bed capacity. Significant delays in emergency department patient flow (due to lack of available hospital beds) leads to delays in the treatment of new patients (as emergency department staff are managing access-blocked patients). This leads to ambulance ramping and longer wait times for newly arrived patients. More patients are therefore likely to leave the ED before receiving the essential treatment they need.

The Australian Government can contribute to alleviating this problem in a number of ways, and in this submission, we are proposing investment in:

- aged care
- rural and regional health care, and
- the NDIS.

2. Aged Care

As Australia's population ages, there is an increasing number of older people with complex health needs that require high quality health care. It is essential that older Australians have access to high quality acute health care, that meets their needs, reflects their health priorities and occurs where they want it.

Older Australians are more likely to have a longer emergency department length of stay (LOS), in comparison to adults and paediatric presentations, with the median extending outside close to the 4-hour National Emergency Admission Target (NEAT). For older patients that need to be admitted to hospital, the length of stay is significantly longer.

ACEM recognises that primary health care is the primary pillar for health care for older Australians, and when access to appropriate care is promoted, the incidence of requiring acute care is reduced. However, even in the presence of high-quality primary health care, older Australians will still periodically need access to acute care. Older Australians should have the choice to receive acute care where they want it – whether that is in the ED or elsewhere (where clinically appropriate).

Efforts to improve clinical care must ensure care aligns with the wishes of the older person. Sometimes decisions are made about older people without informed consent that includes risks benefits and options for care. Advance Care Planning and similar processes are highly effective strategies to avoid transfers between RACFs and EDs where this reflects their goals of care, and this is clinically appropriate.

The benefits of the ED attendance and hospital admission needs to be weighed up with the risks. Improved access to primary and acute care for older people at their residences, whether in the community or at a Residential Aged Care Facility (RACFs), can reduce the risks associated with transfers and hospital visits and assist with reducing demand on over-capacity hospitals. Addressing these issues requires enhanced coordination between the federal and state administered parts of the health system.

The quality of aged care crisis is receiving significant, and overdue, public attention due to the findings of the Royal Commission into Aged Care and the devastating impact of COVID-19 on older Australians. It is imperative that this Budget continues the focus on the reform process initiated by the Royal Commission, while also reflecting the challenges laid bare by COVID-19. It is essential that additional funding is committed by government in line with its response to the Aged Care Royal Commission, with a focus on *Recommendation 4: Integrated long-term support and care for older people*.

Recommendations

- Building on the commitments in the Budget 2021-22 *Residential aged care services and sustainability (Pillar 2 of the Royal Commission response) – Mandatory care time standards and reporting*, fund increased access to clinically trained staff and appropriate systems in RACFs, including increasing care minutes by registered nurses, the use of nurse practitioners.
- Increase Medicare rebates for Level C and D consultations by 10% to better recognise and support complex care
- Introduce post-hospitalisation GP visits, seven days after any unplanned hospital admission
- Fund rebates and service to improve the documentation and implementation of consumer preferences for care (for instance advanced care planning) in residential aged care facilities (RACFs)
- Improve funding for access to high quality palliative care services to be provided both in RACFs and via community programs.
- Fund programs to better integrate IT services such as MyHealthRecord and MyAgedCare.

3. Rural and Regional Health Care

While the Australian public health system is funded and delivered on the basis of universal access to healthcare, regardless of location, in practice, this principle has not consistently delivered equity of either availability of or access to healthcare. People who live in rural areas have shorter lives and higher levels of injury, illness, and disease risk factors than those in major cities. Patients with mental health conditions face unacceptably long delays in accessing appropriate treatment.

Issues felt in metropolitan EDs are exacerbated in rural, regional and remote areas by the geographic maldistribution of the existing workforce. Scaling down medical models used in metropolitan areas for smaller rural communities does not enable efficient or responsive services. Primary care and community-based models should form the backbone of rural mental health services. The lack of available, affordable primary care in rural, regional, and remote settings is a significant driver of poorer health outcomes in many communities. Incentivising the expansion of local primary health care will reduce hospitalisations and health care costs.

The maldistribution of workforce is a significant cause of health inequity for rural, regional and remote areas. Increasing the available specialist workforces available in regional communities must be continued. The government should expand access to the Specialist Training Program to continue to encourage the specialist workforce to train and remain in regional and remote communities. The government needs to provide a more ambitious strategy for rural workforce development.

Recommendations

- Directly fund the expansion of primary care services in rural and regional settings, by developing community-led services in areas of need.
- Increase investment in local mental health primary care, including the attraction and retention of staff.
- Fund an expansion of the Specialist Training Program to facilitate greater regional training opportunities for medical specialists.

4. NDIS

People with disability have a right to accommodation that meets their specific needs. For NDIS participants, accommodation requirements can be complex and Australia does not currently have sufficient supply to meet community needs.

In hospitals across Australia, many NDIS clients are currently waiting in wards, whose treatment has been completed but they are unable to be discharged as there is no suitable accommodation available, despite having an approved plan.

Remaining on a hospital ward unnecessarily is bad for the person with disability and bad for the hospital system. When beds are being utilised for people who are not receiving treatment, this creates blockages and prevents other patients from receiving definitive care. This also means longer wait times in EDs, as patients remain there waiting for space to become available.

There is an urgent need for investment in this accommodation to meet the needs of people with disability. This will have additional flow on effects across the health system by contributing to patient flow so that all people can receive timely access to care.

Recommendations

- Invest in the creation of streamlined systems to support patients in hospital to access the NDIS, and particularly where specialist disability accommodation is required, in collaboration with state and territory governments.
- Increased permanent staffing within NDIA to provide individualised service within the timeframes set out in the participant service guarantee

5. Contact

For more information, please contact Jesse Dean, General Manager, Policy and Regional Engagement at policy@acem.org.au.

Yours sincerely

Dr Clare Skinner
President