



State of Emergency

Australia's Ageing Population

October 2026



Australasian College
for Emergency Medicine

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About ACEM

The Australasian College for Emergency Medicine (ACEM) is the not-for-profit organisation responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Aotearoa New Zealand and Australia. As the peak professional organisation for emergency medicine in Aotearoa New Zealand and Australia, ACEM has a significant interest in ensuring the highest standards of medical care for patients are maintained in emergency departments across both countries.

Our vision is to be the trusted authority for ensuring clinical, professional and training standards in the provision of quality, evidence-based, patient-centred emergency care.

Our mission is to promote excellence in the delivery of quality emergency care to all our communities through our committed and expert members.

Acknowledgement

ACEM acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our Australian office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Authorisation

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State of Emergency: President's message

Australia's ageing population is a modern-day success story, with advances in medicine keeping people alive for longer than ever before. However, due to insufficient preparation, our health system is simply not set up to cope with this success, and for the huge influx of older patients arriving in our emergency departments (EDs) now and in coming decades.



As emergency physicians, we see the consequences of insufficient planning by successive governments at all levels across our health system every day. This includes everything from primary care, residential aged care and home support to hospital services. While pressure is felt across the health system, this is especially the case within the ED.

We see too many frail people made afraid, confused and unwell by an unfamiliar environment, far away from their loved ones, familiar faces, supports and home comforts.

We see older people with complex needs forced to wait disproportionately longer than others for emergency care. The environment to receive this care is far from ideal, with harsh lighting, loud noises and constant interruptions. Desperately needed care takes place in corridors or on hard plastic chairs, while a frantic search for an available bed plays out behind the scenes.

This is ACEM's third **State of Emergency** report. It focuses on Australia's ageing population and the growing impact that inadequate planning has on providing the care that people deserve in EDs and the wider health system.

The data in this report reflects what we experience on the ED floor every day. Australia's population is ageing rapidly, and the number of older Australians has been forecast to continue growing. By 2030, it is projected that nearly one in five Australians will be aged 65 and over. Australia's health system and its health workforce are just not equipped for this demographic change.

Despite the scale and predictability of demographic trends, Federal, State and Territory Governments to date have not done enough to prepare for the volume and complexity of acute care needs as the population ages. This is a significant driver, but not the only one, of the growing pressure on acute health systems.

Too often older people cannot confidently access timely and appropriate care outside of hospital. EDs are absorbing the consequences of these failures across the health system, leading to ambulance ramping, ED overcrowding, corridor care and access block.

Unless these serious issues are addressed as a matter of urgency, as outlined in our recommendations, emergency care will come too late for many Australians. This is a particular risk for older people, who have higher healthcare needs and are more likely to require ED-level care. Without action, they will continue to suffer harm due to extended stays in the ED as well as delayed discharge from hospital.

We all need to know that as we age, we'll be treated with respect and dignity and have access to high quality and timely care.

Dr Peter Allely
ACEM President

Australian national data

There was a record total of **8,924,378 presentations** recorded in 293 public emergency departments (EDs) across Australia in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 16%, compared with a 4% increase among younger people. Older people were significantly more likely than younger people to be classified in higher urgency categories (Australasian Triage Scale (ATS) 1-3), arrive by ambulance and be admitted into hospital.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Older people accounted for **a quarter** of all presentations.



Triage category ATS 1-3

Nearly **seven in 10** older people presenting to an ED were classified ATS 1-3.



Arrived by ambulance

More than half of older people presenting to an ED arrived by ambulance.



Admitted to hospital

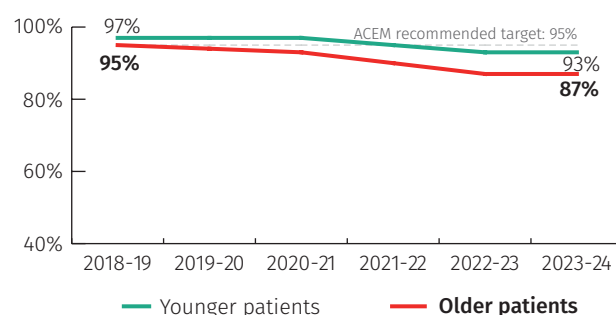
One in every two presentations to an ED among older people resulted in a hospital admission.

ED length of stay

ACEM recommends that most patients, whether discharged or admitted into a hospital bed, should leave the ED within eight hours.

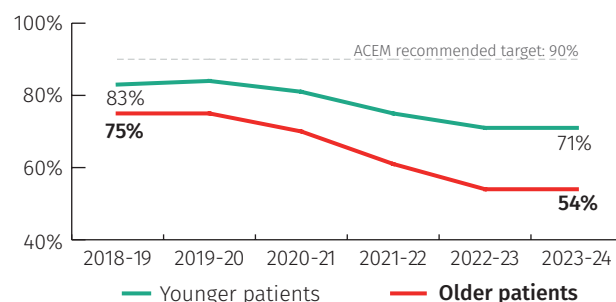
Discharged patients

In 2023-24, **87% of older people** were discharged from the ED within the **eight-hour target**, compared to **93% of younger people**.

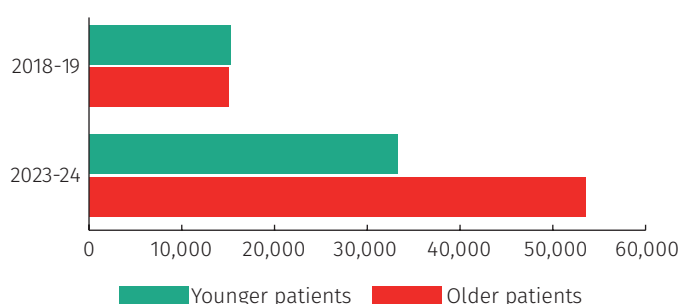


Admitted patients

In 2023-24, only **54% of older people** who were admitted into an inpatient bed left the ED within the **eight-hour target**.



In 2023-24, **53,510 older people** spent longer than 24 hours in the ED before being admitted into an inpatient bed.



Recommendations

ACEM is calling for the Federal, State and Territory Governments and hospitals to take urgent action to improve the quality of care older people receive across the health system, reduce ED demand and improve hospital capacity, and provide sustainable hospital care for all Australians.

1. **Strengthen alternative pathways to acute medical care for older people** to reduce ED demand and hospital admissions.

Recommendations for the Federal Government

- Jointly invest with State and Territory Governments in programs that strengthen integration between hospitals, aged care, community services, Aboriginal Community Controlled Health Organisations, and other support services, including transitional and step-down care, to support early discharge of older patients.
- Jointly invest with State and Territory Governments in additional emergency medicine telehealth support for residential aged care staff and community care services.
- Fund targeted, culturally safe alternative care pathways and outreach programs for Aboriginal and Torres Strait Islander Elders and Older People, co-designed with Aboriginal Community Controlled Health Organisations, to address the disproportionate rise in ED presentations.

Recommendations for State and Territory Governments

- Provide hospitals with adequate funding to deliver and sustain in-reach medical and multidisciplinary services to older people in residential aged care and in the community.
- Provide funding for additional Hospital-in-the-Home places to provide alternatives to hospitalisation and support early discharge for older patients.
- Jointly invest with the Federal Government in additional Hospital to Aged Care Dementia Support Program (HACDSP) places, to support people with dementia in their transition from hospital either back home with appropriate support or into residential aged care.
- Jointly invest with the Federal Government in additional Transition Care Program places and strengthen integration between hospitals, aged care, community services and other support services, particularly for people living with complex conditions, dementia or behavioural symptoms.

Recommendations for hospitals

- Expand and adequately fund geriatric-focused outreach emergency and geriatric programs providing acute assessment and in-home care.

2. Improve patient flow through the ED and reduce access block.

Recommendations for the Federal Government

- Require State and Territory Governments to adopt and report on ACEM's Hospital Access Targets (HAT) to ensure uniform, visible data across jurisdictions.
- Increase Federal Government hospital funding to match State and Territory Government funding in a 50/50 cost-sharing arrangement.
- Commit to ongoing funding for the Emergency Medicine Education and Training (EMET) program to better equip smaller rural and remote EDs to treat older patients locally, reducing inter-hospital transfers and delivering care closer to home.
- Improve how My Health Record, My Aged Care and hospital IT systems connect, so information can be shared easily between services.
- Implement digital platforms that allow visibility of advance care directives across healthcare settings.

Recommendations for State and Territory Governments

- Adequately fund an increase in inpatient bed capacity with demographics-informed planning.
- Adequately fund care coordination services, including culturally appropriate care, for older people with complex health conditions who are hospitalised to assist in discharge planning and linking to other health services.
- Fund hospital security, staff safety training and environmental design upgrades in EDs to reduce the risk of violence associated with overcrowding and extended wait times.

Recommendations for hospitals

- Implement a whole-of-hospital approach to reduce ED length of stay for older people, with shared accountability for patient flow and inpatient bed access across the hospital.
- Increase funding allocation for ED medical staffing to comply with ACEM staffing guidelines outlined in *Constructing a sustainable emergency department medical workforce*.¹
- Expand and adequately resource geriatric-focused ED programs to optimise care for older people and avoid unnecessary hospital admissions.
- Implement violence prevention and staff safety measures in EDs, informed by the recommendations of ACEM's *Breaking Point: An Urgent Call to Action on Emergency Department Safety* report, to address the rising levels of violence linked to overcrowding and access block.

¹ Australasian College for Emergency Medicine. *Constructing a sustainable emergency department medical workforce* G23. August 2023.

3. **Expand prevention mechanisms** to reduce ED attendance and hospitalisation through early intervention.

Recommendations for the Federal Government

- Rapidly expand and adequately resource the residential aged care sector to meet growing demand and complexity, delivering at least 10,000 additional beds per year by 2028.
- Increase funding to residential aged care providers to support the 24/7 registered nurse coverage mandated from July 2023.
- Improve targeted incentives to encourage residential aged care providers to admit residents living with complex conditions, dementia or behavioural symptoms and increase funding for additional Specialist Dementia Units.
- Improve the adequacy, responsiveness and clinical capacity of Support at Home and Commonwealth Home Support Program services to reduce preventable ED presentations and hospital admissions, including introducing maximum wait time standards for each Support at Home Priority System category.
- In collaboration with State and Territory Governments, deliver improved pathways and assistance to navigate and access primary, community and aged care services, including expanding the Aged Care Navigator program as recommended in the Royal Commission into Aged Care Quality and Safety.
- Fund sustainable primary care models, including adequate remuneration for general practitioners (GPs) to provide longitudinal, responsive care for older people, especially those living with complex conditions.
- Redesign the General Practice in Aged Care Incentive (GPACI) program to provide for equitable increases in incentives for all GP practices to provide services within residential aged care.
- Meet the National Preventive Health Strategy's commitment to increase preventive health spending to 5 per cent of the health budget by 2030.

Recommendations for State and Territory Governments

- Incentivise aged care providers to increase their capacity through State and Territory Government levers such as low-interest loans and planning assistance.
- Fund and facilitate a concerted public health campaign focusing on healthy ageing and preventive health.
- Invest greater resources into State and Territory Government health promotion services, including community-based programs that support healthy ageing.

4. **Fund research** into models of primary and acute care to improve outcomes for older people.

Recommendations for the Federal Government

- Establish and fund a National Emergency Medicine Research Foundation to support dedicated, long-term research into emergency medicine and acute care for all patients, including older people.
- Allocate regular targeted funding rounds for emergency medicine research from the Medical Research Futures Fund including research into models of care that improve outcomes for older people requiring acute care.
- Require State and Territory Governments to report age-disaggregated data on all key quality and performance indicators, including length of stay, access block, and exit block.
- Develop and validate health outcome measures for older people that clearly show performance and equity in the delivery of quality care across the acute care system.
- Require the collection and public reporting of ED length of stay, access block and treatment completion data disaggregated by Aboriginal and Torres Strait Islander status, to monitor and address the disproportionate harm experienced by older First Nations people in EDs.

Recommendations for State and Territory Governments

- Implement age-disaggregated data collection for all key quality and performance indicators monitored by hospitals to support improved visibility and care outcomes for older people.
- Collaborate with the Federal Government in developing data systems that improve visibility of extended ED length of stay, access block and exit block.
- Support clinicians to undertake research into models of care that aim to improve health outcomes of older people and reduce ED length of stay and hospitalisations.

Australia's Ageing Population

The emergency department (ED) presentation data in this report has been sourced from the Australian Institute of Health and Welfare (AIHW) National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD) between 2018-19 and 2023-24. A total of 293 public hospital EDs across Australia were included in the 2023-24 NNAPEDCD. A small proportion of presentations did not report data for specific variables and were therefore excluded from the relevant analysis and sections of this report. The NNAPEDCD data was supplemented by other data sources and reports from government and non-government organisations.

Consistent with national definitions, in this report **older people** are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over (considering the health disparities and lower life expectancy experienced by this population).

1. Emergency department presentations: 2018–19 to 2023–24

ED demand across Australia has steadily increased over time, reflecting population growth, changing demographics and the rising acuity and complexity of emergency care needs.² Pressure on ED infrastructure and workforce is also increasing year on year. Almost nine million people presented to EDs across Australia in 2023-24, an increase of nearly 600,000 from 2018-19 figures. While people of all ages are presenting to EDs more frequently, the rise has been primarily driven by the increasing numbers and complex healthcare needs of older Australians. Since 2018-19, the percentage of ED presentations by people in this age group increased by 16 per cent, four times the increase seen in the younger age group. In 2023-24, almost a quarter of people who presented to EDs were from the older demographic.

The number of older people identifying as Aboriginal and Torres Strait Islander presenting to EDs increased by 53 per cent between 2018-19 (108,554 presentations) and 2023-24 (165,952 presentations).

The number of older people presenting to regional, rural and remote (RRR) EDs increased at a much higher rate than for older people presenting to metropolitan EDs. Between 2018-19 and 2023-24 there was an increase in presentations of 25 per cent in regional EDs, 27 per cent in rural EDs and 33 per cent in remote EDs, in comparison to an 11 per cent increase in metropolitan EDs.

Age group	Total presentations	% increase from 2018-19
All age groups	8,924,378	+6.9%
Older people	2,196,705	+16.3%
Younger people	6,727,673	+4.1%

Table 1: Total number of ED presentations in Australia in 2023-24 and percentage increase from 2018-19.

1.1 Future ED presentation projections

In 2024, while older Australians made up only 17 per cent of the population, they accounted for almost a quarter of all ED presentations. Without urgent action, the projected growth in ED presentations by older people will impact disproportionately on healthcare systems.³ Assuming population growth consistent with Australian Bureau of Statistics modelling, projections between 2010 and 2050 show a 177 per cent increase in total ED presentations, with increases of 242 per cent for people aged 65 to 84 and 411 per cent for people aged 85 and over.⁴

2 Diouf I, Boyle J, Yoon HJ, Riahi V, et al. Time trends in the rates of ED visits in Australia, an aged-period-cohort approach. *Emergency Medicine Australasia*. Feb 2026;38(1):e70220

3 Australasian College for Emergency Medicine. *Emergency Medicine Preparedness for Population Ageing*. 2025.

4 Burkett E, Martin-Khan MG, Scott J, Samantha M, Gray LC. Trends and predicted trends in presentations of older people to Australian emergency departments; effects of demand growth, population ageing and climate change. *Aust. Health Rev.* 2017 Jul;41(3):246-253

This increase is not sustainable within current hospital operating systems and funding arrangements. While some older people will continue to require emergency care within an ED setting, people with lower-acuity conditions will need alternative options available and resourced, including appropriate and safe alternative acute care pathways. However, this should complement, and must not replace, investment in ED and inpatient capacity.

1.2 Alternative acute care pathways for older people

As people's healthcare needs change as they age, the health system needs to adapt to the specific care and resource needs of an increasingly ageing population to accommodate rising acute care needs. ACEM recognises that there are already many successful programs delivering acute care outside of the ED. What is needed now is investment to scale these programs so more older people can access them more easily. Preventable ED presentations can be reduced while still delivering an appropriate level of care by providing older people with alternative pathways to care and managing acute conditions at home or in residential aged care. Care at home should be available where possible for older people at high risk of hospital-acquired conditions, in accordance with the person's preferences.

Out-of-hospital care programs provide hospital-level care in a person's home or in residential aged care. These programs can prevent the deterioration of conditions (and development of hospital-acquired conditions), reduce the need for hospitalisation or rehospitalisation, and enable people to be discharged from hospital more quickly, all at a lower cost to the healthcare system. These programs include Hospital-in-the-Home, the Transition Care Program, Hospital to Aged Care Dementia Support Program and Geriatric Rapid Acute Care Evaluation (GRACE).

'There are programs that consistently include frailty/geriatrics teams in the ED, such as access to discharge pathways, hospital-in-the-home, residential aged care in-reach and clinical hub models (e.g. RADAR, RASS, CAREPACT) that support rapid advice and alternatives to transfer. They work best when integrated across hospital, ambulance, primary care and aged care with shared records, clear escalation plans and rapid access to diagnostics.' Emergency physician.

ACEM recommends that governments prioritise funding and further research into programs that can provide alternatives to hospital-based care for conditions that could be treated outside of an ED. The programs below are examples of out-of-hospital acute care programs currently being successfully implemented across Australia.

Transition Care Program

On 30 June 2025, 4900 people were using transitional care or short-term restorative packages across Australia. Jointly funded by Federal, State and Territory Governments, this program supports older people leaving hospital to regain their functional independence, preventing ED reattendance and hospital readmissions. This program aims to increase confidence in home-based care and provide rapid clinical response if required. Program analysis showed that three out of every five people who used transition care returned to the community, and almost nine in 10 (86 per cent) experienced an increase in their functional independence on leaving the program.⁵

5 Australian Institute of Health and Welfare. *Exploring how transitional care supports older people leaving hospital*. 2024.

Geriatric Rapid Acute Care Evaluation

Geriatric Rapid Acute Care Evaluation (GRACE) is a hospital-linked outreach service that provides rapid, specialist assessment for older people experiencing acute deterioration at home, with the aim of early stabilisation, coordinating care in the community and avoiding preventable ED presentations.⁶ The GRACE program has been shown to reduce ED presentations and admission to residential aged care, as well as decrease the average length of stay when hospital admission is unavoidable.

Aged Care Emergency service

This nurse-led ED outreach service provides telehealth (telephone and visual telehealth) consultations to support residential aged care nurses with decision-making and establishing clearly defined goals of care for residents, prior to ED transfer. Through these consultations, decisions can be made about whether the resident requires ED transfer or whether there are alternative pathways to care. A 2023 study of this service demonstrated a 29 per cent decline in the rate of ED presentations when telephone consultations were augmented by visual telehealth.⁷

Virtual Emergency Departments

Virtual Emergency Departments (VEDs) provide secondary triage through comprehensive digitally enabled assessment, helping to prevent the transfer of lower-acuity residential aged care residents to ED when their healthcare needs can be safely managed within their home environment.⁸ This service supports residential aged care staff to provide an appropriate level of care onsite, reducing unwarranted stress on the older person and disruptions to their usual care.^{9,10} Expansion of VED services, backed by investments in research (including the evaluation of patient and safety outcomes), infrastructure and training for residential aged care staff, could support the care of older people within the residential setting.

6 ACT Government Canberra Health Service. *Geriatric Rapid Acute Care Evaluation (GRACE) Service*.

7 Sunner C, Giles M, Barker R, Hullick C, Oldmeadow C, Foureur M. Implementation and evaluation of a nurse-led intervention to augment an existing residential aged care facility outreach service with a visual telehealth consultation: stepped-wedge cluster randomised controlled trial. *BMC Health Services Research*. 2023;23:1429

8 Villani M, Nehme E, Zimmerman D, McManamny T, Krajcar N, et al. Embedding a virtual emergency department pathway within emergency medical services secondary triage for people living in residential aged care. *Prehospital Emergency Care*. Dec 2025

9 Sri-Ganeshan M, Mitra B, Soldatos G, Rosler R et al. Impact of the Southeast Melbourne Virtual Emergency Department on reducing transfers from residential aged care facilities. *Emergency Medicine Australasia*. 2024;36:979-982

10 Dwyer R, Stoelwinder J, Gabbe B, Lowthian J. Unplanned transfer to emergency departments for frail elderly residents of aged care facilities: a review of patient and organisational factors. *J Am Med Dir Assoc*. 2015;16(7):551-62

2. Triage category, arrivals by ambulance and hospital admissions

‘Over the past 30+ years of my emergency career, older people are living longer, and those presenting to ED are living with higher levels of frailty (physical and cognitive), medical and social complexity.’ Emergency physician

2.1 Triage Category

In addition to the rapid increase in the number of people presenting to EDs since 2018-19, people are presenting as sicker and requiring emergency care more urgently. Everyone presenting to an ED is triaged using the Australasian Triage Scale (ATS). This scale is used to rapidly determine clinical urgency and assist staff to identify and prioritise those who are critically ill or injured.¹¹ In 2023-24, almost 60 per cent of people presenting to EDs across Australia were classified in higher urgency triage categories (ATS 1-3). This represents an increase of close to one million (868,818) high-urgency presentations compared to 2018-19. Older age is a marker of higher acuity, with nearly seven in 10 older people presenting to an ED being classified in the higher urgency triage categories ATS 1-3. This is compared to just over five in 10 younger people being classified in the higher urgency categories.

Age group	Triage category 1-3	% of total presentations
All age groups	5,246,392	58.8%
Older people	1,511,903	68.8%
Younger people	3,734,489	55.5%

Table 2: Number and percentage of people triaged in ATS 1-3 in 2023-24.

2.2 Arrivals by ambulance

This higher urgency is also demonstrated through ambulance arrivals. Older people were significantly more likely to arrive at hospital by ambulance than younger people, with half of the former arriving by ambulance compared to fewer than a quarter of the latter. This contributes to rising demand on ambulance services, extending ambulance ramping and growing delays in response times for subsequent ambulance callouts while crews wait at the ED.¹²

Age group	Number arrived by ambulance	% of total presentations
All age groups	2,366,122	26.5%
Older people	1,114,325	50.7%
Younger people	1,251,797	18.6%

Table 3: Number and percentage of people who arrived to an ED by ambulance in 2023-24.

¹¹ Australasian College for Emergency Medicine. *Guidelines on the implementation of the Australasian Triage Scale in emergency departments (G24)*. Nov 2023.

¹² Australian Medical Association. *Ambulance ramping report card*. 2025

2.3 Hospital admissions

This higher acuity also translates into older people being more likely to be admitted into an inpatient bed or critical care unit. In 2023-24, one in every two presentations to the ED among older people resulted in a hospital admission, compared to fewer than one in four presentations among younger people. Many of these people face extended stays in the ED due to delays in accessing an available inpatient bed (see section 3 for more information on ED length of stay (LoS)).

Age group	Number admitted to hospital	% of total presentations
All age groups	2,673,331	30.0%
Older people	1,117,810	50.9%
Younger people	1,555,521	23.1%

Table 4: Number and percentage of people who were admitted into hospital from an ED in 2023-24.

The data above demonstrates the enormous strain on EDs, with patients presenting as sicker and with increasingly complex health conditions. Hospital funding and workforce capacity have not kept pace with rising demand and, as the Australian population continues to age, the strain on EDs, clinicians and health systems will increase.

An increasing number of people presenting to EDs, particularly older people, require admission into an inpatient bed. However, hospitals increasingly lack sufficient inpatient beds to accommodate the number of patients requiring admission (see section 3.1 for more information on inpatient bed numbers). This causes blockages in the ED and long waits for patients and is known as access block.

3. Access block

Access block occurs when ED patients requiring admission into an inpatient bed are unable to be transferred due to no bed being available, so they remain in the ED for longer than eight hours.

Access block is not only an ED problem – it is a whole-of-health system issue.¹³ If patients requiring admission cannot move through the ED into an inpatient bed, new patients cannot be brought into the ED. This leads to overcrowded waiting rooms and increased waits for ambulance crews on hospital ramps.¹⁴

'[Due to] ramping delays, definitive triage and time-critical treatment, older patients can deteriorate quickly and quietly (sepsis, hypoxia, pain, delirium) while waiting in an environment not customised to the needs of an older person.' Emergency physician

Access block is the single most pressing patient safety issue facing EDs across Australia and is associated with an increased risk of poor patient outcomes. Research has shown that patients attending an ED affected by access block, have an increased risk of death within seven days of presentation.¹⁵

Access block is also one of the leading contributors to increased levels of violence experienced in EDs across Australia. ACEM revealed the unacceptable levels of violence and aggression faced every day by Australia's emergency medicine workforce in its 2025 report *Breaking Point: An Urgent Call to Action on Emergency Department Safety*.¹⁶ As access block leads to longer wait times, people can become more frustrated and anxious about their health or that of a companion. This can lead to verbal and physical violence directed at healthcare staff. ED violence is becoming increasingly common and has far-reaching consequences. Violent incidents affect other patients in the ED, take their toll on ED staff morale, contribute to burnout, and are a significant factor in experienced healthcare professionals choosing to leave the workforce.¹⁷

Long wait times can also result in people leaving the ED before their treatment has commenced (or been completed). In 2023-24, nearly one in 20 older people left the ED before their treatment had been completed, putting them at risk of deteriorating conditions and missed diagnoses. This impact is even more pronounced for Aboriginal and Torres Strait Islander people. More than one in 10 Aboriginal and Torres Strait Islander older people – more than 18,000 individuals in 2023-24 – leaving the ED before the commencement or completion of their treatment.

3.1 Inpatient bed capacity has not kept pace

A major factor causing access block is that the number of inpatient beds has not kept pace with population growth and changing demographics. This is largely due to the lack of action taken to prepare for the increasing volume, acuity and complexity of acute care needs associated with an ageing population. Inpatient bed capacity has remained static at 2.5 beds per 1000 population since 2018-19.

Older people are admitted to hospital more often and stay for longer than younger people.¹⁸ In 2023–24, older Australians made up just under 17 per cent of the population yet represented 50 per cent of occupied inpatient bed days in public hospitals.¹⁹ As Australia's population continues to age, governments at all levels need to increase investment in hospital resourcing and inpatient capacity for hospital systems to remain sustainable over the long term.

13 Sax Institute. *Access block: a review of potential solutions*. Sept 2022

14 Yon HJ, Boyle J, Diouf I, Bosley E, Staib A et al. The association between access block and ambulance ramping, and the impact of COVID 19: A retrospective observational cohort study of 25 Queensland hospitals. *The Medical Journal of Australia*. 2026;224:e70141

15 Jones PG, van der Werf B. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. *Emerg Med Australas*. 2021 Aug;33(4):6550664

16 Australasian College for Emergency Medicine. *Breaking Point: An Urgent Call to Action on Emergency Department Safety*. 2025.

17 Australasian College for Emergency Medicine. *2025 Sustainable Workforce Survey*. 2025

18 Australian Medical Association. *National public hospital performance*. 2024.

19 Australian Medical Association. *Public Hospital Report Card*. 2026.

3.2 Emergency department length of stay

As outlined above, the increasing volume, acuity and complexity of ED presentations is placing increased pressure on hospitals, leading to people in EDs waiting for extended periods of time. Older people are staying longer in EDs than younger people, whether they are being admitted into an inpatient bed or being discharged from the ED.

EDs are designed to provide a high patient throughput, with rapid assessment and treatment during initial diagnosis and emergency medicine care. They are not appropriate environments for longer term care. They are noisy, busy and active environments that can be overwhelming. For an older person with frailty and/or complex needs, this unfamiliar and overstimulating environment can heighten confusion, distress or anxiety, particularly for those living with dementia or delirium. Current ED environments are not tailored to their needs.

Older patients can deteriorate quickly when waiting in an environment that is not customised to their care. Research has shown that longer ED length of stay (LoS) is associated with worse outcomes, especially for patients waiting for admission into hospital.²⁰ Delays of longer than five hours to inpatient admission are associated with longer hospital LoS and an increase in all-cause 30-day mortality.²¹ While the mortality risk of long ED waits is now well established, further research is needed to understand exactly how these delays affect older patients, so that health systems can act to prevent avoidable harm.

Hospital Access Targets

ACEM has developed Hospital Access Targets (HAT) to recognise different patient journeys, with distinct time-based targets for admitted, discharged and Short Stay Unit patients. These targets assist in collating specific data to clarify where bottlenecks are and highlights the patients who are more likely to experience access block.²² HAT have been adopted by a number of jurisdictions in Australia. Consistent national adoption, led by the Federal Government, would allow performance to be benchmarked across jurisdictions and identify where and why patients experience the greatest delays.

Emergency department length of stay for discharged patients

ACEM's HAT recommend that at least 95 per cent of patients who are discharged from an ED depart within eight hours. Patients who can be discharged from the ED are generally those with lower-acuity conditions, whose health can be safely managed outside of hospital in the community.

The percentage of discharged patients seen within the eight-hour target has declined significantly since 2018-19. In 2023-24, 87 per cent of older people were discharged within this target, compared to 95 per cent in 2018-19.

Patients discharged from the ED with a length of stay less than 8 hours

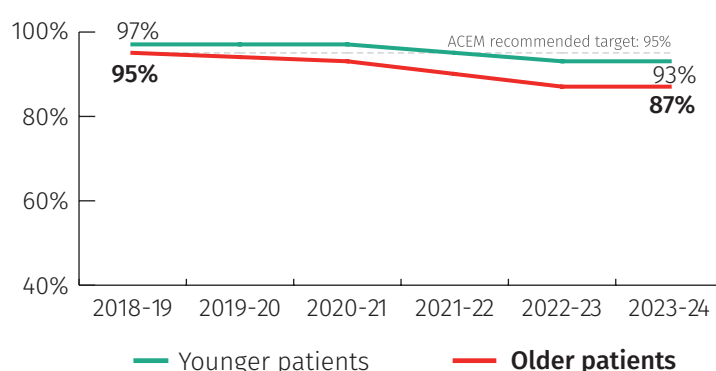


Figure 1: Percentage of discharged patients with an ED length of stay of less than eight hours.

Note: Dotted line shows ACEM's recommended target for hospital discharge – at least 95 per cent of patients to be discharged from the ED should spend less than eight hours in the ED.

20 Hunt V. Older adults are spending too long in ED – Here's why and what could help. *JAMA Network*. July 18, 2025;334(7):560-561

21 Jones S, Moulton C, Swift S, Molyneux P, Black S, et al. Association between delays to patient admission from the emergency department and all-cause 30-day mortality. *Emerg Med J*. 2022;39:168-173

22 Australasian College for Emergency Medicine. *Solutions to Access Block*.

EDs have implemented models of care to reduce the length of time spent in ED for these patients, including Short Stay Units and Fast Track, and will continue to commit resources into these models. However, ED LoS has continued to rise despite these initiatives and other programs designed to reduce demand and prevent presentations (see section 2 of this report). ED clinicians will continue to do what they can within the ED environment, however many of the solutions lie elsewhere in the hospital. These initiatives largely target patients who are discharged from the ED, yet it is the admitted stream (patients waiting for an inpatient bed) that is driving access block and has the greatest impact on ED LoS for all patients.

Emergency department length of stay for admitted patients

Patients waiting to be discharged from an ED are experiencing increasingly long delays. However, for patients awaiting admission into an inpatient bed, waits can be even more prolonged. The main cause of extended ED LoS for patients waiting for an inpatient bed is access block.

Older people awaiting an inpatient bed are disproportionately affected by prolonged ED LoS. This can have negative impacts on their physical and psychological health. Due to the limited space and staffing available in EDs, patients must often wait in corridors, chairs or other ED areas not designed for ongoing medical care.

For ED patients admitted to a hospital inpatient bed, ACEM's HAT recommends that at least 90 per cent should leave the ED within eight hours. Hospitals are finding it increasingly difficult to meet this target across all age groups, however this trend has been more pronounced for older people. In 2023-24, hospitals met this HAT target for only half (54 per cent) of older people, well below the 71 per cent achieved for younger people. This growing gap reflects the fact that older people, who are more likely to require admission and have higher acuity needs, are bearing the greatest burden of access block.

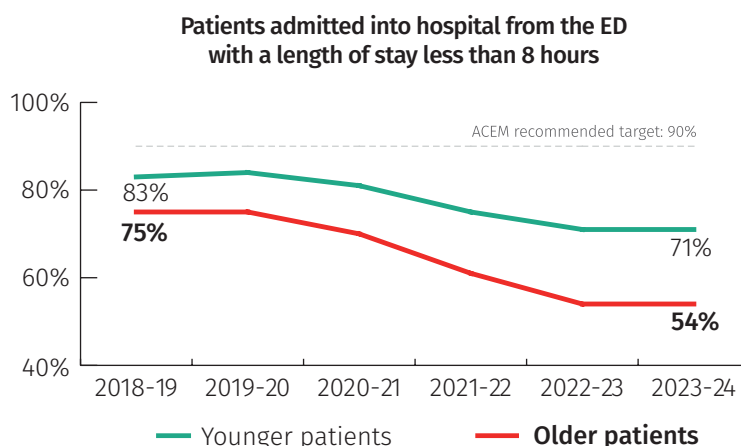


Figure 2: Percentage of admitted patients with an ED length of stay of less than eight hours.

Note: The dotted line shows ACEM's recommended target for hospital admissions - at least 90 per cent of patients needing admission into an inpatient bed should spend less than eight hours in the ED.

Emergency department length of stay longer than 24 hours

Growing numbers of patients are waiting in ED for longer than 24 hours for admission into a hospital inpatient bed. ACEM strongly believes that 24-hour stays in ED should be a 'never event', which is defined as a patient safety incident so serious and preventable that it should never occur, and regards this as a failure of the system.²³ Despite this, ED LoS in excess of 24 hours are becoming more commonplace across Australia. In 2023-24, older people were significantly more likely than younger people to experience an ED LoS greater than 24 hours, especially those requiring hospital admission. Almost one in 20 older people waited more than 24 hours in the ED before being admitted to an inpatient bed, compared with one in 50 younger people. This equates to nearly 40,000 more older people experiencing these prolonged waits than in 2018-19.

Excessive ED LoS is more prevalent among older people waiting to be admitted to an inpatient bed in regional (10.5 per cent) and rural (5.2 per cent) EDs than patients in metropolitan (3.9 per cent) or remote (1.8 per cent) EDs. That means more than one in 10 older people in regional EDs waited longer than 24 hours for an inpatient bed in 2023-24.

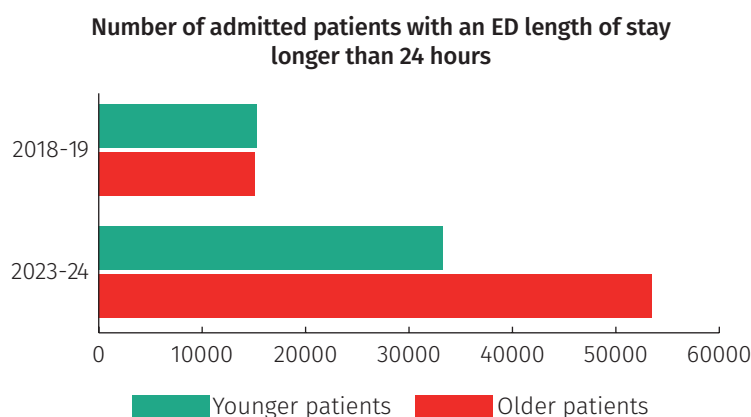


Figure 3: Number of admitted patients with an ED length of stay of longer than 24 hours.

3.3 Extended ED lengths of stay result in avoidable patient harm

Spending more than eight hours waiting in the ED is becoming more common across Australia as increased presentations, insufficient inpatient beds and the healthcare needs of an ageing population have an effect. The result is avoidable patient harm. In 2023-24, almost half of all older people who were waiting for an inpatient bed spent more than eight hours in the ED, while almost 5 per cent waited longer than 24 hours.

Extended periods of time spent in the ED can have both physical and psychological impacts on older people and can lead to longer inpatient stays and premature admission into residential aged care. These impacts include an increased risk of delirium due to sleep disruption, immobility and a change of environment, as well as psychological distress attributed to the busy, noisy surroundings.

Prolonged ED stays can also result in delays in receiving time-critical treatment, potentially worsening existing health issues and causing new complications. Older people are more likely to experience a hospital-acquired condition (HAC), leading to longer hospital stays. In 2023-24, the average length of stay for people with at least one HAC was 18 days, compared to 4.1 days for those without a HAC.²⁴ Lack of mobility while in the ED can also put older people at higher risk of falls and pressure injuries.

'The complications I see most after extended stays in ED are delirium, falls, pressure injuries, hospital-acquired infections, and rapid functional decline from immobility and lack of sleep. These harms are often compounded by prolonged fasting, enforced immobility, not getting enough fluids or food, and missing out on usual medications.' Emergency physician

²³ Bowman CL, De Gorter R, Zaslow J, Fortier JH, Garger G. Identifying a list of healthcare 'never event' to effect system change: a systematic review and narrative synthesis. *BMJ Open Quality*. 2023 Jun 22;12(2):e002264

²⁴ Australian Institute of Health and Welfare. *Hospital-acquired complications*. 2026.

3.4 Strategies to reduce ED length of stay

Hospitals, along with State and Territory Governments, have implemented both hospital-based and outreach models to help reduce ED LoS, ED presentations and hospital admissions, and improve patient outcomes. This includes residential aged care in-reach services, rapid-assessment models and geriatric-informed ED models of care, including clinically appropriate use of ED Short Stay Units for modified comprehensive geriatric assessment and optimised transitions of care.

ED design informed by universal design principles ensures that acute care environments are tailored to the needs of a diverse range of patients, including older people living with frailty. The ACEM policy *P963 Emergency Department Design Principles: Developing Functional, Safe and Therapeutic EDs* has more information on universal design within EDs.²⁵

These programs often rely on unstable funding arrangements or are run as short-term pilots with no ongoing funding, undermining their ability to deliver consistent, long-term benefit. Governments should provide sustained funding to expand these models of care, alongside investment in research to strengthen the evidence base for scaling them further.

‘Short-term or piecemeal funding creates stop-start services that struggle to recruit/retain skilled clinicians, build relationships with residential aged care/community providers, and generate the data needed to refine and scale what works. When programs shrink or end, demand rebounds to ED and inpatient wards, worsening access block, ambulance ramping and avoidable patient harm.’ Emergency physician

The following case studies demonstrate how integrated, multidisciplinary models of care can improve safety, quality and patient-centred outcomes for older people while reducing ED LoS and hospital admissions.

Geriatric Emergency Medicine Unit

Logan Hospital has established a purpose-built Geriatric Emergency Medicine Unit (GEMU) within the ED. This approach recognises that older patients often experience longer ED stays, higher admission rates and avoidable harm from prolonged exposure to a busy ED environment. The unit focuses on both the clinical and non-clinical needs of people over 70 and provides streamlined assessment, early intervention and discharge planning tailored to older patients. Early performance indicators have demonstrated a reduction in prolonged ED stays and in 72-hour re-presentation for patients aged 70 and over.

Whole-of-hospital responses

The Royal Melbourne Hospital is taking a multi-pronged approach to improving care provided to older people in the ED and across the hospital, reducing ED presentations, inpatient admissions and the rate of readmission after discharge. This includes programs within the ED itself, such as the Emergency Department Geriatricians and Care Coordinator programs, both aimed at reducing admissions for older people presenting to the ED. It also includes the Trauma in Older Persons Service (TOPS), which improves care for older people injured by trauma, including falls. The hospital also supports outreach programs, including the Older Persons Club, which provides rapid access to at-home care as an ED alternative and Residential Aged Care In-reach, which provides care within residential aged care and supports staff and residents while reducing preventable ambulance transfers and ED presentations.

²⁵ Australasian College for Emergency Medicine. *Emergency Department Design Principles: Developing Functional, Safe and Therapeutic EDs*. 2025.

4. Exit block

A driver of access block and expanding ED LoS is the growing number of inpatient beds occupied by 'long stay' older patients. These patients are medically cleared to be discharged but cannot leave hospital because a residential aged care placement or suitable in-home care is not available for them.

This is known as exit block (also referred to as bed block). It is a symptom of a healthcare system that is struggling to meet community demand for health and social services.²⁶ Exit block is a system-wide transition challenge sitting at the interface between health, aged care, and community support.

'Our healthcare system often shows age bias, especially when it places blame on older people for issues like ED overcrowding and access block. Instead, this reflects systemic failures in planning ahead for the needs of our ageing population.' Emergency physician

Lack of accessible data makes it impossible to quantify the true extent of both access and exit block and their harmful impacts. All levels of government should coordinate the collection of age-disaggregated data on exit block and its associated harms, to develop and implement effective, targeted solutions at a national level.

According to the National Aged Care Blockage Report Card presented to the Minister for Health and Ageing, the Hon Mark Butler, MP, by state and territory ministers at the Health Ministers' Meeting on 12 December 2025, 3049 older Australians were stuck in public inpatient beds awaiting a residential aged care placement at that time. More recent reports indicate that this number had increased to 3274 in February–April 2026. Targeted programs to address exit block could save Australian governments a conservatively estimated \$1 billion per year.²⁷

Many of the older people currently stranded in inpatient beds awaiting placement in residential aged care are living with complex conditions, dementia or behavioural symptoms. Limited residential aged care capacity, an increasingly regulated aged care environment in response to the findings of the Royal Commission into Aged Care Quality and Safety, and workforce challenges have all constrained the aged care sector's ability to accept residents with complex needs, particularly those living with frailty, dementia or behavioural symptoms. As a result, public hospitals are increasingly functioning as aged care providers of last resort, a role they are neither designed nor funded to perform. Governments have not adequately invested in aged care capacity or the workforce needed to meet the needs of this growing and increasingly complex cohort.

Aboriginal and Torres Strait Islander Elders and Older People must be also placed at the centre of decision making that affects their aged care journey. Too often this is not happening, with extended hospital waits for placement leaving them failed by a system that adequate investment could fix. Co-designing the planning and delivery of aged care pathways with Aboriginal and Torres Strait Islander Organisations and local communities is what will change this, by ensuring those pathways are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander Elders and Older People.²⁸

Exit block has a direct effect on EDs. It reduces bed turnover in inpatient wards, leaving fewer beds available for new admissions. This is a significant and growing contributor of ED access block, as patients who require hospital admission cannot leave the ED as there is no inpatient bed available. This leads to excessive waits within EDs, patients being treated or waiting in corridors, overcrowded ED waiting rooms and ambulance ramping.

The reduced number of hospital inpatient beds available for new patients due to exit block also increases competition for the limited number of unoccupied hospital beds. This can cause the cancellation of elective surgeries and other planned care due to inpatient and ICU beds being filled by more urgent cases.

Left unaddressed, exit block will continue to erode the capacity of hospitals to respond, not only to everyday demand, but to periods of surge such as winter flu or a mass casualty event. Solving it requires investment, not only in aged care and community support, but in the workforce that delivers care across every part of this system.

²⁶ Australian Medical Association. *Hospital exit block*. 2023.

²⁷ State and Territory Ministers of Health. *National aged care blockage report card*. Dec 2025.

²⁸ National Aboriginal and Torres Strait Islander Ageing and Aged Care Council. *Aboriginal and Torres Strait Islander Consultation A Non-Negotiable In Hospital Bed Block Solution*. 2026

5. The ED workforce

Increasing demand, combined with the growing complexity and urgency of care needs and increasingly prolonged ED LoS, places significant strain on the ability of ED staff to provide safe, timely care. Managing acutely unwell older people in the ED for extended periods increases the risk of avoidable patient harm, which can lead to associated moral injury to ED staff, negatively impact staff retention and contribute to burnout.

‘The daily witness of this avoidable injury also causes moral injury and burnout in staff – this is not the care any of us want to see older persons (those who once cared for us) receive.’ Emergency physician

Effective assessment and management of older patients in the ED relies on the skills and knowledge of a multidisciplinary team led by an emergency medicine specialist, ideally a Fellow of the Australasian College for Emergency Medicine (FACEM). EDs must be appropriately staffed to reflect the increasing complexity and specific functional and psychological needs of older patients, which are often complicated by comorbidities.

Many EDs face workforce challenges, especially at the senior decision-maker level. Although the number of emergency medicine specialists has increased over time, in 2025, 35 per cent of ACEM-accredited EDs across Australia had unfilled emergency specialist positions. Further to this, 27 per cent of these EDs had vacancies for longer than six months.²⁹ When EDs are short-staffed, vacant positions are often filled by locums or temporary staff, greatly increasing hospital costs and affecting the continuity of high-quality patient care.

The ACEM guideline *Constructing a sustainable emergency department medical workforce* outlines the considerations health services must make when planning for appropriate, effective, sustainable and comprehensive ED medical staffing.¹ Recent ACEM Annual Site Census findings indicate that fewer than one in five ACEM-accredited EDs meet the minimum emergency medicine specialist staffing level recommended in this guideline.²⁹

Without adequate staffing, ED clinicians struggle to provide the level of care required for increasing numbers of patients with high-acuity, complex health conditions. Staff shortages in the ED can result in bed closures, further limiting the number of available ED treatment spaces.

However, simply increasing staffing numbers without also addressing the skills mix will not solve the problem of understaffing. EDs are most effective when care is led by emergency medicine specialists working within a multidisciplinary team. ACEM cautions against the growing narrative that non-medical practitioners can simply replace medical practitioners to alleviate the ED staffing crisis. Without structured supervision and teaching by senior clinicians experienced in emergency medicine training, non-medical practitioners may lack the skills and knowledge needed for the complexity and acuity of ED patients, putting patient safety at risk.

As Australia’s population ages, the demand for specialist emergency care will only grow, and the workforce required to meet it must grow with it. A sustainable ED workforce, appropriately staffed and skills-mixed, and culturally safe, is not a matter of convenience but a precondition for the health system to safely meet the needs of older Australians in the decades ahead.

²⁹ Australasian College for Emergency Medicine. *Annual Site Census 2023-24*.

Emergency Medicine Education and Training

In the many EDs that cannot access a FACEM, particularly in regional, rural and remote (RRR) Australia, structured training and supervision for the existing workforce is essential to safe patient care. ACEM's Emergency Medicine Education and Training (EMET program) provides education, training and supervision to doctors and other health professionals working in EDs and emergency care services who are not specifically trained in emergency medicine. There are more than 600 hospitals with EDs or emergency services in Australia, however only about one-third are staffed by FACEMs.³⁰ Hospitals without FACEMs are typically located in RRR locations with clinical staffing models that include general practitioners, rural generalists, medical officers, nurses, paramedics and allied health workers. Lead hospitals (Hubs) work closely with smaller RRR EDs and emergency services to identify local needs and deliver mostly onsite training. EMET is funded by the Australian Government's Department of Health, Disability and Ageing Specialist Training Program and continued investment in this program is essential to maintaining safe emergency care in areas without specialist coverage.

30 Australasian College for Emergency Medicine. *ACEM Membership and Trainee Demographics and Workforce 2025*. 2025

6. Early intervention to reduce ED demand

An old adage holds that ‘prevention is better than cure’. Reducing demand for ED services through preventive healthcare and timely access to high-quality primary care will reduce pressure on hospitals and allow EDs to focus on their main task of providing emergency care and stabilisation of acutely unwell people.

Australia currently spends approximately 3 per cent of its healthcare budget on preventive health.³¹ Through the National Preventive Health Strategy 2021-2030, Australia has committed to increase this to 5 per cent by 2030.³² However, this still lags behind other OECD countries, including Canada at 7 per cent and the United Kingdom at 6 per cent. Investments in preventive healthcare, as well as in primary health and the provision of aged care services within the community, will greatly reduce demand for hospital services and admissions into residential aged care.

‘Prolonged waiting times for homecare packages and lack of timely access to holistic primary care both equally contribute to ED presentation and hospital admission. Prolonged hospital stays [exit block] and therefore access block, are contributed to by lack of timely, responsive access to home care packages and lack of access to aged care beds, particularly for those who have complex needs.’ Emergency physician

Older people need more support to remain healthy in the community, reducing ED presentations, hospitalisation and lowering healthcare costs. Necessary supports at home often do not arrive early enough or are not well coordinated, leading to hospitalisations that could have been prevented with earlier health intervention or disease management. In 2023-24, 6 per cent (almost 800,000) of all hospitalisations were classified as potentially preventable, equating to a cost of \$7.7 billion.³³

‘Delays to accessing approved aged care packages and aged care facility approvals and access mean that often the person’s care needs have increased in the interim, necessitating crisis admission to hospital due to lack of adequate support to continue living independently at home.’ Emergency physician

6.1 Home-based aged care support wait times

The number of older Australians accessing home care services has grown markedly. Between 2017 and 2024, the number of people using home care increased from 71,900 to 275,000, an increase of 283 per cent.³⁴ Consequently, wait times have soared for an assessment or an aged care package at an appropriate level, or to access care in a residential home. According to new data, between November 2025 and March 2026, Australians waited an average of 12 months to access a bed in residential aged care or for support at home.³⁵ In December 2025, there were an estimated 230,000 Australians on the waitlist for home care support, either for an assessment or an appropriate package. The Royal Commission into Aged Care Quality and Safety recommended that older people should receive timely, high quality support and care in accordance with assessed need and that older people are waiting too long for support.³⁶

Waiting long periods of time for home-based aged care support heightens the risk of health deterioration, ED presentations, hospitalisations, and premature entry into residential aged care, especially for people with complex healthcare needs.³⁷

6.2 Residential aged care investment

While progress has been made since the Royal Commission into Aged Care Quality and Safety, insufficient preparation by successive governments has led to an ongoing deficit in residential aged care capacity, especially for people living with complex conditions, dementia or behavioural symptoms.

31 Organisation for Economic Cooperation and Development. *Health at a glance* 2025.

32 Department of Health, Disability and Ageing. *National Preventive Health Strategy 2021-2030*. 2021.

33 Australian Institute of Health and Welfare. *Potentially preventable hospitalisations*. 2025.

34 Australian Institute of Health and Welfare GEN Aged Care Data. *People using aged care*. 2025.

35 Australian Government Department of Health, Disability and Ageing. *Aged Care Act 2024 – Wait times report*. 2026.

36 Australian Government. *Royal Commission into Aged Care Quality and Safety*. 2021

37 Australian Government Office of the Inspector-General of Aged Care. *Progress Report: Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety*. 2025.

Many providers remain underfunded and understaffed to supply the high level of care many older people require. Without onsite highly qualified staff, residents are often transferred to EDs with conditions that may be better managed in their place of residence. Managing these conditions onsite reduces preventable hospitalisation and further decline.³⁸ Increasing training to boost all aged care staff capacity to manage residents with higher care needs, in particular dementia, is required so residents can be provided with appropriate care in their home environment. All aged care staff must also be provided with cultural safety training to ensure that care meets the needs to Aboriginal and Torres Strait Islander Elders and Older People and is culturally safe.

Governments have started responding to this staffing gap. The requirement for a Registered Nurse (RN) on-site 24/7 from June 2023 was a step forward, though it is too early to tell if this is reducing ED transfers. More needs to be done at a faster pace to close the remaining gap.

In 2023-24, there were 218,000 people living in permanent residential care, an increase of 36,000 people since 2018-19.³⁹ The 2026-27 Federal Budget announced funding for additional residential aged care beds, but this falls well short of the need. The Federal Minister for Health and Ageing identified that an estimated 10,000-plus additional beds are needed each year for the next 20 years to meet demand.⁴⁰ However, in the last financial year only 802 additional aged care beds became available, which represented a 60 per cent reduction in new bed growth compared to the previous year.⁴¹ At this rate, aged care capacity will not catch up to meet demand but will actually fall further behind.

6.3 Navigating the complex aged care system

The aged care system is extremely challenging to navigate, especially given the recent changes with the new Aged Care Act 2024 (including the introduction of the Support at Home program).⁴² This is compounded for people with low income and those in hardship who may be discouraged to apply for a fee reduction supplement due to the complex and slow application process. As a result, many older people are not receiving the care they need, particularly those with cognitive decline, limited support networks, distrust of government or difficulty completing application requirements.

'The aged care system is also extremely challenging to navigate even for those of us with high health literacy, with the result that it is almost inaccessible for the most vulnerable older persons.' Emergency physician

The programs outlined below are designed to assist older people to navigate the aged care system. Funding for these services needs to be increased to ensure more older people can access the assistance they require to remain healthy and safe living in their own home or in residential aged care.

Aged Care Navigators, available through My Aged Care, provide one-on-one support to eligible older people with complex care needs who require intensive assistance to access and navigate the aged care system. Currently this service is only available to older people with complex needs. However, given the challenges in navigating the aged care system and the demand for assistance, the eligibility criteria for this program should be expanded.

Care managers assist people with Support at Home packages with the day-to-day coordination of their care. This is particularly important for people with complex care needs who require multiple or intensive supports. Care managers provide older people with a single point of contact and also link the person with essential services. Current funding for care managers within the aged care system has not kept pace with need and further investment is required.

38 Cain P, Alan J, Porock D. Emergency transfers from residential aged care: what we can learn from secondary qualitative analysis of Australian Royal Commission data. *BMJ Open*. 2022 Sep 20;12(9):e063790

39 Australian Institute of Health and Welfare GEN Aged Care Data. *Interface between the aged care and health systems*. 2026

40 Butler M. *National Press Club Address*. 22 April 2026.

41 Hicks T. *2024/25 residential aged care bed supply analysis*. Oct 2025

42 Australian Government Department of Health, Disability and Ageing. *New Aged Care Act*. 2024.

6.4 Investment in primary care

'There is no substitute for timely, regular access to a general practitioner who knows the person well. This is increasingly challenging to access, particularly for those living in residential aged care. It is critical that government adequately funds primary care to provide complex primary care to frail older persons.'
Emergency physician

Preventive primary care, including health assessments, chronic disease management, and care delivered by GP-led multidisciplinary teams, helps older people stay healthy at home or in residential aged care longer.⁴³ Recent primary care funding changes, which are aimed at increasing access over continuity of care, are having unintended consequences for people with complex conditions requiring longitudinal, responsive care.

New research has shown that older people who see a regular GP are up to 28 per cent less likely to go to an ED or be hospitalised, compared to those who frequently see new doctors.⁴⁴ Providing regular GP care within residential aged care facilities through home visits helps to maintain health and wellbeing in older people. Unfortunately, many people who move into residential aged care are required to change GPs, as their existing GP is unable to provide home visits within their aged care home.

The current General Practice in Aged Care Incentive (GPACI) program provides eligible GP practices with quarterly incentive payments for providing registered patients in residential aged care with care planning and regular visits. However, the current incentive payments are insufficient to cover smaller GP practices' expenses, and thus the program tends to favour larger practices.⁴⁵ Without reform to better support smaller practices, the benefits of the GPACI program will continue to be unevenly distributed, leaving many older Australians, particularly those in regional and rural areas served by smaller practices, without access to this care.

Advance care directives

Advance care directives (ACD) are legal documents that state a person's preferences for treatment and care if they are unable to express or do not have the capacity to determine their goals and wishes regarding their treatment and care. An ACD enables a person to appoint a substitute decision maker.⁴⁶ Identifying an ACD in the ED has reportedly been low due to incompatible IT systems and lack of staff education and training.⁴⁷ Digital platforms need to be available to allow for easy access to a person's ACD documents across health settings.

43 Inacio MC, Schwabe J, Crotty M, Williams H, Wesselingh SL et al. The impact of primary health care services, continuity of care and patterns of care on mortality and hospitalisations-related outcomes in residents of long-term care facilities: a comprehensive national evaluation. *Age and Ageing*. 2026 Feb 1;55(2):afag026

44 Caughey GE, Schwabe J, Pulling BW, Crotty M, Williams H, et al. Primary health care services and continuity of care are associated with better health outcomes in the older population. *Journal of American Geriatrics Society*. 2026;0:1-14

45 Australian Government Department of Health, Disability and Ageing. *Early insights from the General Practice in Aged Care Incentive*. 2025.

46 Australasian College for Emergency Medicine. *End of life and palliative care in the emergency department*. 2025.

47 Osman AD, Howell J, Yates P, Jones D, Braitling G. Examining emergency departments practice on advance care directives and medical treatment decision making using the Victorian Emergency Minimum Dataset. *Australasian Emergency Care*. Sept 2024;27(3):155-160

7. Recommendations

Recommendations for the Federal Government

- Jointly invest with State and Territory Governments in programs that strengthen integration between hospitals, aged care, community services, Aboriginal Community Controlled Health Organisations, and other support services, including transitional and step-down care, to support early discharge of older patients.
- Jointly invest with State and Territory Governments in additional emergency medicine telehealth support for residential aged care staff and community care services.
- Fund targeted, culturally safe alternative care pathways and outreach programs for older Aboriginal and Torres Strait Islander people, co-designed with Aboriginal Community Controlled Health Organisations, to address the disproportionate rise in ED presentations.
- Improve how My Health Record, My Aged Care and hospital IT systems connect so information can be shared easily between services.
- Implement digital platforms that allow visibility of advance care directives across healthcare settings.
- Increase Federal Government hospital funding to match State and Territory Government funding in a 50/50 cost-sharing arrangement.
- Commit to ongoing funding for the EMET program to better equip smaller rural and remote EDs to treat older patients locally, reducing inter-hospital transfers and delivering care closer to home.
- Require State and Territory Governments' to adopt and report on ACEM's Hospital Access Targets (HAT) to ensure uniform, visible data across jurisdictions.
- Rapidly expand and adequately resource the residential aged care sector to meet growing demand and complexity, delivering at least 10,000 additional beds per year by 2028.
- Increase funding to residential aged care providers to support the 24/7 registered nurse coverage mandated from July 2023.
- Improve targeted incentives to encourage residential aged care providers to admit residents living with complex conditions, dementia or behavioural symptoms and increase funding for additional Specialist Dementia Units.
- Improve the adequacy, responsiveness and clinical capacity of Support at Home and Commonwealth Home Support Program services to reduce preventable ED presentations and hospital admissions, including introducing maximum wait time standards for each Support at Home Priority System category.
- In collaboration with State and Territory Governments, deliver improved pathways and assistance to navigate and access primary, community and aged care services, including expanding the Aged Care Navigator program as recommended in the Royal Commission into Aged Care Quality and Safety.
- Fund sustainable primary care models, including adequate remuneration for GPs to provide longitudinal, responsive care for older people, especially those living with complex conditions.
- Redesign the General Practice in Aged Care Incentive (GPACI) program to provide for equitable increases in incentives for all GP practices to provide services within residential aged care.
- Meet the National Preventive Health Strategy's commitment to increase preventive health spending to 5 per cent of the health budget by 2030.
- Establish and fund a National Emergency Medicine Research Foundation to support dedicated, long-term research into emergency medicine and acute care for all patients, including older people.
- Allocate regular targeted funding rounds for emergency medicine research from the Medical Research Futures Fund including a call for research into models of care that improve outcomes for older people requiring acute care.
- Require State and Territory Governments to report age-disaggregated data on all key quality and performance indicators including LoS, access block and exit block.
- Develop and validate health outcome measures for older people that clearly show performance and equity in the delivery of quality care across the acute care system.
- Require the collection and public reporting of ED length of stay, access block and treatment completion data disaggregated by Aboriginal and Torres Strait Islander status, to monitor and address the disproportionate harm experienced by older First Nations people in EDs.

Recommendations for State and Territory Governments

- Provide hospitals with adequate funding to deliver and sustain in-reach medical and multidisciplinary services to older people in residential aged care and in the community.
- Provide funding for additional Hospital-in-the-Home places to provide alternatives to hospitalisation and support early discharge for older patients.
- Jointly invest with the Federal Government in additional Hospital to Aged Care Dementia Support Program places to support people with dementia in their transition from hospital back home with appropriate support or into residential aged care.
- Jointly invest with the Federal Government in additional Transition Care Program places and strengthen integration between hospitals, aged care, community services and other support services, particularly for people living with complex conditions, dementia or behavioural symptoms.
- Adequately fund an increase in inpatient bed capacity with demographics-informed planning.
- Adequately fund care coordination services, including culturally appropriate care, for older people with complex health conditions who are hospitalised to assist in discharge planning and linking to other health services.
- Fund hospital security, staff safety training and environmental design upgrades in EDs to reduce the risk of violence associated with overcrowding and extended wait times.
- Incentivise aged care providers to increase their capacity through State and Territory Government levers such as low-interest loans and planning assistance.
- Fund and facilitate a concerted public health campaign focusing on healthy ageing and preventive health.
- Invest greater resources into State and Territory Government health promotion services, including community-based programs that support healthy ageing.
- Implement age-disaggregated data collection for all key quality and performance indicators monitored by hospitals to support improved visibility and care outcomes for older people.
- Collaborate with the Federal Government in developing data systems that improve visibility of extended ED lengths of stay, access block and exit block, as well as the harms associated with these delays of care.
- Support clinicians to undertake research into models of care that aim to improve health outcomes of older people and reduce ED lengths of stay and hospitalisations.

Recommendations for hospitals

- Expand and adequately fund geriatric-focused outreach emergency and geriatric programs providing acute assessment and in-home care.
- Implement a whole-of-hospital approach to reduce ED length of stay for older people, with shared accountability for patient flow and inpatient bed access across the hospital.
- Increase funding allocation for ED medical staffing to comply with ACEM staffing guidelines outlined in *Constructing a sustainable emergency department medical workforce*.
- Expand and adequately resource geriatric-focused ED programs to optimise care for older people and avoid unnecessary hospital admissions.
- Implement violence prevention and staff safety measures in EDs, informed by the recommendations of ACEM's *Breaking Point: An Urgent Call to Action on Emergency Department Safety* report, to address the rising levels of violence linked to overcrowding and access block.

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9. Definitions

Access block: Access block refers to the situation where patients requiring admission to hospital from the ED have an ED length of stay greater than eight hours. This includes patients who were referred for admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital, or who died in the ED.⁴⁸

Admission: A hospital admission is determined by the need for interventions, investigations, monitoring or other management that would not be considered part of an ED attendance.⁴⁹

Ambulance ramping: Ambulance ramping/off-stretcher delay occurs when paramedics are unable to complete transfer of clinical care of their patients to the hospital ED within a clinically appropriate timeframe, specifically due to lack of an appropriate, staffed clinical space in the hospital or the ED.⁵⁰

Bed block: Bed block is a situation when patients are unable to move from one area of a healthcare organisation to another. This includes patients unable to be transferred from an ambulance to an ED bed (ambulance ramping), patients referred for admission who cannot be discharged from the ED due to lack of inpatient beds (access block), and patients who have been medically cleared for discharge from an inpatient bed but cannot be safely discharged (exit block).

Exit block: Exit block is defined as a situation when patients receiving hospital inpatient care are medically cleared to be discharged but cannot be safely discharged so are occupying an inpatient bed longer than clinically necessary. Common reasons for this include waiting for placement in residential aged care or funding for in-home care at an appropriate level or disability support.²⁶

Modified Monash Model (MMM): The Modified Monash Model (MMM) is used to categorise metropolitan, regional, rural, remote and very remote areas according to both geographical remoteness and town size. The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM1 to MM7, MM1 is a major city and MM7 is very remote.⁵¹

Older people: Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over (considering the health disparities and lower life expectancy experienced by this population).⁵²

Patient flow: Patient flow refers to patient movement through a healthcare organisation from arrival through to admission, if required, and discharge.

Short Stay Unit (SSU): An SSU is designed and designated for the short-term treatment, observation, assessment and reassessment of patients following triage and assessment in ED.⁵³

Triage: A triage system is a standard method of rapidly determining clinical urgency of all incoming patients to assist staff to identify and prioritise those who are critically ill or injured.¹¹

48 Australasian College for Emergency Medicine. *Policy on standard terminology* P02. 2025.

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52 Australian Institute of Health and Welfare. *Older Australians*. 2024.

53 Australasian College for Emergency Medicine. *Emergency Department Short Stay Units*. March 2024.

Australia



There was a total of **8,924,378 presentations** recorded in 293 public emergency departments (EDs) across Australia in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 16% compared with a 4% increase among younger people. Older people were significantly more likely than younger people to be classified in higher urgency categories (ATS 1-3), arrive by ambulance and be admitted into hospital.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	8,924,378	+6.9%
Older people	2,196,705	+16.3%
Younger people	6,727,673	+4.1%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	5,246,392	58.8%
Older people	1,511,903	68.8%
Younger people	3,734,489	55.5%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	2,366,122	26.5%
Older people	1,114,325	50.7%
Younger people	1,251,797	18.6%



Admitted to hospital

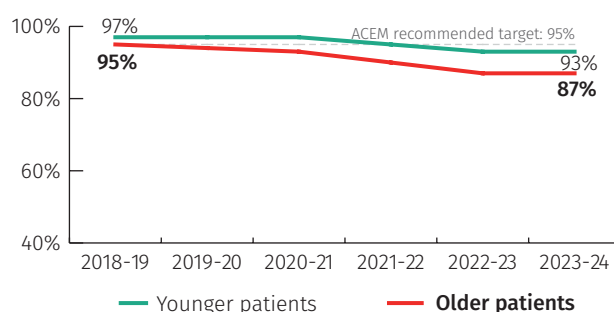
Age group	No. admitted to hospital	% of total presentations
All age groups	2,673,331	30.0%
Older people	1,117,810	50.9%
Younger people	1,555,521	23.1%



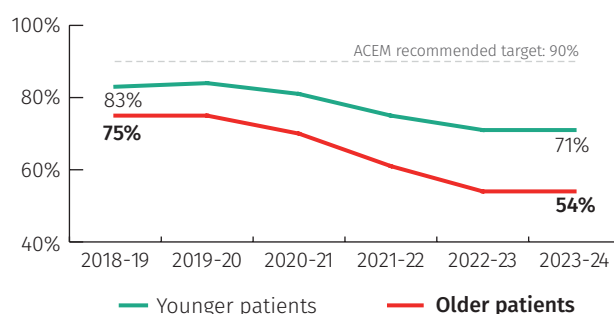
Inpatient public hospital beds

Years	No. of beds per 1000	No. of hospital beds
2018-19	2.53	63,119
2023-24	2.52	67,280

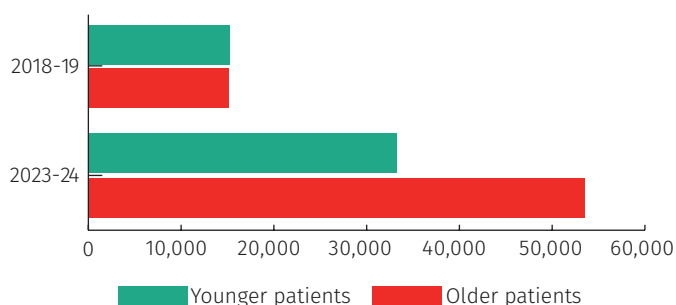
Patients discharged from the ED with a length of stay less than eight hours



Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





Australian Capital Territory

There was a total of **154,333 presentations** recorded across two public emergency departments (EDs) in the ACT in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 14%, compared with an increase among younger people of under 1%. Against the national trend, in 2023-24 ACT EDs showed an improvement in the number of admitted patients leaving the ED for a hospital bed within eight hours. For older patients this was an increase from 62% in 2018-19 to 76% in 2023-24.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	154,333	+3.4%
Older people	32,993	+14.4%
Younger people	121,340	+0.8%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	88,593	57.4%
Older people	22,904	69.4%
Younger people	65,689	54.1%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	35,094	22.8%
Older people	15,862	48.1%
Younger people	19,232	15.9%



Admitted to hospital

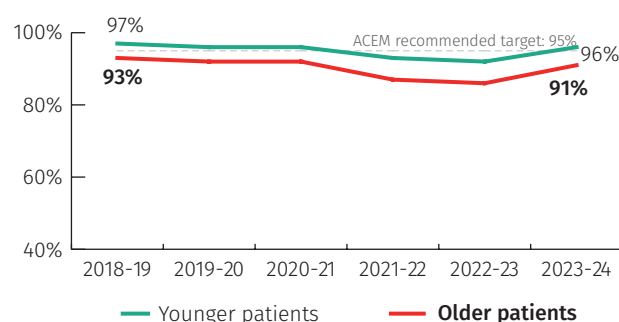
Age group	No. admitted to hospital	% of total presentations
All age groups	63,525	41.2%
Older people	22,183	67.3%
Younger people	41,342	34.1%



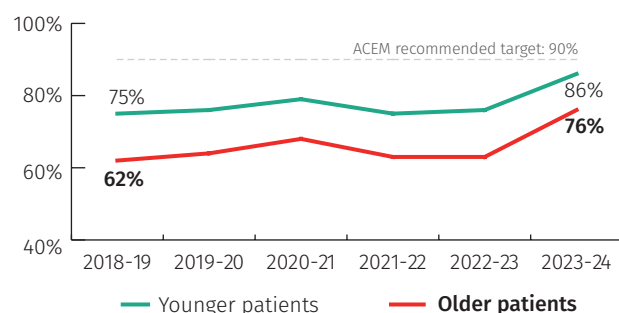
Inpatient public hospital beds

Years	No. of beds per 1000	No. of inpatient beds
2018-19	2.61	1110
2023-24	2.85	1345

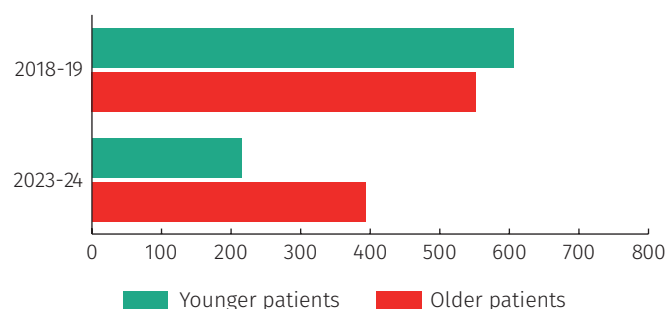
Patients discharged from the ED with a length of stay less than eight hours

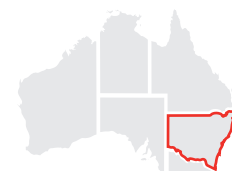


Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





New South Wales

There was a total of **3,124,629 presentations** recorded across 172 public emergency departments (EDs) in NSW in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 13% compared with a 2% increase among younger people. In 2023-24, more than 1400 older people were triaged into the most urgent triage categories every day, an increase of around 250 older patients each day from 2018-19.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	3,124,629	+5.0%
Older people	818,946	+13.4%
Younger people	2,305,683	+2.3%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	1,674,868	53.6%
Older people	523,888	64.0%
Younger people	1,150,980	50.0%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	742,790	23.8%
Older people	384,761	47.0%
Younger people	358,029	15.5%



Admitted to hospital

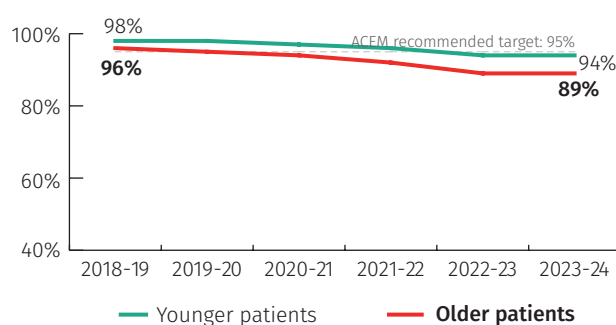
Age group	No. admitted to hospital	% of total presentations
All age groups	762,135	24.4%
Older people	361,472	44.1%
Younger people	400,663	17.4%



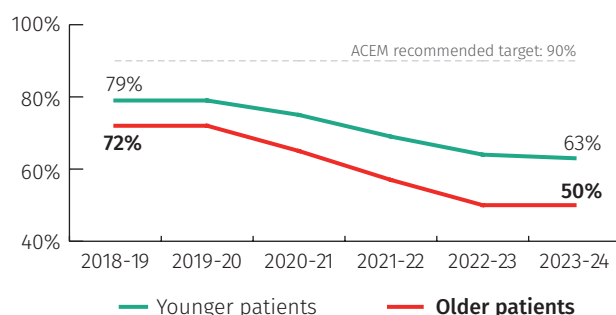
Inpatient public hospital beds

Years	No. of beds per 1000	No. of inpatient beds
2018-19	2.67	21,224
2023-24	2.54	21,238

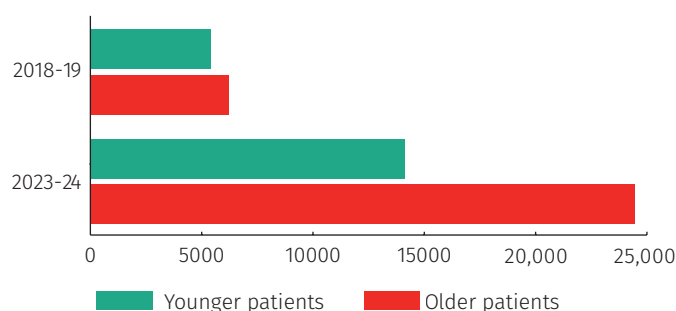
Patients discharged from the ED with a length of stay less than eight hours



Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





Northern Territory

There was a total of **184,165 presentations** recorded across six public emergency departments (EDs) in the Northern Territory in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 38% compared with a 6% increase among younger people. In 2023-24, 1175 older people presented to the ED per 1000 population, which means on average each older person presented to the ED more than once.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	184,165	+11.6%
Older people	41,183	+37.5%
Younger people	142,982	+5.9%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	88,113	47.8%
Older people	23,034	55.9%
Younger people	65,079	45.5%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	41,804	22.7%
Older people	15,298	37.2%
Younger people	26,506	18.5%



Admitted to hospital

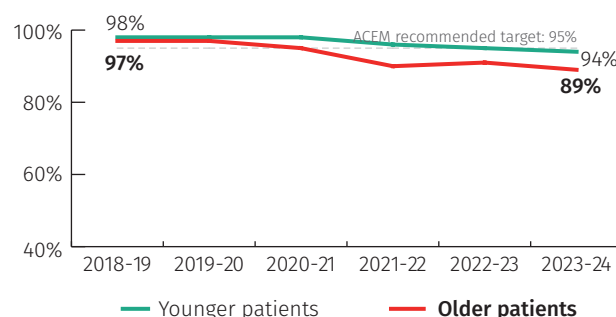
Age group	No. admitted to hospital	% of total presentations
All age groups	58,179	31.6%
Older people	19,857	48.3%
Younger people	38,322	26.8%



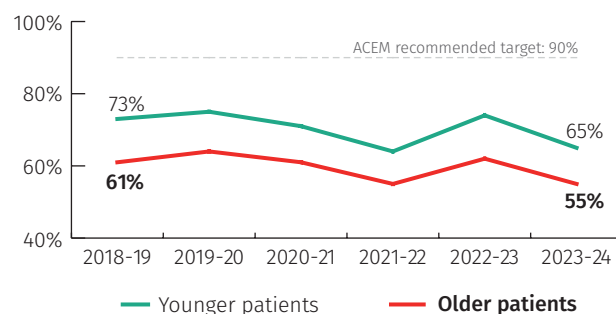
Inpatient public hospital beds

Years	No. of beds per 1000	No. of inpatient beds
2018-19	3.95	977
2023-24	4.1	1057

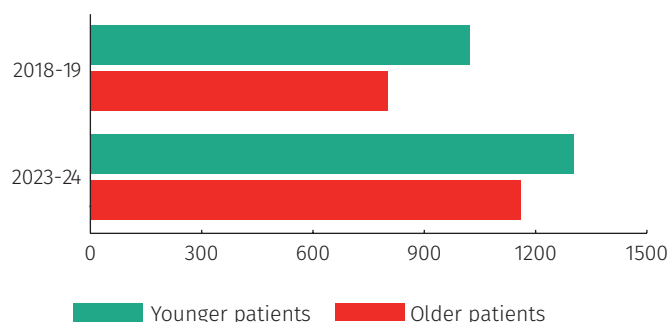
Patients discharged from the ED with a length of stay less than eight hours

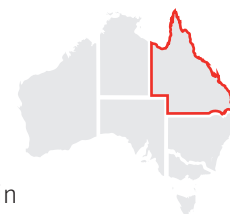


Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





Queensland

There was a total of **1,764,126 presentations** recorded across 26 public emergency departments (EDs) in Queensland in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 26% compared with a 10% increase among younger people. In 2023-24, 78.6% of older people were triaged into the more urgent triage categories, which is almost 900 patients per day.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	1,764,126	+13.0%
Older people	411,628	+26.0%
Younger people	1,352,498	+9.5%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	1,206,097	68.4%
Older people	323,727	78.6%
Younger people	882,370	65.2%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	635,718	36.0%
Older people	258,738	62.9%
Younger people	376,980	27.9%



Admitted to hospital

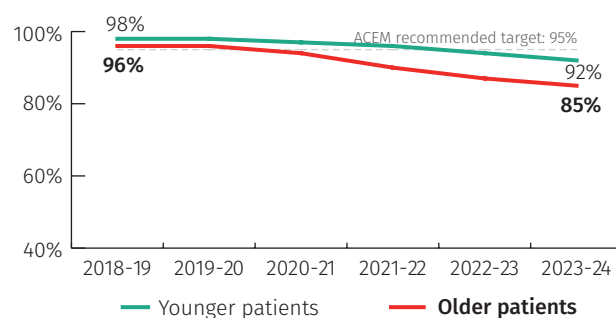
Age group	No. admitted to hospital	% of total presentations
All age groups	603,413	34.2%
Older people	234,513	57.0%
Younger people	368,900	27.3%



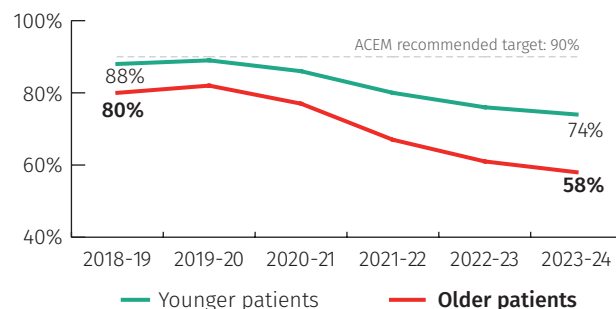
Inpatient public hospital beds

Years	No. of beds per 1000	No. of inpatient beds
2018-19	2.52	12,597
2023-24	2.57	14,021

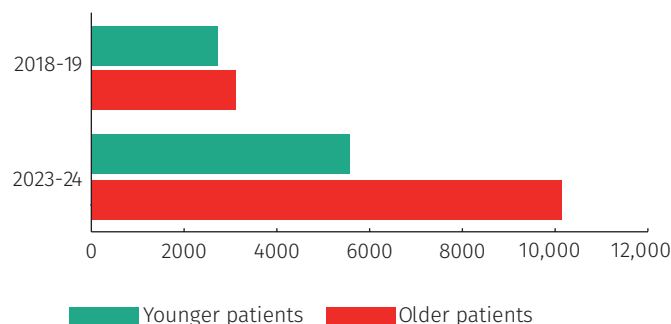
Patients discharged from the ED with a length of stay less than eight hours



Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





South Australia

There was a total of **590,593 presentations** recorded across 18 public emergency departments (EDs) in South Australia in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 20% compared with a 12% increase among younger people. In 2023-24, 75,911 older people were admitted to hospital from the ED, which equates to more than 200 every day.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	590,593	+13.7%
Older people	157,496	+19.7%
Younger people	433,097	+11.6%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	357,799	60.6%
Older people	112,201	71.2%
Younger people	245,598	56.7%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	170,628	28.9%
Older people	85,870	54.5%
Younger people	84,758	19.6%



Admitted to hospital

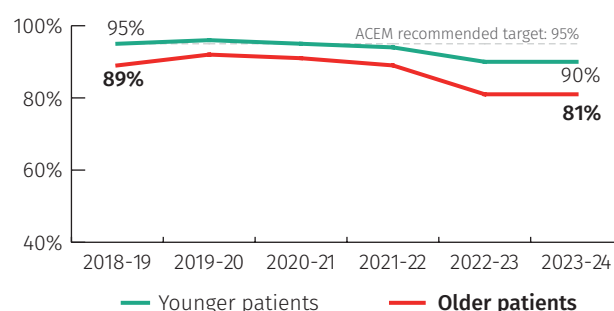
Age group	No. admitted to hospital	% of total presentations
All age groups	173,477	29.4%
Older people	75,911	48.2%
Younger people	97,566	22.5%



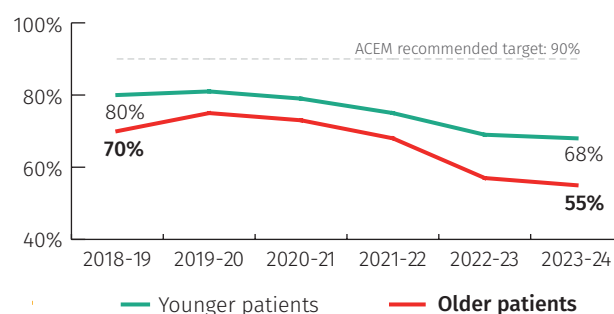
Inpatient public hospital beds

Years	No. of beds per 1000	No. of inpatient beds
2018-19	2.62	4581
2023-24	2.79	5180

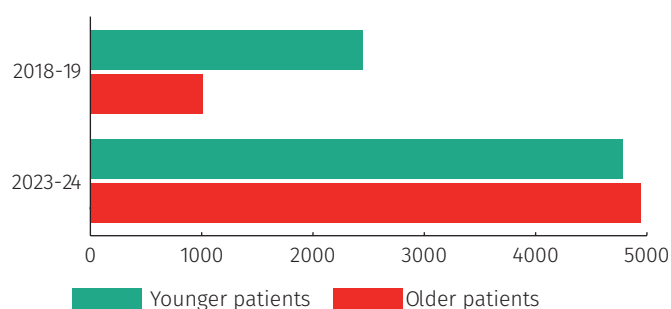
Patients discharged from the ED with a length of stay less than eight hours



Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





Tasmania

There was a total of **175,975 presentations** recorded across four public emergency departments (EDs) in Tasmania in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 19% compared with a 2% increase among younger people. For patients admitted to hospital from the ED, ACEM recommends that 90% of patients depart the ED within eight hours. In 2023-24, this target was met for only 40% of older patients, compared to 61% of younger patients.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	175,975	+6.0%
Older people	47,200	+19.1%
Younger people	128,775	+1.9%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	106,298	60.4%
Older people	33,737	71.5%
Younger people	72,561	56.3%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	52,872	30.0%
Older people	25,885	54.8%
Younger people	26,987	21.0%



Admitted to hospital

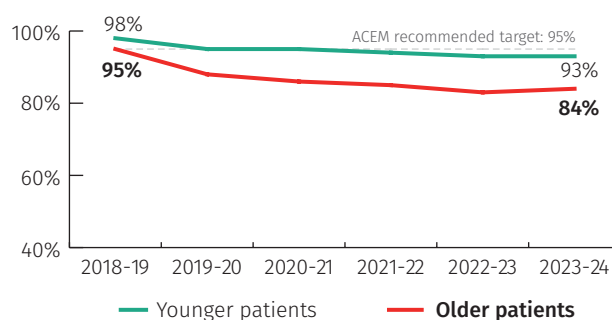
Age group	No. admitted to hospital	% of total presentations
All age groups	51,642	29.3%
Older people	24,468	51.8%
Younger people	27,174	21.1%



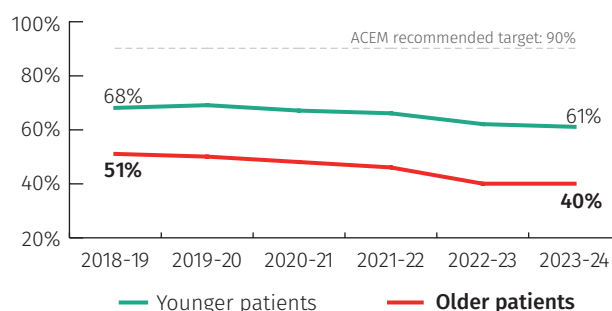
Inpatient public hospital beds

Years	No. of beds per 1000	No. of inpatient beds
2018-19	2.64	1416
2023-24	2.98	1712

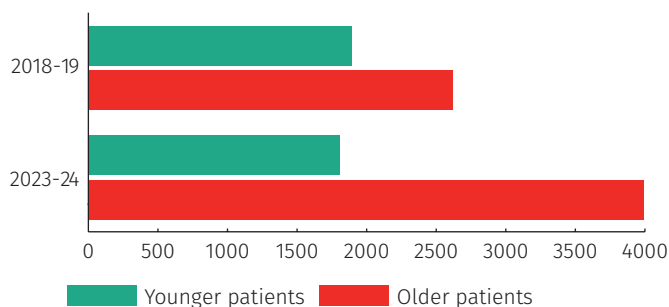
Patients discharged from the ED with a length of stay less than eight hours



Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





Victoria

There was a total of **1,911,722 presentations** recorded across 41 public emergency departments (EDs) in Victoria in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 11% compared with a less than 1% increase among younger people. In 2023-24, 274,181 older people were admitted to hospital from the ED, which equates to over 750 admissions every day.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	1,911,722	+2.8%
Older people	456,204	+10.9%
Younger people	1,455,518	+0.6%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	1,160,731	60.7%
Older people	320,746	70.3%
Younger people	839,985	57.7%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	486,940	25.5%
Older people	230,559	50.5%
Younger people	256,381	17.6%



Admitted to hospital

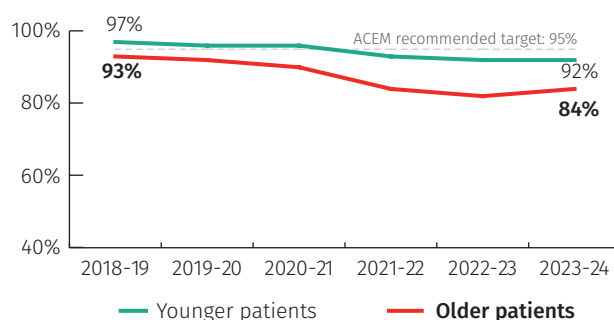
Age group	No. admitted to hospital	% of total presentations
All age groups	709,951	37.1%
Older people	274,181	60.1%
Younger people	435,770	29.9%



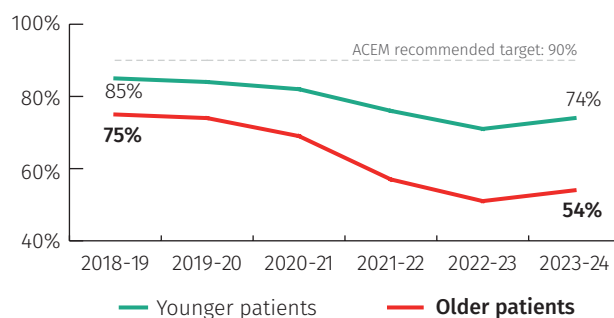
Inpatient public hospital beds

Years	No. of beds per 1000	No. of inpatient beds
2018-19	2.35	15,084
2023-24	2.33	15,856

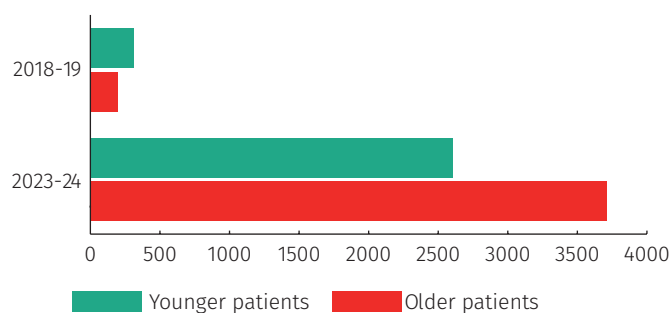
Patients discharged from the ED with a length of stay less than eight hours



Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





Western Australia

There was a total of **1,018,835 presentations** recorded across 24 public emergency departments (EDs) in Western Australia in 2023-24. Between 2018-19 and 2023-24, the number of older people attending EDs increased by 17% compared with a 4% increase among younger people. In 2023-24, 105,225 older people were admitted to hospital from the ED, which equates to 288 every day.

Older people are defined as non-Indigenous people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over.



Total presentations

Age group	Total presentations	% increase from 2018-19
All age groups	1,018,835	+6.7%
Older people	231,055	+16.5%
Younger people	787,780	+4.1%



Triage category ATS 1-3

Age group	Triage category 1-3	% of total presentations
All age groups	563,893	55.4%
Older people	151,666	65.7%
Younger people	412,227	52.3%



Arrived by ambulance

Age group	No. arrived by ambulance	% of total presentations
All age groups	200,276	19.7%
Older people	97,352	42.1%
Younger people	102,924	13.1%



Admitted to hospital

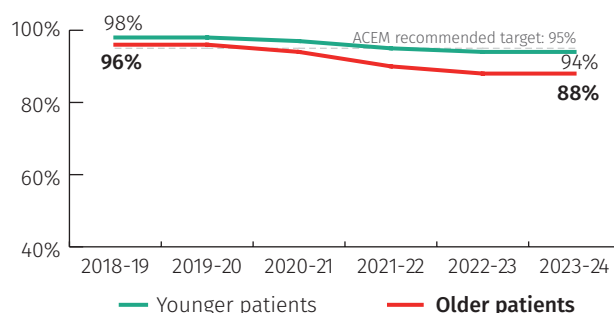
Age group	No. admitted to hospital	% of total presentations
All age groups	251,009	24.6%
Older people	105,225	45.5%
Younger people	145,784	18.5%



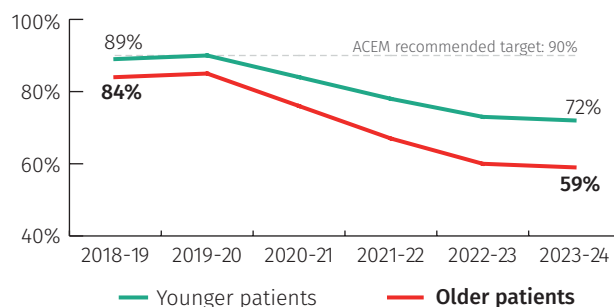
Inpatient public hospital beds

Years	No. of beds per 1000	No. of inpatient beds
2018-19	2.34	6130
2023-24	2.38	6871

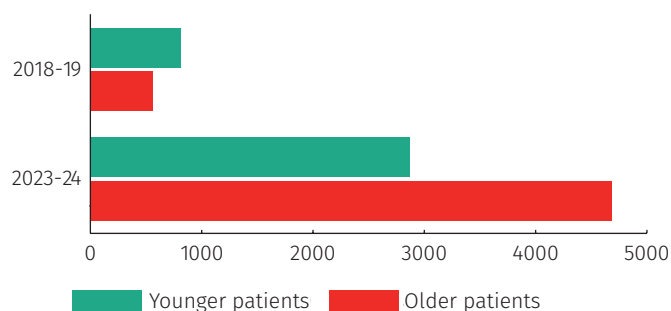
Patients discharged from the ED with a length of stay less than eight hours

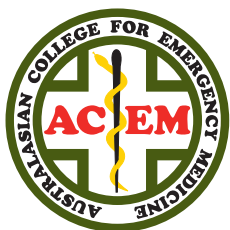


Patients admitted into hospital with an ED length of stay less than eight hours



Number of admitted patients who spent longer than 24 hours in ED





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