



ACEM 2026–27

Federal Pre-Budget Submission

January 2026



Australasian College
for Emergency Medicine

[acem.org.au](https://www.acem.org.au)

The Australasian College for Emergency Medicine (ACEM; the College) appreciates the opportunity to provide this submission to the Treasury regarding the 2026-27 Federal Budget.

As the peak professional organisation for emergency medicine across Australia and Aotearoa New Zealand, ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine. ACEM has a vital interest in ensuring that every patient who presents to an emergency department (ED) receives safe, timely and high-quality emergency care.

To ensure our healthcare system is resilient and equitable, ACEM has identified four strategic priorities for the upcoming Budget:

- Continuing the successful Emergency Medicine Education and Training (EMET) program to support the provision of emergency care across Australia's regional, rural and remote (RRR) communities;
- Establishing a dedicated, long-term funding stream for emergency medicine research;
- Prioritising Federal Government investment in aged care capacity, in-reach and transition-of-care models to improve hospital flow, reduce bed block and prevent avoidable ED presentations for older Australians; and
- Seeking national leadership and action to address the escalating crisis of violence and aggression directed at healthcare professionals.

By addressing these critical areas, the Federal Government can ensure that EDs across Australia are not only prepared for current pressures but are future-proofed for the challenges ahead.

The College welcomes the opportunity to discuss these recommendations in further detail and provide additional evidence to support Treasury's consideration.

1. Ongoing funding for the continuation of the Emergency Medicine Education and Training program.

Almost one-third of Australians live in RRR areas, where health outcomes are poorer and access to timely care is more limited than in metropolitan areas.¹ EDs in these communities see higher rates of presentations per patient population but lower workforce capacity. ACEM's 2024 *State of Emergency* report found that while the demand for emergency care per head of population in RRR areas is 27 per cent higher than in metropolitan areas, the available emergency medicine specialist workforce is 22 per cent lower.²

As a result, many RRR EDs have reduced capacity to manage high-acuity presentations, trauma and major incidents safely and efficiently.³ Without sustained investment in workforce capability, these gaps will persist and widen as demand continues to grow. Addressing these disparities requires targeted workforce education, supervision and retention strategies, such as the Emergency Medicine Education and Training (EMET) program.

EMET is a highly successful joint initiative of ACEM and the Commonwealth Government, federally funded since 2011. In February 2025, the Minister for Health and Ageing, the Hon Mark Butler, recognised EMET's success in correspondence to the College, noting 'the Australian Government acknowledges the success of the EMET program and the contribution it makes to the regional, rural and remote medical workforce.' Despite this acknowledged success, EMET continues to operate under short-term funding extensions, limiting workforce planning, constraining hub capacity and creating uncertainty for participating services and clinicians.

1 Australian Institute of Health and Welfare. Rural and remote health. 2024. [cited 20 January 2026]. Available from: <https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health>

2 Australasian College for Emergency Medicine. State of Emergency 2024: Regional, Rural and Remote. Melbourne (AU): ACEM; 2024.

3 Tatkovic A, Moore K, Lim J. Casemix and performance of Australian emergency departments: a comparison of major city, region and remote locations' *Emergency Medicine Australasia*. 2024 April;36(2):243-51.

EMET ensures that health professionals delivering emergency care in MM2–7 locations can access regular, high-quality education and supervision, regardless of geography. It strengthens RRR emergency care through:

- FACEM-led education, training and supervision for non-specialist doctors and health professionals;
- Locally tailored training aligned to community need, service capability and workforce profile; and
- Structured training pathways through ACEM’s Associateship Training Programs.

EMET at a glance

Improved patient safety and quality of care in RRR Australia



- Reducing critical health incidents and ‘near-miss’ events, ensuring safer care in isolated settings;
- Strengthening multidisciplinary clinical teams that are agile and responsive to the specific emergency care needs of their local communities; and
- Improving the appropriateness of diagnostic test ordering, generating significant cost savings and optimising patient pathways.

A stable and sustainable RRR emergency medicine workforce



- Providing essential emergency medicine training to non-specialist doctors, nurses and other health professionals;
- Delivering education, training and supervision that is customised to community needs; and
- Strengthening staff confidence and job satisfaction, which correlates to higher retention rates and more stable healthcare teams.

Alignment with national health strategic priorities



- Addressing all five key outcome areas of the *National Strategic Framework for Rural and Remote Health*;
- Supporting the objectives of the *National Medical Workforce Strategy 2021-2031* by decentralising specialist expertise; and
- Complementing the *Specialist Training Program* by strengthening non-specialist emergency care pathways and supervision.

Proven impact of EMET

Since 2011, EMET has delivered more than 28,000 education and training sessions, reaching nearly 250,000 attendances by doctors, nurses and paramedics working across RRR Australia. This includes a substantial volume of locally delivered workshops, simulation-based training, case reviews and mentoring activities alongside structured training pathways and formal qualifications.

EMET has played a critical role in building clinical capability, continuity and confidence within the RRR emergency care workforce. Qualitative and quantitative evidence demonstrates that access to context-specific education improves workforce satisfaction and retention, reduces locum reliance and improves training pathways. By bolstering the generalist rural workforce, EMET enables a more flexible and responsive emergency medicine network that meets local community needs.

These workforce improvements translate directly into better patient and community outcomes. Services participating in EMET report fewer avoidable high-severity emergency incidents, earlier recognition and management of critical illness and major trauma, and improved diagnostic appropriateness with a reduction in unnecessary investigations. Clinicians are more confident to initiate timely retrievals for critically ill and injured patients, while also delivering a wider range of emergency and acute care services locally, reducing the need for transfer and improving access to care for rural and remote communities.

EMET also strengthens the emergency medicine workforce pipeline over the longer term. More than 1400 doctors have completed ACEM non-specialist emergency medicine qualifications through EMET, embedding them within a supportive national network of FACEM supervision, mentoring and professional development. Graduates of the Advanced Emergency Medicine Training Program now provide senior clinical leadership across RRR EDs, while intermediate and advanced trainees demonstrate high retention, with nearly 80 per cent remaining in RRR practice and two-thirds continuing to work at the same site where they undertook some or all of their training.

Complementing these outcomes, the FACEM workforce in RRR Australia has increased by 58 per cent since 2014, with Fellows of the Australasian College for Emergency Medicine (FACEMs) in RRR areas now representing almost 30 per cent of the national workforce. These gains are the product of sustained, place-based investment. Ongoing short-term funding extensions risk undermining these outcomes by disrupting supervision continuity, discouraging clinician participation and limiting the ability of hubs to retain experienced FACEM educators.

Program model and delivery

EMET operates through a hub-and-spoke model and currently consists of 59 EMET Hubs supporting more than 550 training sites across RRR Australia.

EMET Hubs are typically larger regional or outer-metropolitan hospitals with on-site FACEMs and education infrastructure. Hubs provide FACEM-led training, supervision and education to clinicians delivering emergency care across their local networks and RRR sites. Commonwealth funding primarily supports protected FACEM educator time and project support roles that maximise clinical education delivery.

Training sites include hospitals and other clinical services where staff manage emergency presentations in RRR settings. In very remote locations, emergency care may be delivered through nursing posts supported by services such as the Royal Flying Doctor Service. Clinicians at these sites participate in EMET through a combination of outreach, travel to training locations and online education.

A core benefit of the EMET delivery model is the ability to tailor to local workforce capacity and constraints, while also maintaining consistent national standards. There are several delivery approaches used, including:

- Hub-based and outreach supervision of non-specialist clinicians;
- Support for doctors undertaking ACEM’s Associateship Training Programs;
- Buy-in supervision where specialist capacity is limited; and
- Retrieval-based education for communities too small to sustain a hub model.

EMET is overseen by a National Program Steering Committee, with representation from rural generalist stakeholders, including the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. The committee provides governance and assurance through approval of funding decisions, application of program guidelines, performance oversight and whole-of-program evaluation.

Government action needed

To protect the demonstrated benefits of EMET and avoid further inefficiencies associated with repeated short-term extensions, ACEM is seeking:

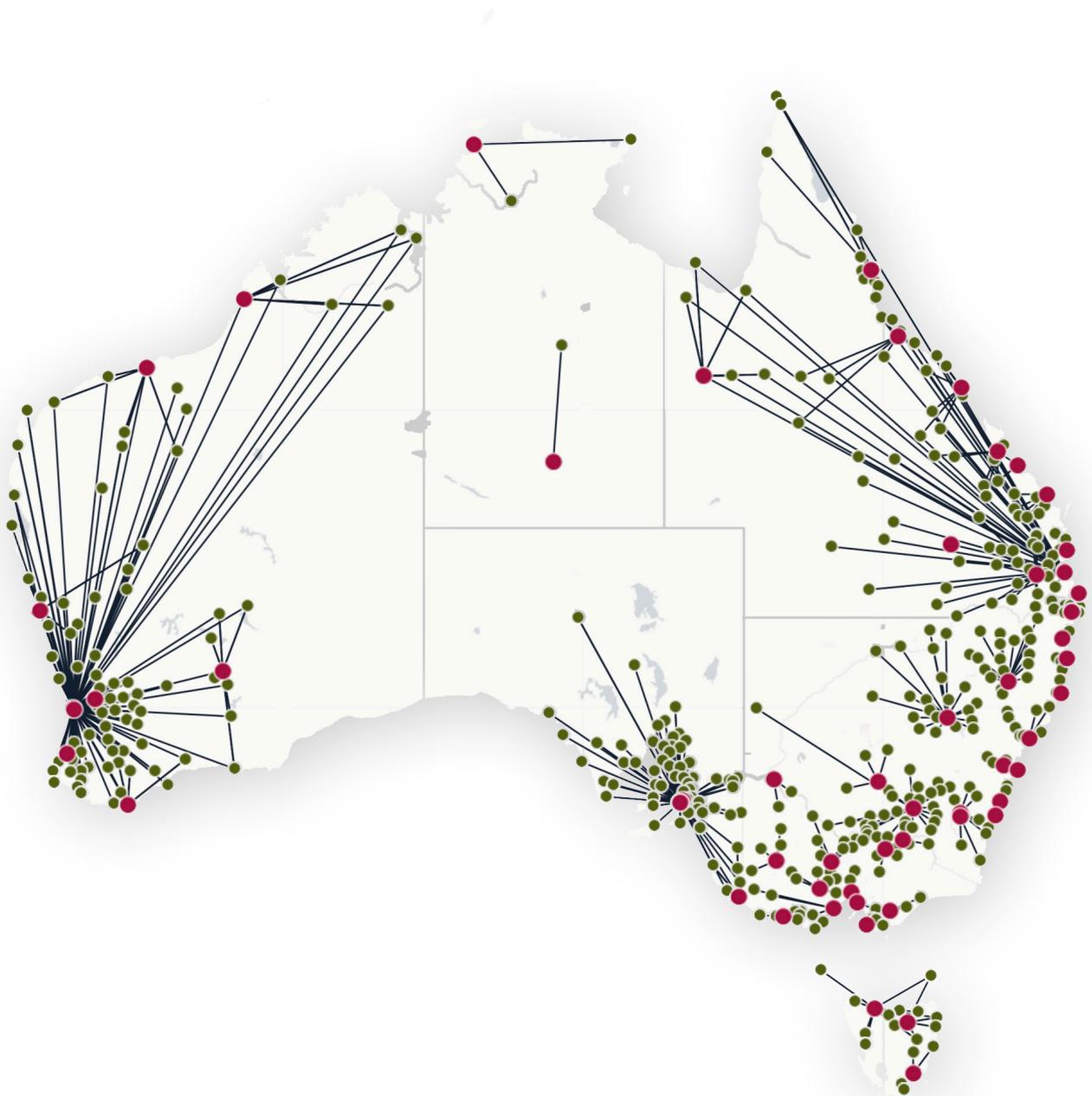
- Ongoing funding of the existing EMET program.
- Additional funding for up to five (5) extra Hubs to address unmet need in more rural and remote areas.

Measure	Investment required annually (\$)			
	2026-27	2027-28	2028-29	2029-30
Ongoing funding of the existing EMET program	\$6.5m*	\$13.0m	\$13.0m	\$13.0m
Funding up to five (5) additional EMET Hubs	\$1.1m	\$1.1m	\$1.1m	\$1.1m

* As funding is already committed until the end of the 2026 calendar year, a further six months’ funding is required for the 2026-27 period.

Emergency Medicine Education and Training (EMET) map

- EMET Hub
- EMET Training Site
- Providing emergency medicine education and training



2. The establishment of a dedicated funding stream for emergency medicine research across Australia.

ACEM calls for the establishment of a permanent, dedicated funding stream for emergency medicine research. From July 2024 to June 2025 there were over 9.1 million ED presentations across Australia, the highest ever recorded, with annual ED presentations increasing at a rate greater than population growth since 2019-20.⁴ Despite this translating to over 10 per cent of all clinical encounters in Australia, emergency medicine remains critically underfunded.

In 2025, only 0.4 per cent of National Health and Medical Research Council (NHMRC) funding was awarded to projects in the field of emergency medicine research.⁵ This low proportion of funding does not reflect the quality of emergency medicine research proposals, but rather the complexity of emergency care, which focuses on undifferentiated patients that do not align as neatly with single-disease funding streams. This funding gap leaves many standard emergency treatments supported only by 'consensus' rather than high-level evidence. In contrast, fields such as cardiology or oncology receive significantly higher proportions of funding (5 per cent and 11 per cent respectively)⁶, creating a disparity in the evidence base for acute care.

To address this, ACEM proposes two viable pathways for the Commonwealth:

1. **Priority option: The establishment of a National Emergency Medicine Research Foundation** (NEMRF; the Foundation), an ACEM-led body designed to nationalise Queensland's highly successful Emergency Medicine Foundation (EMF) model. This is ACEM's preferred approach as it ensures that research is driven by clinical need, governed by experts in the field and directly translated into ED practice.
2. **Alternative option: The creation of a dedicated, regular ring-fenced emergency medicine research stream** within existing frameworks, such as the Medical Research Future Fund (MRFF) or the NHMRC, ensuring sustainable annual grant opportunities specifically for acute care innovation. This option builds upon the 2022 MRFF initiative for research to reduce pressure on EDs, the only time to date that dedicated funding opportunity has been provided for research to improve acute care systems in hospital EDs.⁶

Either approach would address the longstanding structural underinvestment in emergency medicine research and provide the certainty required to support nationally significant, high-impact studies.

Rationale for dedicated investment

EDs and emergency medicine research are uniquely positioned to address national health priorities and lift health system productivity. As the health system's 'canary in the coal mine', EDs are where unmet need elsewhere (for example, mental health aged care and primary care) first manifests, often in more acute and resource-intensive forms. Without a dedicated and contemporary emergency medicine evidence base, clinical practice guidelines may lag behind innovation, contributing to inefficiencies in care delivery, avoidable admissions, prolonged length of stay and suboptimal patient outcomes.⁷

Investment in emergency medicine research therefore delivers productivity benefits well beyond the ED itself. Evidence-informed models of care improve patient flow, reduce unnecessary investigations and admissions, shorten hospital stays and support clinicians to deliver the right care at the right time. These system efficiencies translate directly into improved workforce productivity, reduced pressure on hospital capacity and faster return of patients to work, family and community roles.

There is also a compelling economic case for this investment. Since 2008, the Queensland-based EMF has awarded \$24.6 million to 293 research grants, helping to build an active emergency medicine research culture in Queensland.⁸ Evidence from the EMF demonstrates that targeted emergency medicine research

4 Australian Institute of Health and Welfare. Emergency department care. 2025. [cited 14 January 2026]. Available from: <https://www.aihw.gov.au/hospitals/topics/emergency-departments>

5 National Health and Medical Research Council. Summary of the results of the NHMRC 2025 Grant Application Round - Updated 22 December 2025. [cited 14 January 2026]. Available from: <https://www.nhmrc.gov.au/funding/data-research/outcomes>

6 Australian Government Department of Health. \$24 million for research to reduce pressure on emergency department. 7 February 2022. [cited 20 January 2026]. Available from: <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/24-million-for-research-to-reduce-pressure-on-emergency-departments?language=en>

7 Guerra-Farfán E, Garcia-Sanchez Y, Jornet-Gilbert M, Nuñez J, Balaguer-Castro M, Madden K. Clinical Practice Guidelines: The good, the bad, and the ugly. *Injury*. 2023;54(3):S26-S29.

8 Emergency Medicine Foundation. Annual Report 2023-2024. 2024. [cited 14 January 2026]. Available from: <https://emergencyfoundation.org.au/wp-content/uploads/2025/11/EMF-Annual-Report-2024-2025.pdf>

delivers an extraordinary return on investment. A KPMG evaluation of EMF-funded projects identified a return of \$53 for every \$1 invested, yielding tens of millions of dollars in economic and productivity benefits through improved clinical practices, system efficiencies and reduced hospital utilisation. By scaling this nationally, the Commonwealth can improve patient safety and cement Australia's status as a world leader in acute health research.

Should the Commonwealth choose to integrate this funding into existing models such as the MRFF or NHMRC rather than a standalone Foundation, ACEM emphasises that this funding must be 'ring-fenced' to remain effective. At a minimum, funding should be commensurate with the allocation provided through the MRFF's *Emerging Priorities and Consumer-Driven Research Initiative* in 2022. A dedicated emergency medicine research stream would require a defined annual allocation, specialist peer review and a strong focus on implementation to deliver productivity and system-wide benefits.

Case studies

A dedicated national funding stream would empower ACEM to scale high-impact clinical trials that have already demonstrated the ability to reduce hospital costs and improve patient flow. The following examples highlight the potential for systemic savings:

- The EDNA Network:** The Emerging Drugs Network of Australia (EDNA) acts as a real-time, multi-state 'toxico-surveillance' system. By rapidly identifying new illicit drugs in the ED, clinicians can treat overdoses more accurately and public health authorities can issue faster warnings.⁹ As the 2024 'Excellence in Research and Innovation' winner at the 2024 WA Health Excellence Awards, this rapid translation of data into clinical action aligns with federal harm-minimisation goals and prevents avoidable ICU admissions.
- The Pneumothorax Trial:** In 2021, an ACEM-endorsed clinical trial proved that 'conservative management', or watchful waiting, for collapsed lungs is as effective as invasive surgery. Winning the Australian Clinical Trial of the Year Award, this approach spared 85 per cent of patients from surgery, resulting in fewer complications and significantly shorter hospital stays.¹⁰ Nationalising this evidence-based protocol directly reduces bed block and surgical costs.
- The BUCKLED Trial:** This world-leading 2023 Australian study demonstrated that point-of-care ultrasound can safely replace x-rays for many paediatric arm fractures.¹¹ By moving to an 'ultrasound-first' model, EDs can bypass radiology wait times, eliminate radiation exposure for children, and significantly reduce the length of stay. This scalable model is particularly valuable for resource-limited RRR hospitals.
- The PEACHY-O Trial:** As one of the largest international studies on paediatric agitation, this trial confirmed that oral sedation is a safe and effective first-line alternative to invasive injections.¹² This shift reduces the need for security intervention and intensive observation, protecting staff from violence while streamlining care in high-pressure environments.



Professor Daniel Fatovich FACEM presents on EDNA findings at the United Nations, Vienna, Austria, 12 March 2025.

While these examples represent world-class innovation, they are currently the result of ad-hoc grants and localised efforts. Dedicated emergency medicine research funding would provide the infrastructure to nationalise findings, support implementation science and ensure funding security for multi-jurisdictional projects and networks.

9 Smith JL, Soderstrom J, Dawson A, Alfred S, Greene S, Isoardi K, McCutcheon D, Oosthuizen F, Ezard N, Burcham J, Fatovich DM. The emerging Drugs Network of Australia: A toxico-surveillance system of illicit and emerging drugs in the emergency department. *Emerg Med Australas.* 2022 Feb;34(1):58-64.

10 Brown SGA, Ball EL, Perrin K, Asha SE, Braithwaite I, Egerton-Warburton D, et al. Conservative versus interventional treatment for spontaneous pneumothorax. *New Eng J Med.* 2020;382(5):405-415.

11 Snelling PJ, Jones P, Bade D, Bindra R, Byrnes J, Davison M, et al. Bedside ultrasound conducted in kids with distal upper limb fracture in the emergency department (BUCKLED): a protocol for an open-label non-inferiority diagnostic randomised control trial. *Trials.* 2021 April 14;22(1):282

12 Bourke EM, Kochar A, Shellshear D, Borland ML, Jani S, Goerge S et al. PEACHY-O: Pharmacological emergency management of agitation in children and young people: a randomised controlled trial of oral medication. *Ann Emerg Med.* 2025 Jul;86(1):1-11

Governance and accountability

ACEM has extensive experience delivering nationally governed programs with strong accountability frameworks, including EMET and as a founding partner of the EMF. This includes the establishment of governing bodies, transparent funding guidelines, independent peer review and robust monitoring and evaluation processes.

Whether delivered through a standalone NEMRF or via a ring-fenced federal funding stream, ACEM proposes a nationally representative governance model with specialist peer review to ensure funding decisions are fair, unbiased and focused on high-impact research priorities, including Indigenous health equity and RRR access.

Research priority areas

ACEM has identified three strategic priorities for immediate investment to address existing gaps in the Australian health evidence base:

- **Equity for RRR communities:** While universal access is a core principle of Australian healthcare, RRR communities face significant disparities in service availability. A dedicated research focus is required to answer clinical questions unique to non-metropolitan acute care settings. By funding research outside of traditional urban tertiary centres, the Commonwealth can improve local health outcomes, reduce expensive patient transfers, and provide professional incentives that assist in the recruitment and retention of the rural workforce.
- **Aboriginal and Torres Strait Islander health equity:** Building on ACEM's strong track record of managing Indigenous-led, federally funded projects, this priority focuses on making EDs culturally safe for both patients and staff. Funding will support research that addresses the systemic impacts of racism and discrimination in acute care. This includes scaling successful initiatives, such as picture-based communication tools and Indigenist reviews of the medical workforce, to ensure First Nations peoples have access to high-quality, comprehensive and culturally safe emergency care.
- **Building early career emergency physician research capacity:** Heavy clinical workloads and intense competition often prevent early career physicians from engaging in research. ACEM seeks to provide a dedicated pathway for New Fellows and trainees to lead innovation. By supporting this under-represented group, the College can ensure a sustainable pipeline of clinician-researchers who are equipped to solve the long-term challenges in Australian EDs.

Government action needed

ACEM is calling for a formalised investment to support the growth of emergency medicine research in Australia. This funding would be utilised to assess and award grants for potentially lifesaving clinical trials and health system innovations.

In 2022, the MRFF issued a targeted call for acute care research through *Models of Care to Improve the Efficiency and Effectiveness of Acute Care Grant Opportunity*. Although this proved the high demand and effectiveness of acute care research, there has been no dedicated federal funding for this sector since. As such, ACEM seeks to move beyond ad-hoc opportunities toward a sustainable, recurring investment model.

Priority option: ACEM is seeking an investment of \$3 million for the 2026-27 financial year to establish a National Emergency Medicine Research Foundation, followed by an ongoing grant pool of \$25 million per annum, which has been based on the funding made available through the MRFF's 2022 targeted call.

This grant pool would facilitate both large-scale multi-site trials and smaller, targeted projects focusing on:

- **Clinical Innovation:** Developing new, evidence-based protocols to improve patient safety;
- **Health System Transformation:** Identifying efficiencies that reduce bed block, improve hospital flow, and generate tangible savings; and
- **Equity-Focused Research:** Prioritising the unique challenges of RRR communities and Indigenous health equity.

Measure	Investment required annually (\$)				
	2026-27	2027-28	2028-29	2029-30	2030-31
Establishment of NEMRF and capacity building	\$3m	-	-	-	-
Ongoing NEMRF funding	-	\$25m	\$25m	\$25m	\$25m

Alternative option: Should the Commonwealth prefer to deliver this outcome within existing mechanisms, funding of \$25 million per annum is sought, again in alignment with the one-off MRFF targeted call.

Measure	Investment required annually (\$)				
	2026-27	2027-28	2028-29	2029-30	2030-31
Ongoing, ring-fenced emergency medicine research funding stream	\$25m	\$25m	\$25m	\$25m	\$25m

3. Immediate and sustained Commonwealth action on aged care.

Australia's ageing population is a primary driver of ED overcrowding, bed block and ambulance ramping. These pressures are not caused by inappropriate ED use by older people, but by systemic underinvestment in sustainable funding models for primary care services and longitudinal general practitioner (GP) care, residential aged care facility (RACF) capacity, home support and transition pathways that sit largely within Commonwealth responsibility. Without coordinated federal action, pressures on EDs and hospitals will continue to escalate, with measurable harm to older Australians.

“Over the last 30+ years of my emergency medicine career, older persons are living longer and those presenting to ED are living with higher levels of frailty [both] physical and cognitive, medical and social complexity.”
- Emergency physician

Older people already account for around one quarter of all ED presentations and present with significantly higher acuity than younger populations. From age 65 onwards, ED presentations increasingly result in hospital admission, with admission rates exceeding 50 per cent by ages 75–84 and approaching 70 per cent among those aged 95 years and over.¹³ As Australia's population ages, these pressures will intensify, with ED presentations among people aged 65–84 projected to increase by 242 per cent by 2050, and by 411 per cent among those aged 85 years and over.¹⁴

Underinvestment in residential and community-based aged care is driving hospital demand

State and territory health systems are under growing pressure because older people are unable to access timely and appropriate care outside hospital. According to the National Aged Care Blockage Report Card presented to the Minister for Health and Ageing, the Hon Mark Butler by state and territory health ministers at the Health Ministers' Meeting on 12 December, 3049 older Australians are currently stuck in public hospitals waiting for a RACF placement at a cost of well over \$1 billion per year.

Once in hospital, discharge is frequently delayed due to limited RACF capacity, inadequate clinical capability to manage high-acuity residents, and insufficient access to community-based supports. While states fund

¹³ Australian Institute of Health and Welfare. Emergency department care 2024-25. Canberra: AIHW; 2025.

¹⁴ Burkett E, Martin-Khan MG, Scott J, Samanta M, Gray LC. Trends and predicted trends in presentations of older people to Australian emergency departments: effects of demand growth, population aging and climate change. Aust Health Rev. 2017 Jul;41(3):246-253.

and operate public hospitals, the levers that determine whether older people can leave hospital safely sit primarily with the Commonwealth. These include RACF capacity, adequate Commonwealth Home Support Program (CHSP) and the availability of primary care services to provide follow up and coordinate post-hospital care.

Despite the scale and predictability of demographic trends, insufficient action has been taken to prepare for the volume and complexity of acute care needs associated with population ageing. Capacity has declined against key indicators, with the number of hospital beds available for every 1000 Australians aged over 65 in 2025 at the record low number of 14.3, less than half of the capacity in the early 1990s.¹⁵

“When there is no reliable ‘step-up/step-down’ pathway [such as] hospital in the home, rapid response teams or transitional care, the ED becomes the default risk-management option.”
- Emergency physician

Additionally, older people receiving services through the CHSP experience higher rates of ED presentations, unplanned and potentially avoidable hospitalisations and longer hospital stays than those presenting from RACFs.¹⁶ This indicates that current community-based aged care provision is not meeting demand or complexity, resulting in avoidable reliance on hospitals and applying further pressure on the aged care-health system interface.

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. This represents a structural cost shift from the Commonwealth to state hospital systems, with public hospitals absorbing unmet aged care need rather than delivering acute care.

This underinvestment is driving bed block, delayed discharge and patient harm

Once older people enter hospital, timely discharge is frequently constrained. Limited RACF capacity, an increasingly regulated aged care environment and workforce challenges have reduced aged care providers' willingness to accept residents with high-acuity needs, dementia or complex behaviours. This reluctance is often driven by insufficient staffing, limited onsite clinical care and inadequate funding to manage complexity.

As a result, many older people remain in hospital despite no longer requiring acute care, increasing their risk of hospital-acquired complications such as delirium, falls, infection and functional decline.¹⁷

“The daily witnessing of avoidable injury causes moral injury and burn-out in staff – this is not the care any of us want to see older persons receive.”
- Emergency physician

These system failures have direct patient safety consequences. ED overcrowding and bed block contribute to ambulance ramping, which is increasingly linked to preventable harm and death. Older people are disproportionately affected, as they are more likely to arrive by ambulance, require admission, and experience deterioration while waiting for care.¹⁸

Primary care funding has inadvertently created access issues for older people

Alongside aged care capacity, access to well-funded, longitudinal primary care is a critical determinant of whether older people can be supported safely in the community. Recent changes to Medicare funding prioritise episodic care for short-term health problems, rather than the ongoing management of chronic

¹⁵ Australian Medical Association. Public Hospital Report Card. Canberra (AU): AMA; Feb 2025.

¹⁶ Harrison SL, Lang C, Eshetie TC, Crotty M, Whitehead C et al. Hospitalisations and emergency department presentations by older individuals accessing long-term aged care in Australia. Aust Health Rev. 2024;48(2):182-190.

¹⁷ Australasian College for Emergency Medicine. Care of older persons in the emergency department. Melbourne (AU): ACEM; 2020.

¹⁸ Burkett E, Martin-Khan MG, Gray LC. Comparative emergency department resource utilisation across age groups. Aust Health Rev. 2019;43(2):194-199.

and complex conditions required as people age. In hospitals right across Australia, high-quality, longitudinal GP care delivered within multidisciplinary community teams is central to sustaining hospital services as the population ages.

However, GPs are increasingly unable to sustain service provision to RACFs under current funding settings, a problem further compounded in RRR areas. Maintaining the status quo in primary care funding will only reproduce existing access failures and continue to drive avoidable ED presentations and hospital admissions among older people. GPs must be adequately incentivised to provide longitudinal primary care within multidisciplinary models, particularly for frail older people living in RACFs.

“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 fund primary care to provide complex primary care to frail older persons.”
- Emergency physician

Evidence-based solutions exist, but cannot be sustained by hospitals alone

States and territories have implemented hospital-based and outreach models that demonstrably improved care for older people, including geriatric-informed ED models, RACF in-reach services and rapid community-based assessment programs. Where adequately resourced, these models reduce ED length of stay, prevent unnecessary admissions and improve patient outcomes.

However, these initiatives are largely funded, delivered and sustained by state health budgets alone. Without sufficient and predictable Commonwealth funding for aged care capacity, primary care and hospital-aged care interface programs, states cannot scale or sustain these models. In the absence of adequate federal investment, the burden of underfunded aged care continues to fall on public hospitals.

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

Case study 1 – Timely ED intervention for high-risk older patients

The Geriatric Emergency Department Intervention (GEDI) model embeds gerontology-trained nurses and emergency physicians within the ED to identify older patients at risk of hospitalisation and functional decline. The focus is on early assessment, rapid multidisciplinary input and coordinated discharge planning.

Case example:

An 82-year-old woman presents to the ED after a fall. While she has no major injuries, she has multiple comorbidities, mild cognitive impairment and lives alone with the support of Commonwealth Home Support Program services. She is frail, anxious and at risk of functional decline if admitted to hospital.

Under the GEDI model, she is identified early and reviewed by a gerontology-trained nurse and emergency physician. A focused geriatric assessment is completed, medications are reviewed and collateral history is obtained from family and community providers. Rather than being admitted, same-day allied health input and urgent community supports are arranged, with follow-up coordinated through her GP.

She is safely discharged home, avoiding unnecessary hospitalisation, reducing ED length of stay and preserving inpatient bed capacity.

Case study 3 – Community-based intervention for acute deterioration

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 stabilising patients early and coordinating care in the community.

Case example:

A 79-year-old man with chronic heart failure and mobility limitations and early dementia lives at home with support through the Commonwealth Home Support Program. Over several days, he becomes increasingly short of breath, raising concern from his carer.

Following referral to GRACE, a specialist geriatric clinician conducts a rapid community assessment, identifies early decompensation and adjusts treatment. Nursing and allied health supports are coordinated, with clear follow-up and escalation plans agreed with the GP.

The patient stabilises at home, avoiding an ED presentation, while remaining connected to hospital services should his condition worsen.

Case study 2 – Specialist care delivered in the residential aged care facility (RACF)

Residential In-Reach provides hospital-linked specialist assessment and treatment within RACFs, supporting staff and residents while preventing avoidable ambulance transfers and ED presentations.

Case example:

An 88-year-old RACF resident develops increasing breathlessness and reduced mobility. Under traditional pathways, this would likely result in an ED transfer.

Instead, the RACF staff contact the Residential In-Reach team. A specialist clinician attends the facility, conducts a rapid assessment and initiates treatment in consultation with the GP and RACF staff. Medications are adjusted, allied health follow-up is arranged and a clear escalation plan is established. The resident remains safely in the RACF, receiving timely specialist care while avoiding the risks and disruption associated with the hospital transfer.

Case study 4 – Patient-centred care in integrated models

Advance Care Directives (ACDs) support care that aligns with a person's values, particularly during emergency presentations and transitions between care settings. When embedded within multidisciplinary models, ACDs strengthen shared decision-making and reduce unwanted or non-beneficial interventions.

Case example:

An 85-year-old man with advanced lung disease and moderate dementia attends the ED with worsening breathlessness. At triage, the care team identifies an ACD documented in his My Health Record and held by his GP and RACF.

With his preferences clearly established, emergency and geriatric clinicians engage his substitute decision-maker and develop a care plan aligned with his goals. Community-based palliative support is coordinated through a GRACE-type service, with follow-up arranged through his RACF.

This approach avoids unwanted invasive treatment, supports a timely transition out of hospital and demonstrates how advance care planning enhances the safety and quality of care for older people with complex needs.

Government action needed

To protect older Australians from avoidable harm and restore flow and capacity across the health system, the Commonwealth must lead coordinated reform and investment at the aged care–acute care interface. ACEM calls on the Commonwealth to:

1. Expand and adequately resource residential aged care facilities to meet growing demand;
2. Provide targeted investment to enable aged care providers to care for residents with dementia and complex behaviours;
3. Review and fund sustainable primary care models, including adequate remuneration for GPs to provide longitudinal, responsive care for older people;
4. Fund states and territories to deliver and sustain in-reach medical and multidisciplinary services to RACFs;
5. Improve the adequacy, responsiveness and clinical capability of CHSP services to reduce avoidable ED presentations and hospital admissions; and
6. Jointly invest with states and territories in hospital–aged care interface programs, including transitional and step-down care.

Without sustained Commonwealth investment in aged care capacity and clinical support, pressures on EDs, ambulances and inpatient services will continue to worsen. Addressing this structural failure is essential to improving outcomes for older Australians and ensuring EDs can deliver timely, high-quality acute care for all patients.

4. National action to combat emergency department violence.

For years, ACEM has sounded the alarm on the escalating crisis of violence in EDs. In February 2025, the College released the landmark *Breaking Point: An Urgent Call to Action on Emergency Department Safety*, which provided undeniable evidence that ED violence is a systemic occupational safety failure.

Despite these repeated calls for reform, national action remains stagnant. While some jurisdictions have implemented isolated, piecemeal measures, a cohesive federal strategy to protect frontline healthcare workers is still dangerously absent. Despite employers' legal obligation to provide safe workplaces, current conditions in EDs fall short of this standard. The consequences are clear: persistent exposure to violence is eroding workforce morale, driving burnout, and undermining recruitment and retention across emergency medicine.

Normalisation of violence and underreporting

Evidence from *Breaking Point* shows that ED violence is widespread and frequent. The report revealed that nine out of ten respondents experienced at least one incident of violence in their ED within a single week, with 79 per cent reporting incidents that included physical violence. Despite these statistics, the true scale of the problem is obscured by widespread under-reporting. Emergency clinicians are currently trapped in a culture of 'learned helplessness', where onerous and inconsistent reporting systems discourage the documentation of incidents. This has led to a damaging environment where verbal and physical aggression is increasingly normalised as an unavoidable part of the job, rather than being treated as a breach of a safe workplace.

"The reporting system is onerous and not easily accessible. As nothing seems to change there is a learnt helplessness to report. Some staff think someone else will report. A recent audit on Code Blacks revealed only 25-30 per cent of Code Blacks are reported in the safety event system."
– Emergency physician

EDs are widely recognised as high-risk settings for violence, yet the true scale of the problem remains underestimated due to widespread under-reporting.^{19 20} Emergency clinicians describe reporting systems that are time-consuming and inconsistent, particularly when incidents are attributed to medical causes or perceived as minor. More concerning is a loss of confidence that reporting will lead to meaningful action, compounded by a damaging culture in which violence is normalised as “part of the job”.

Hospital security

Across Australia, access to trained hospital security officers remains fragmented and inconsistent. More than 40 per cent of EDs currently rely on hospital-wide security services or have no dedicated security presence at all.²¹ Because these staff are shared across entire hospital grounds, they cannot provide the constant, embedded presence required to manage the high-risk behavioural disturbances unique to the ED.

“They are very effective when present but frequently attend codes in other parts of the hospital. Concurrent Code Grey/Black occur frequently in our health service and there is insufficient EFT to meet the demand.”
– Emergency physician

There are currently no national standards governing security roles in healthcare settings, creating a ‘postcode lottery’ for staff safety. ACEM maintains that where security officers are adequately resourced, specifically trained, and embedded within the multidisciplinary team, they significantly improve safety and support effective clinical de-escalation.

Government action needed

The current ‘postcode lottery’ of staff safety is no longer tenable. Violence in EDs is a national workforce safety failure that cannot be resolved through fragmented, jurisdiction-by-jurisdiction responses. ACEM is calling on the Commonwealth to move beyond mere acknowledgement of this crisis and provide the national leadership necessary to embed ED safety as a core health system priority. Without a unified federal response, the safety and wellbeing of Australia’s frontline emergency workforce will continue to be compromised.

To resolve this, ACEM proposes a three-pillared approach for Commonwealth action:

1. National data, transparency and accountability for ED safety

The absence of consistent national data has allowed ED violence to remain hidden and normalised. The Commonwealth must establish clear expectations for measurement, reporting and accountability.

The Commonwealth should:

- Develop and mandate a nationally consistent ED violence and aggression reporting framework, supported by standardised tools for use across all states and territories.
- Require regular, standardised reporting on ED violence as a condition of hospital funding agreements with states and territories.
- Ensure ED safety indicators, including staff exposure to violence and aggression, are publicly reported and incorporated into the Australian Institute of Health and Welfare’s Australian Health Performance Framework.
- Through the Australian Commission on Safety and Quality in Health Care (ACSQHC), embed transparent reporting of violence and aggression within the ACSQHC accreditation standards.

¹⁹ Nikathil S, Olaussen A, Gocentas R, Symons E, Mitra B. Workplace violence in the emergency department: A systematic review and meta-analysis. *Emerg Med Australas*. 2017;29:265-75.

²⁰ Victoria Auditor-General. *Occupational Violence Against Healthcare Workers*. Melbourne: Victorian Government Printer; 2015.

²¹ Australasian College for Emergency Medicine. *Breaking Point: An urgent call to action on ED safety*. Melbourne (AU): ACEM; 2025.

2. A nationally recognised, trained and embedded ED security workforce

Security capability in EDs is currently inconsistent, inadequately defined and poorly integrated. This exposes staff and patients to unacceptable risk.

The Commonwealth should:

- Formally recognise hospital security officers as integral members of the ED multidisciplinary team, with a nationally consistent scope of practice and role definition.
- Establish national minimum competency and training requirements for hospital security officers working in EDs, distinguishing the role from general security work and reflecting the complexity of healthcare environments.
- Provide targeted Commonwealth funding to support workforce development, including incentives for registered training organisations to deliver accredited training aligned with national competency standards.

3. National leadership to prevent violence against healthcare workers

Violence against healthcare workers has been allowed to become normalised. Reversing this requires visible national leadership and cultural change.

The Commonwealth should:

- Declare violence against healthcare workers a national crisis and lead a comprehensive campaign to raise greater public awareness of the prevalence, severity of the violence being inflicted and the profound impact it is having on healthcare workers across Australia.
- Through the ACSQHC, introduce a National Standard on violence and aggression that sits alongside other standards contained within the National Safety and Quality Health Service Standards.



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