Aotearoa New Zealand

State of Emergency 2026

Practical reforms to improve patient access and flow; enhance workforce sustainability; and address systemic health inequity for Māori in Aotearoa New Zealand's emergency departments

September 2026

Australasian College
for Emergency Medicine

acem.org.au

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 Māori as tangata whenua and as partners in Te Tiriti o Waitangi in Aotearoa New Zealand.

In recognition of our bi-national College, ACEM acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands on 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.

Authorisation

Authorised by Dr Michael Connelly, Australasian College for Emergency Medicine.
Level 2, City Chambers, 142-144 Featherston St, Wellington Central, Wellington 6011.

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Chair's introduction

Emergency medicine specialists work tirelessly 24 hours a day, 365 days a year to deliver high-quality emergency care for the people of Aotearoa New Zealand. Whether it's a person experiencing a heart attack, a child with an injured arm, treating sepsis in a new mother or comforting a family embracing palliative therapy for a loved one, our doctors treat everyone with skill and compassion.

In Aotearoa New Zealand's first-ever *State of Emergency* report, the Australasian College for Emergency Medicine (ACEM, the College) provides an in-depth look, through data and the voices of members, at a health system in crisis.

There are individual triumphs in emergency departments (EDs) every day. However, ED staff, who are determined to deliver the best possible care no matter the adversity or the lack of resources, are being pushed to a breaking point.

Never has there been this level of concern. The health system needs major support to stop its negative spiral.

The time to act is now, through investment in community supports, inpatient capacity and workplace modernisation that assists our emergency medicine specialists and grows the workforce so that we can continue delivering high-quality emergency care.

Demand on our EDs is climbing year-on-year, as is the proportion of patients who are very unwell and need hospitalisation. However, the sector has a chronic shortage of inpatient beds, which have not kept pace with population growth and needs. Access block is a patient safety issue and creates the greatest risk felt by staff in EDs across the motu. Disruptions in patient flow mean patients who require admission are left stuck in the ED, with staff managing ward-based inpatient issues as well as acutely unwell patients.

We do not have enough emergency medicine specialists to meet patient demand. Workforce capacity is projected to get worse with more emergency medicine specialists set to retire, move overseas or work part-time to cope with the pressure. Additionally, there is an inadequate training pipeline to fill these growing needs. To ensure future workforce sustainability, recruitment and retention must be prioritised.

The report also presents data that demonstrates the persistent inequities that Māori experience in emergency care. We know the system must improve to meet the overall health needs of Māori patients, their whānau and communities. But we do not know the full scale of current inequities, because significant gaps in data quality limit how well we can measure and benchmark Māori health outcomes. Closing those data gaps is the first step to being accountable for this inequity. ACEM is a leader in efforts to embed culturally safe care, and we are committed to seeing that change through.

This report is built on data but also on sharing the lived experiences of our members.

I first caught a glimpse of the beautiful Taranaki Maunga in 2004 after completing my training in Atlanta in the United States at a large public hospital. After a brief stint in Waikato ED, I am now Director of Emergency Medicine at Taranaki Base and the rural Hawera Hospital.

Returning to EDs in Aotearoa 12 years ago, I enjoyed an environment without the stresses that existed in 'pressure cooker' EDs abroad. I distinctly recall being able to sit next to my patients to understand what was leading to their illness and what life adjustments were needed to prevent future ED visits, to improve an individual's or family's pae ora.

These moments are now becoming increasingly rare in EDs throughout the nation. Rising presentations, more complexity, and loss of capacity is being felt everywhere. Privacy is at a premium, with patients being cared for in corridors and ambulance bays within a metre or two of a complete stranger also needing high-level care.

Relative ED and inpatient capacity continue to diminish across the sector. Larger centres are often operating at well over their usual capacity and many rural EDs have lost or are at risk of losing on-site medical expertise. The system has caused burnout in many members of the ED team, and these people have moved to different environments or other careers. The question must be, 'How do we change the system to support those who work within it?', not the other way around.

This report seeks to inform the systemic reform we need to reach this goal, taking a whole-of-government and whole-of-health system approach. Our members will work alongside government and other stakeholders to achieve this reform.

As emergency medicine specialists we love what we do, however we are working under extraordinary pressure every day. This is not sustainable for our workforce or our patients.

This report is a reality check, and within that reality is a call to action. Whole-of-health system reform and increased, sustained resourcing is required. The pressure on our EDs will not ease without these changes.

We are committed to continuing our high-quality emergency care for the people of Aotearoa New Zealand, but cannot do it alone. Let us move forward together to achieve improvements across the entire health sector as we strive for a healthier Aotearoa New Zealand.

He waka eke noa!

Dr Michael Connelly, FACEM

Aotearoa New Zealand National Council Chair
Australasian College for Emergency Medicine
September 2026

National health snapshot

Aotearoa New Zealand

Across Aotearoa New Zealand there are 40 emergency departments (EDs), 20 of which are accredited by ACEM. Together, these EDs are where the vast majority of Fellows of the Australasian College for Emergency Medicine (FACEMs) and trainees do their work to care for the country's population.

Access and flow profile as of 2024–25

Demand

Record-high ED presentations of **more than 1.4 million annually, up 21%** from 2015-16.

Patient profile

27% of patients aged 65+, **23% of patients** identified as Māori.

ED length of stay

Only **79% of discharged** patients and **56% of admitted or transferred** patients met the ED six-hour benchmark target.

Access

66% of patients triaged into the more urgent triage categories (ATS^ 1-3); **8% of patients** left before the commencement or completion of treatment.

Workforce profile as of 31 December 2025

Total FACEMs	Full-time (38+ hrs per week)	More than one workplace	Workplace(s) in RRR*
461	**58%**	**21%**	**37%**

Equity: Cultural support for Māori

Five out of 20 ACEM-accredited EDs reported that the quality of the Indigenous status data collected is very good or excellent.

15 out of 20 ACEM-accredited EDs reported that they have a dedicated Māori health unit.

Four out of 20 ACEM-accredited EDs reported that the Kaitakawaenga/Māori Health Liaison Officer or equivalent sees more than 25% of Māori patients.

^ Australasian Triage Scale
* Regional, rural and remote, encompassing Urban 2 and Rural 1-3 areas as defined by the Geographic Classification for Health.
Workforce profile refers to self-reported ACEM Portal data; FACEM totals include members with workplace details only.

Priorities

ACEM makes 14 recommendations across this report's three priority areas: five for Access and flow, five for Workforce and four for Māori health equity. The full list, with supporting rationale cross-referenced, concludes this report.

Priority: Access and flow

Recommendations in this priority area address barriers to patient access and flow. Investment in inpatient and aged care capacity would help relieve the access and exit blocks that drive longer ED stays. Digital infrastructure and a national performance framework would make blockages visible and drive accountability across the whole hospital and the entire health system nationally.

Priority: Workforce

Recommendations in this priority area address workforce pressures. Investment in training, retention and rural distribution would reduce reliance on international recruitment and close the gap in access to specialist emergency care between urban and rural areas.

Priority: Māori health equity

Recommendations in this priority area address Māori health equity. Cultural safety training, Te Tiriti-aligned policy settings and investment in Māori-led models of care, and improvements in the quality of ethnicity data are needed. These would help collectively address the gaps in triage, mortality and workforce representation documented throughout this report.

A note on data and sources

Explanatory methodology on data and sources used and referenced in this report is available at the end of the document under: How did we get this data?

Access and flow

Patients are put at risk when access is difficult and flow is slow

Demand for emergency care has continued to grow over time. In 2024-25, **a record 1,459,972 annual presentations** were reported across 40 public EDs, representing a 21 per cent increase since 2015-16. The ongoing growth in demand places increasing pressure on EDs and contributes to challenges in maintaining timely patient flow. Poor patient flow is driven by factors across the health system, including emergency care demand, inpatient hospital capacity and the availability of community-based supports for safe and timely discharge from the ED.

The impacts of patient presentations are influenced by both the total number of patients arriving at the ED and the proportion requiring more urgent and complex care. Together, these drivers test how well the health system is equipped to provide patients with the care they need, whether that is a hospital bed, discharge home or a referral to community-based care.

Between 2015-16 and 2024-25, Aotearoa New Zealand EDs saw two significant shifts and neither can be explained by population growth alone.

21%	**13%**	**66%**
Rise in annual presentations from 2015-16 to 2024-25	Population growth over the same period	Presentations triaged as high urgency (Australasian Triage Scale (ATS) 1–3) in 2024-25 (up from 55% in 2015-16)

More people are arriving and requiring urgent and complex care

Annual ED presentations rose by 21 per cent over the previous decade while the population grew by approximately 13 per cent (*Figure 1*).[1] On a population-adjusted basis, presentations per 1000 people rose from 256 to 274. As Figure 1 shows, the percentage increase in presentations to the ED since the COVID-19 pandemic has surpassed the percentage growth in population over the past few years and the gap is increasing.

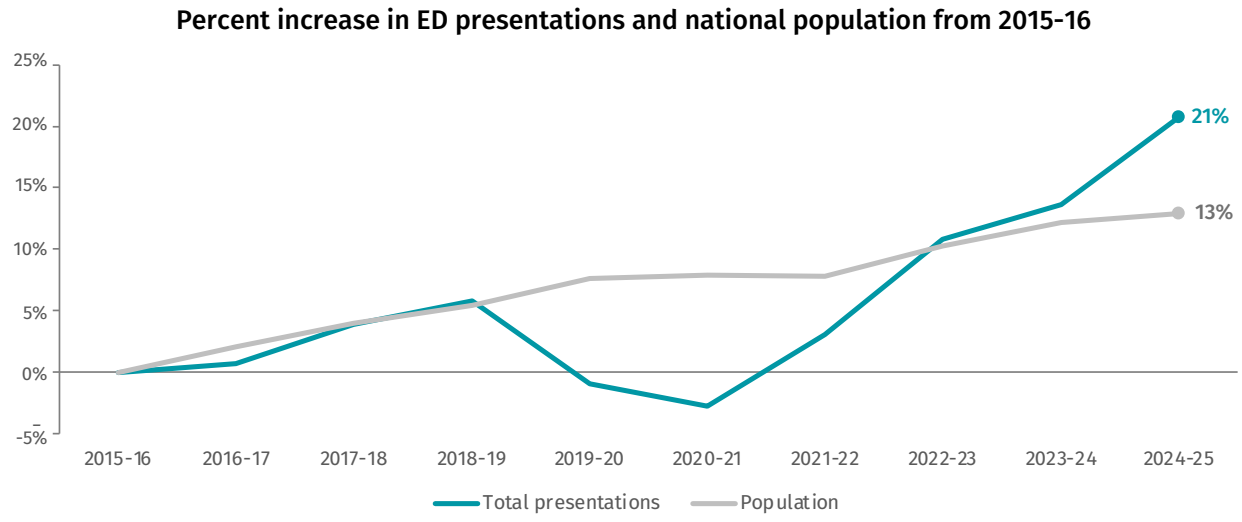

Figure 1: *Percentage increase in ED presentations and national population from 2015-16 to 2024-25, using 2015-16 as the reference year.*

1 Stats NZ. *Population*. March 2026

At the same time, the patients arriving are requiring more urgent emergency and complex care, reflected in the triage categories used to prioritise them. Triage is how EDs manage patients presenting with a wide range of health conditions and symptoms. The ATS is the clinical tool used to prioritise patients according to urgency, with categories 1 to 3 covering patients requiring an immediate to urgent clinical response and categories 4 to 5 covering semi-urgent to non-urgent presentations.[2]

The proportion of patients triaged ATS 1 to 3 rose from 55 per cent to 66 per cent between 2015-16 and 2024-25 *(Figure 2)*. Two in every three patients arriving at an ED now require immediate to urgent care once assessment is complete. Some of this shift may reflect a change to triage practice and documentation.

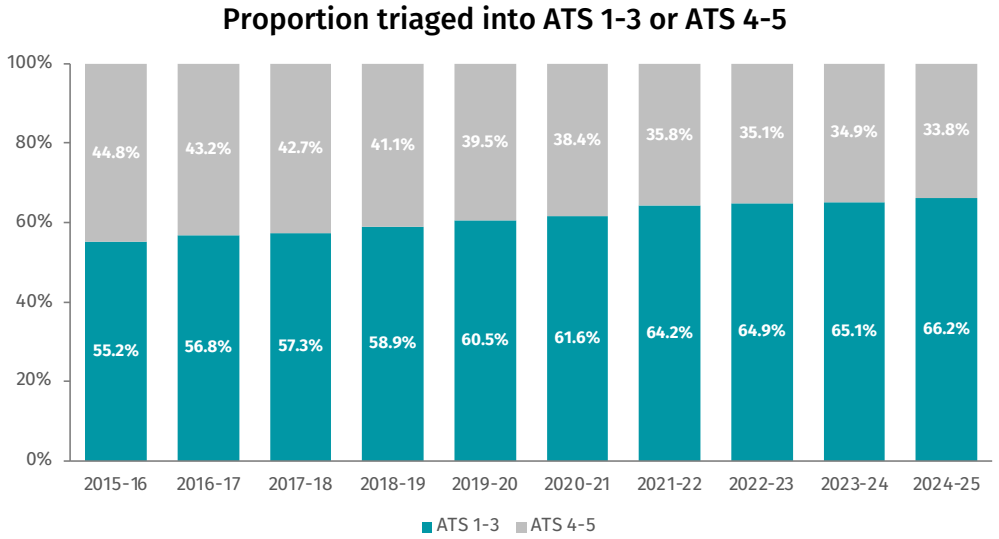

Figure 2: *Proportion of patients triaged into more urgent (ATS 1-3) and less urgent (ATS 4-5) triage categories, between 2015-16 and 2024-25.*

Patients classified in ATS 1-3 typically require more urgent and complex care, often spending longer in the ED and occupying treatment spaces for extended periods. Their care frequently requires senior clinical oversight, specialist emergency care, nursing support, diagnostic services and, very often, timely access to an inpatient bed once assessment is completed. On this last point, the system is failing most visibly.

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, transferred to another hospital or who died in the ED.[3]

Inpatient bed capacity has not kept pace with demand

A major factor driving access block is that inpatient bed supply has not kept pace with demand. Aotearoa New Zealand's bed supply has been shrinking on a population-adjusted basis, even as an ageing population drives greater volume, acuity and complexity of acute care needs. This lack of investment in inpatient beds reduces timely transfer from the ED for patients requiring admission leading to access block.

2 Australasian College for Emergency Medicine. G24 *Guidelines on the implementation of the Australasian Triage Scale in emergency departments*. November 2023

3 Australasian College for Emergency Medicine. P02 *Policy on Standard Terminology*. 2025

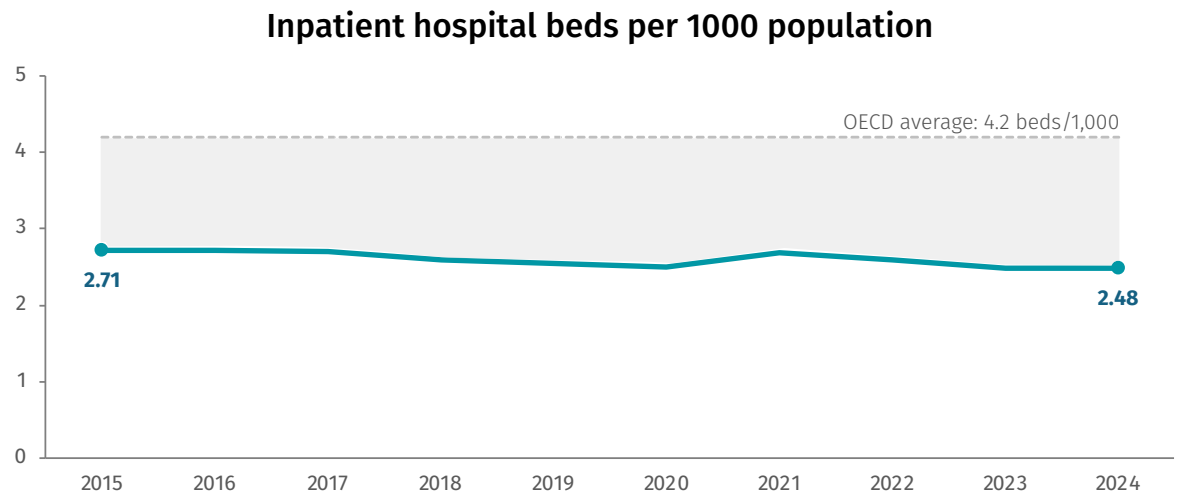

Figure 3: *Inpatient bed supply per 1000 population in Aotearoa New Zealand, 2015-2024.*

Between 2015 and 2024, inpatient bed supply fell from 2.7 to 2.5 beds per 1000 population *(Figure 3)*[4]. This indicates that, while the absolute number of hospital beds increased, it did not keep pace with population growth at a time when both the demand for, and complexity of, ED care was rising. This places Aotearoa New Zealand well below the Organisation for Economic Co-operation and Development (OECD) average of 4.2 beds per 1000 people in 2023.[5]

Alternative service provision – such as ED short stay units, telehealth and virtual care and urgent care centres – may be easing pressure on ED overcrowding by providing appropriate pathways for patients with lower-urgency conditions who do not require emergency care. These alternative services may assist in meeting the lower urgency unmet demand, however they do not address rising levels of patient urgency.

More patients are being categorised as ATS 1-3, the cohort most commonly associated with hospital admission. The system continues to receive more patients requiring admission than it can safely absorb. This is creating rising levels of access block, as inpatient capacity is insufficient to meet demand, leading to longer waits in EDs for patients who need to be admitted to another part of the hospital.

ED Length of Stay

Patients are staying longer in the ED. Length of stay (LoS) – the time a patient spends in the ED from arrival to admission or discharge – is a key marker of system pressure. As presentations grow in volume, acuity and complexity, hospitals are less able to move patients through the ED promptly, extending patient LoS.

Health New Zealand's Shorter Stays in Emergency Departments target measures patient LoS directly, aiming for 95 per cent of all patients to be admitted, discharged or transferred within six hours. ACEM's Hospital Access Targets takes a more nuanced approach, recognising that patients follow different clinical journeys and that a single time target cannot accurately capture this variation. ACEMs Hospital Access Targets set separate benchmarks, aiming for 95 per cent of discharged patients and 80 per cent of admitted or transferred patients to leave the ED within six hours. Neither of these targets is currently being met nationally.

4 Organisation for Economic Co-operation and Development. *Hospital Beds*. 2024
5 Organisation for Economic Co-operation and Development. *Health at a Glance 2025:* OECD Indicators. 2025

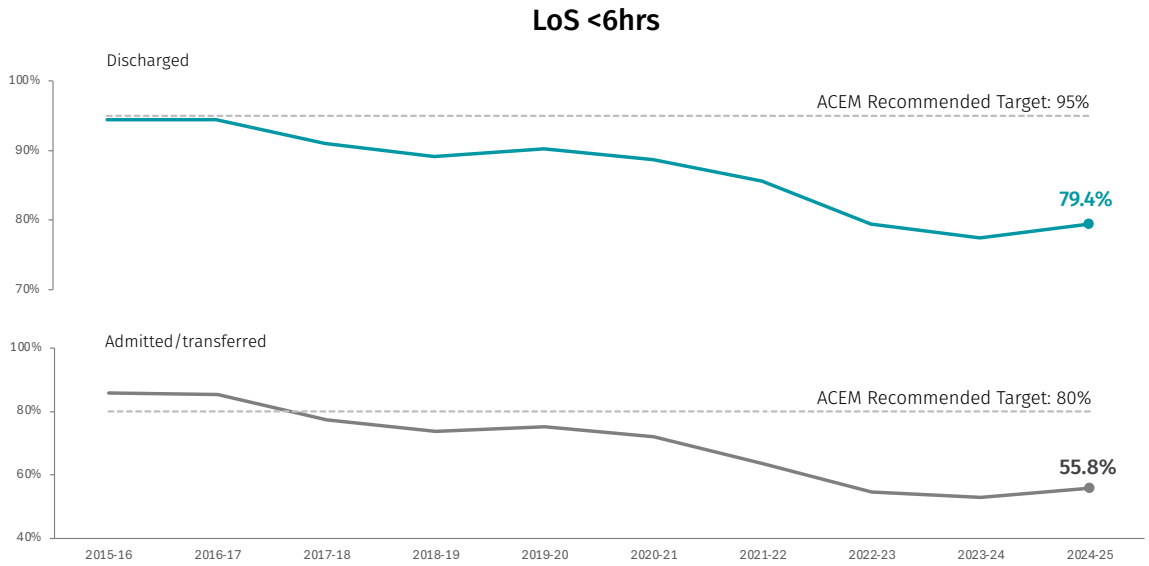

Figure 4: *Proportion of patients with an ED length of stay of six hours or less, by disposition, 2015–16 to 2024–25. Dotted lines show ACEM's Hospital Access Targets.*

The proportion of admitted and transferred patients with an ED LoS of six hours or less has declined steadily since 2015-16, and far more sharply than for discharged patients (*Figure* 4). This uneven decline has widened the gap between the two groups, a pattern consistent with a bed-constrained system.

A further sign of this pressure is the proportion of patients who left before treatment was commenced or completed, which rose from 4.0 per cent to 7.5 per cent of patients over the decade. Patients who leave before treatment commenced (or did not wait) are a recognised measure of ED overcrowding. A survey of Aotearoa New Zealand EDs found the rates of those who leave ED prematurely significantly correlated with under-resourcing, a lack of doctors and a lack of beds relative to the population.[6, 7]

A system under strain is failing several groups in particular

Demand on the health system is growing faster than its capacity to respond, with several distinct groups absorbing the consequences the most. Older people often require more time-intensive and complex care and, more often, a bed outside of the ED that the system does not have the capacity to provide. People living in rural communities are left underserved compared to those living in urban areas. The final priority section in this report focuses on Māori as a population the health system underserves.

Another population, people in mental distress, are not discussed in this report. The deficiencies of the health system in caring for this population are profound, well-documented and warrant a separate, standalone analysis. ACEM also recognises that the government has recently adopted a new mental health strategy and implementation plan and, at this stage, it is too early to provide further feedback on how that strategy will address the problems in accessing mental healthcare.

Older people

Advances in modern medicine mean people are living longer, which means they rely on the health system for more years than any previous generation. New Zealanders aged 65 and over made up 17 per cent of the population in 2024 and will exceed 20 per cent by 2034.[8] In 2024-25, this group accounted for 27 per cent of presentations to EDs *(Figure 5*). Additionally, one in three hospitalisations is for someone in this age group.[9] This is a symptom of a system that has not planned for the outcomes of demographic and technological change.

6 Morley C, Unwin M, Peterson GM, Stankovich J, Kinsman L. Emergency department crowding: a systematic review of causes, consequences and solutions. *PLOS One*. August 30, 2018.
7 Jones P, Faure S, Munro A. Variation in resources and impact on performance: results of the emergency department benchmarking survey. *NZ Med J.* 2021;134(1540):64–75.
8 Health New Zealand | Te Whatu Ora. *Health and Independence Report 2024.* Wellington: Health New Zealand; 2025.
9 Health New Zealand | Te Whatu Ora. *Hospital events web tool.*

Older patients often present with multiple and more complex conditions that take longer to assess and are more likely to require admission into hospital.[10] Many have extended hospital stays, even after they have been medically cleared for discharge. Older patients often remain in hospital for days, weeks and, in some cases, months, not because they need acute care, but because there is nowhere else for them to go. Aotearoa New Zealand faces a projected shortage of almost 12,000 aged residential aged care beds by 2032, with wait times in 2023 for high-priority placement between 92 and 219 days depending on the region.[11] When an aged care bed does not exist, an inpatient bed cannot be freed, and a vicious cycle begins. The cost is carried by the next patient, left waiting in the ED, the waiting room or still in the community. These costs then ripple outwards, leading to longer waits throughout the system.

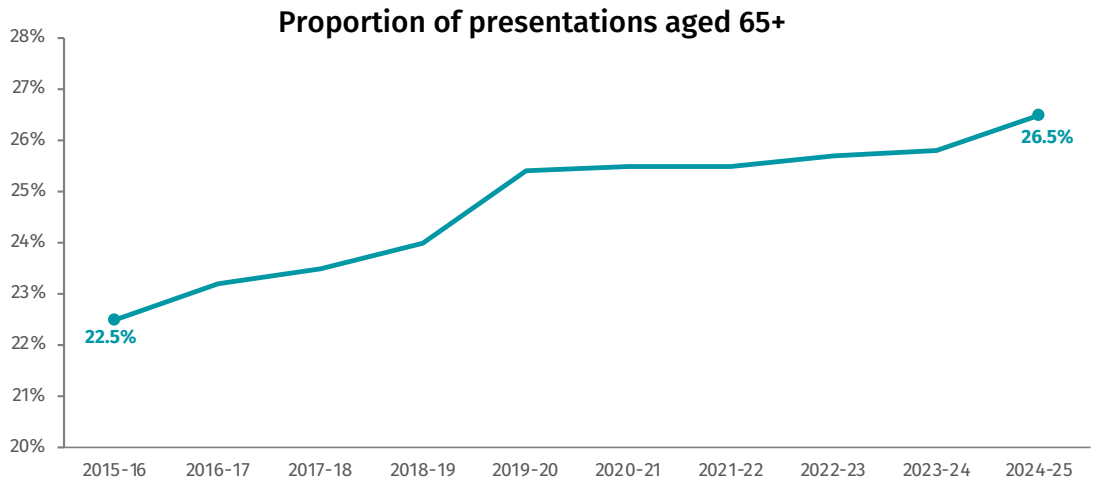

Figure 5: *Growth in emergency department presentations by older patients, 2015–16 to 2024–25.*

Rural communities

Beyond regional differences, geography compounds the pressures described earlier. Rural EDs see a higher proportion of Māori patients, an older patient profile and faster presentation growth than urban EDs (*Table 1*).

Table 1: Presentations to urban vs. rural EDs

Characteristics and time-based performances	Urban EDs	Rural EDs
10-year presentation growth	+15.4%	+28.9%
Self-identified as Māori	17.8%	29.5%
Those aged 65+	25.5%	28.0%
Classified as higher urgency ATS 1–3	69.4%	62.0%
Discharged patients with ED LoS less than 6 hours	72.6%	87.2%
Admitted or transferred patients with ED LoS less than 6 hours	54.2%	58.2%

Note: Urban EDs refers to those located in Urban 1, and Rural EDs refers to those in Urban 2 and Rural 1-3 areas.

Rural EDs are absorbing the fastest growth in demand while serving a population with proportionally more Māori and older patients, up 28.9 per cent over the decade compared to 15.4 per cent in urban EDs. Workforce undersupply is worse in rural areas and the ability of rural hospitals to look after the most complex cases is more limited than that of urban facilities. This growth is compounding existing inequity, with Māori communities particularly affected by systemic gaps in the health system. This is addressed in the report's dedicated section for Māori health equity.

10 Australasian College for Emergency Medicine. *P51 Policy on Care of Older Persons in the Emergency Department.* April 2021
11 Moore D, Loan J, Rohani M, Trill R et al. *A review of aged care funding and service models.* 16 January 2024

The LoS figures appear to show rural EDs performing better, however this can be misleading. Rural EDs generally have smaller patient volumes and more limited inpatient capacity compared to larger urban hospitals. Complex patients are often triaged and transferred directly from rural hospitals to urban centres. Some are sent to urban centres after retrieval, bypassing rural EDs when their capacity does not meet the most complex case needs. All of this understates the true pressure on rural EDs. Once this is accounted for, the admitted and transferred figure of 58.2 per cent within six hours is only marginally ahead of the urban rate of 54.2 per cent, despite that lower acuity mix. Even though rural EDs see fewer of the most complex cases, they still only meet the target for less than 60 per cent of patients.

Access to primary care is also more limited in rural communities, which has a knock-on effect on EDs. Patients who do not have a regular primary care provider lack continuity of care and the long-term health benefits that provides. These benefits include better management of identified chronic conditions, preventive care and early intervention, and opportunities for ongoing health promotion. EDs tend to become the safety net for patients not served by this essential part of the healthcare system. Any commentary reflecting on the challenges in rural EDs must acknowledge the vital role of rural primary care.

Out-of-date digital infrastructure needs modernisation

Pressure felt within EDs is compounded by outdated hospital IT systems that often cannot communicate across different healthcare services. This shows up on the floor as clinicians re-entering the same patient information across multiple systems that don't talk to each other, chasing paper results and making decisions without being able to see a patient's full history. Every minute spent on this administrative load is a minute not spent on patient care, and every gap in a patient's history impacts the safety of the decision being made.

ACEM recognises that the government is attuned to this need and is in the early stages of a national transformation plan.[12] It is crucial that this plan be effectively implemented. Better and more reliable data infrastructure allows for improved decisions, enabling hospital systems and government to more effectively allocate resources to areas of greatest need, with speed and accuracy. Specifically, this plan must include initiatives to better integrate Electronic Medical Records (EMRs) with pharmacy, laboratory and radiology services.

Funding has grown, but not in step with demand

The government points to record health funding as evidence the system is being adequately resourced. On paper, this is true. Core Crown health expenses were $17.2 billion in 2017-18 and $18.3 billion in 2018-19,[13] growing to a budgeted $33.4 to $34.2 billion by 2026-27 – almost doubling in nominal terms.[14] Figures are presented as a range to accommodate different accounting methods.

However, nominal figures alone do not show whether funding has kept pace with demand. Between 2018 and 2026, Aotearoa New Zealand's population grew from around 4.9 million to 5.4 million people, an increase of more than 10 per cent.[1] Over the same period, the number of people aged 65 and over, who account for a disproportionate share of hospital and ED presentations, grew faster still: from 15 per cent of the population (approximately 735,000 people) in 2018 to 17.4 per cent (approximately 931,000 people) by 2026, and on track to pass one million by 2028.[15] [16] A doubling of nominal funding looks different once set against a population that is both larger and older.

Measured against the cost of population growth, ageing, and rising wage and input costs, Aotearoa New Zealand's health system was underfunded by an average of $3.2 billion a year between 2010 and 2017 (in 2025 dollars), a shortfall that accumulated to around $33 billion in underinvestment between 2009–2018.[17, 18] By a separate measure, Aotearoa New Zealand's health spending share of GDP (7.4 per cent from 2023 to 2025), still trails the 7.7 per cent average of 16 comparable countries, a gap worth an estimated $1.1 to $1.2 billion in 2025 alone.[18] This problem is growing, not shrinking, despite nominal increases in topline funding figures. More funding will produce real value – more beds, more staff, more services – the benefits of which will be seen and felt by both patients and hospital staff.

12 Health New Zealand | Te Whatu Ora. *Health Digital Investment Plan*. 2025
13 figure.nz. *Core Crown spending on health in New Zealand*. 2026
14 Ministry of Health. *Health funding trends. 2026-27 Vote Health funding compared to 2025/26*. 2026
15 Stats NZ. *National population estimates: at 30 June 2026*. 2026
16 Stats NZ. *One Million People Aged 65+ by 2028* [Media release]. Wellington: Stats NZ; 2026.
17 Cumming J, Rosenberg B. *How much funding is needed for Health in the 2026 Budget?* The Post. May 27 2026
18 Tenbensel T, Rosenberg B, Cumming J, Lorgelly P. *NZ's health spending isn't enough for current needs, let alone future ones, researchers say.* The Conversation; 24 June 2026.

Recommendations

- Increase investment in inpatient capacity across the hospital system to ease the effects of access block.
- Expand investment in specialist aged care facilities and community partnerships, so older patients with complex needs can remain in the community or be discharged quickly and safely when hospital care is required.
- Continue upgrading digital health infrastructure, including integrated ordering systems for laboratory, radiology and pharmacy, and tools to support efficient clinical documentation.
- Replace the Shorter Stays in Emergency Department targets with ACEMs Hospital Access Targets to expose blockages across all patient streams and drive accountability at a whole-of-hospital level.
- Mandate clinical input in patient flow decision-making at every level so decisions are driven by clinical need.

Members share their experiences and insights

Unprecedented pressures in EDs throughout Aotearoa New Zealand are not abstract. They are felt acutely by emergency medicine specialists. In this report we interview three emergency medicine physicians who share their experiences and insights on emergency medicine in Aotearoa New Zealand.

All three interviewees described emergency medicine as a rewarding specialty. Yet every day they are up against systemic barriers beyond their individual control to provide the care their patients need. Their personal accounts reveal a committed and dedicated workforce that continues to look after everyone while being increasingly required to compensate for failures in the hospital and other parts of the health system.

Emergency medicine – 'the specialty that looks after everyone'

The opportunity to work in a strong public health system was a compelling reason why Dr Rebecca (Bex) Goodwin chose to move from the United States to Aotearoa New Zealand two years ago.

Dr Goodwin received her medical degree from the University of Washington and completed a combined residency in Internal and Emergency Medicine at Virginia Commonwealth University.

She is now based at Gisborne Hospital and will gain her fellowship in 2027.

Emergency medicine appealed to her for many reasons.

'It's the specialty that looks after everyone regardless of their ability to pay. Emergency medicine is the ultimate equaliser. Also, working in the ED is team-based and you have close working relationships with all your colleagues.'

She was especially keen to work in a smaller regional hospital and, after visiting different parts of Aotearoa New Zealand, decided Gisborne was the ideal place to settle with her family.

'Gisborne is the most amazing community I've ever been part of. The people here are like nowhere else. Tough as nails yet warm, friendly and accepting. We immediately felt at home. My colleagues are my friends, my patients are my neighbours, my friends are my family. I feel like I can be the doctor and the person I want to be.'

Dr Goodwin loves her profession, including the variety of presentations and the team-based approach, but said that the pressure on EDs has risen dramatically in the past two years.

'I think Gisborne is a microcosm for what is happening across New Zealand,' she said. 'Our volume of patients has increased and every day is just busier. When you begin your day the ED is already full, including patients waiting from the night before.'

Regular workforce shortages are also increasing the pressure on the ED and have made it more difficult to cope with rising demand. Even though she is on parental leave, Dr Goodwin has been working in the ED to cover for colleagues who have had to work many extra shifts and need a break.

'You want to preserve your colleagues and help them to avoid burnout,' she said.

Dr Goodwin, who was the recipient of the Peter Freeman 'Making a Difference' Award at last year's ACEM Aotearoa New Zealand Emergency Medicine Conference, held in Gisborne, said that having enough trainees in the ED is often undervalued.

She was heartened that the head of department at Gisborne Hospital had focused on increasing the number of trainees in the ED to support the needs of patients.

‘That perspective from learners keeps senior medical officers (SMO) on our toes,’ she said.

‘Learners keep us up to date. You can’t think, “This is how I’ve always done it”, when you have a learner asking you why. As an SMO you want to be teaching trainees the latest evidence-based practice and modelling the highest level of care.’

Dr Goodwin said that workforce retention remains a big challenge, especially as the ED is constantly short-staffed and stressed.

‘It’s getting harder. I moved here because of the lifestyle, but when you begin to lose the lifestyle there are days you ask yourself – why am I choosing this?’

She holds the firm view that you need to make the job better to improve workforce recruitment and retention. Her two key recommendations are to pay a competitive salary and to employ more staff in the ED to reduce pressure.

‘Both require investment,’ Dr Goodwin said.

These workforce pressures come at a time when EDs are operating at or over capacity and are increasingly unable to move patients into wards due to a lack of inpatient beds. This leaves the ED to manage the repercussions of access block, including looking after patients in a corridor until an inpatient bed becomes available.

Dr Goodwin worries about both patients and staff. ’It can be traumatic for patients as they hear and see all the chaos of the ED. It’s not ideal. There is no privacy for the patient. You can’t provide appropriate care in that environment, and ironically sicker patients who need beds and/or monitoring are often left waiting.’

Long ED waits and bed block are impacting patients and their families, as well as the ED team. ‘It’s just a bad situation for everybody,’ she said.

‘The data and research are clear – people waiting a long time in the ED can die. We know the longer they are waiting in the ED the worse their mortality risk is. It’s particularly pronounced for critically ill patients and older vulnerable patients.’

Dr Goodwin knows that ED staff are particularly fearful of what may happen to those who are forced to wait for a long time in the waiting room. ‘Someone may have evolving chest pains, or something vague which then becomes life threatening,’ Dr Goodwin said. ‘But there are so many patients waiting you just don’t know.’

ED stress is also amplified by the mounting frustration of patients who face long waits, which she feels is totally warranted, but fears its consequences. ‘It ramps up a sense of injustice and anger from patients and that stress and discomfort is borne by our staff,’ Dr Goodwin said.

While Gisborne Hospital does not often have the ten hour plus wait times experienced in larger hospital EDs, it is frequently overwhelmed.

Patient access and flow challenges are not caused by the ED and do not start there, but the people in the ED live with the daily consequences. Dr Goodwin believes improving communication between inpatient and outpatient realms could alleviate significant challenges such as improving medication reconciliations, seeing what changes GPs or inpatient teams have made to a patient’s journey, following up on a result or hospitalisation or referral.

‘All this work is arduous and time consuming in our current digital settings and capabilities. Furthermore, many patient’s are admitted to hospital as it is too difficult to coordinate their care as an outpatient. Others return due to medication confusion. It’s no wonder patients become frustrated when their doctors can’t get on the same page.

‘Strengthening community pathways and outpatient alternatives is so important,’ she said. ‘But right now the system is burdensome and all of us fear patients getting lost in the system.’

‘At the end of the day the ED will be there for you. It’s who we are. But we need the healthcare system to be there for us, otherwise we won’t be able to help everyone when they need us most.’

Workforce

The people who keep emergency departments running

The emergency medicine workforce is critical to improving the emergency care delivered across Aotearoa New Zealand, but it is under sustained strain. This is becoming evident in the numbers that matter. The local trainee pipeline is not keeping pace with Fellow of the Australasian College for Emergency Medicine (FACEM) growth, with international medical graduates (IMGs) now making up 57 per cent of the specialist workforce, and nearly a third of FACEMs reporting that they intend to retire within the next decade.[19, 20]

The current emergency medicine workforce

FACEMs are the most senior clinicians in an ED: those who have completed five to seven years of specialist emergency medicine training beyond medical school and who hold ultimate clinical responsibility for ED patients. There are 461 FACEMs in Aotearoa New Zealand, alongside a further 178 FACEM trainees. Trainees are clinicians enrolled in the FACEM Training Program, who work under FACEM supervision while completing the requirements for fellowship. Trainees are also referred to as registrars. FACEM and FACEM trainee demographics are shown in Table 2.[19]

Table 2: Aotearoa New Zealand FACEMs and trainees, December 2025

	FACEMs	FACEM trainees
Total	461	178
Female	210 (45.6%)	104 (58.4%)
Average age	48.0 years	34.6 years
Self-identify as Māori	17 (3.7%)	11 (6.2%)
International medical graduates	261 (56.6%)	73 (41.0%)
New in 2025	34 (7.4%)	39 (21.9%)
Withdrawals/retirements in 2025	7 (1.5%)	11 (6.2%)

Note: International medical graduates refers to those who obtained their primary medical degree outside of Australia and Aotearoa New Zealand.

Overreliance on international recruitment

In 2025, 34 new Fellows were credentialled against seven withdrawals or retirements, a net gain of 27 FACEMs.[19] However, this growth does not mean the workforce is secure. This growth is unevenly distributed, increasingly dependent on factors Aotearoa New Zealand does not control and not supported by growth in the pipeline behind it.

IMGs make up 57 per cent of Aotearoa New Zealand's FACEM workforce, higher than ACEM's overall fellowship average of 44 per cent.[19] This has shown sustained growth to date, but it leaves the workforce exposed to shifts in immigration settings and global competition for specialist doctors, both of which are outside the country's control.

The trainee pipeline itself is an additional, long-term vulnerability. The number of ED presentations has reached a record high over the past decade. However, the trainee cohort, the total group of trainees active in the programme at a given time, has not grown with them, and has declined slightly since 2019.[19] More trainees are needed simply to keep pace with demand already in the system, before any further growth is accounted for. Growing that pipeline depends on conditions inside the ED, and whether trainees want to enter the specialty and remain there.

19 Australasian College for Emergency Medicine *ACEM Membership and Trainee Demographics and Workforce.* 2025.
20 Australasian College for Emergency Medicine. *Sustainable Workforce Survey Report.* Melbourne: ACEM; 2025.

This shortage falls hardest outside the major centres. Rural EDs operate with fewer than half the ED specialist full-time equivalent (FTE) of urban sites, rely more heavily on locums, and each rural trainee manages nearly twice the presentation load of their urban counterparts.[21] ACEM leads in delivering a range of programs focused on rural training, with the long-term goal of sustainably supporting rural EDs and addressing the maldistribution of the ED workforce that sees many rural hospitals facing a chronic struggle to attract and retain staff. Funding programs that are proven to work can directly address some of the issues of workforce shortages and misallocation.

Burnout has risen, while full-time employment has fallen

In 2025, almost 200 FACEMs and trainees (approximately one-third of the Aotearoa New Zealand workforce) responded to ACEM's Sustainable Workforce Survey. Comparing this against the 2019 survey shows a workforce under immense strain. Personal and work-related burnout are reported by more than half of the workforce. Discrimination, bullying and sexual harassment (DBSH) by patients and carers remains high. However, in positive news colleague-related DBSH has reduced significantly. The proportion of respondents working part-time hours has more than doubled with nearly three-quarters planning to reduce/further reduce their hours of clinical practice *(Figure 6)*.[20]

In addition, respondents were asked to provide the leading causes of stress in their workplace; ED overcrowding, staff shortages and access block were the most common responses.

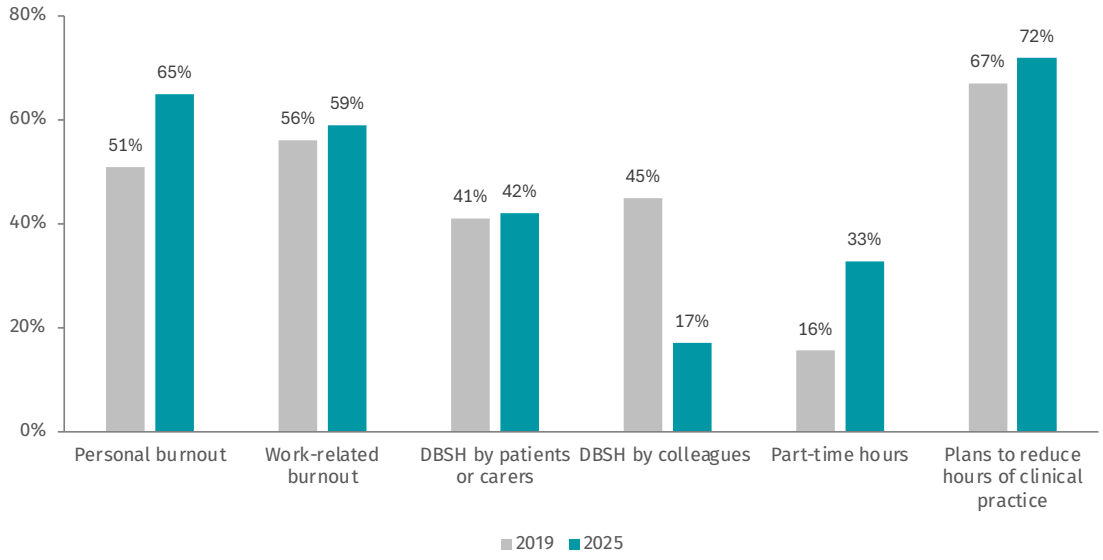

Figure 6: *Key findings from ACEM's Sustainable Workforce Survey, 2019 vs 2025.*

Patient flow and workforce sustainability are inseparable. A FACEM caring for patients in a corridor because no inpatient bed is available is forced to work in conditions that compromise safe and dignified care. This creates moral injury as clinicians are held responsible for outcomes arising from circumstances they have no power to change. The personal and professional consequences of a system struggling to remain functional are transferred to those working within it. Burnout is not an individual failing; it is the predictable result of sustained and unresolved systemic pressure. When these conditions persist, clinicians may ultimately have little choice but to reduce their hours or leave the profession altogether.

The data also reveals another strategy clinicians use to protect themselves: reducing their hours. Flexibility has long been one of emergency medicine's strengths. Part-time work chosen to accommodate parenting, further study, or a more sustainable work-life balance should be regarded as a feature of the specialty, not a workforce problem. Increasingly, however, FACEMs are reducing their hours not by preference, but simply to remain in the job.

21 Australasian College for Emergency Medicine. *ACEM Annual Site Census*. 2025.

When experienced clinicians reduce their FTE to cope with the pressure, headcount no longer reflects the workforce's true clinical capacity. A specialist working 0.6 FTE to protect themselves from burnout does not provide the same coverage as a full-time specialist. A workforce structured in this way therefore requires more people merely to maintain the same level of clinical coverage.

This is the cycle traced by the data. Overcrowding and access block drive moral injury and burnout. Burnout leads clinicians to reduce their hours or leave the specialty early. The resulting loss of workforce capacity places even greater pressure on those who remain, further worsening overcrowding and access block.

Recommendations

- Invest in emergency medicine training and retention to meet national workforce need.
- Support ACEM's commitment to rural FACEM training by increasing and investing in training opportunities outside of urban areas, using innovative and flexible delivery models.
- Retain all current and future domestically trained and IMG specialists across their full careers, with long-term investment in the existing workforce being more cost-effective than relying on short-term staffing solutions.
- Streamline recruitment and support for qualified IMGs as an interim measure of increasing human resources while domestic training pipelines are strengthened.
- Set requirements to increase the number of Māori specialists in the health system in line with the parity targets ACEM has committed to through Te Rautaki Manaaki Mana, backed by targeted investment.

Workforce capacity ‘an ongoing challenge’

FACEM Dr Harriet Harper, an emergency medicine specialist at Nelson Hospital, enjoys the variety of patient presentations to the ED and applying practical skills and knowledge to time-critical cases.

‘I’m a very curious person, so emergency medicine suits me perfectly.’

Dr Harper, who did most of her training at Christchurch Hospital, said she likes working in a regional hospital where she knows nearly everyone in the hospital and the community.

‘I always felt that Nelson is where I belonged. I’m also a mountain biker and we have excellent mountain biking trails.’

Dr Harper gained her Fellowship in 2018 and, reflecting on the changes she has experienced in the ED over the past decade, said the pressure had grown significantly, as had the emotional toll.

‘I feel quite anxious coming to work a lot of the time,’ she said. ‘There is immense pressure to get a lot done in a short space of time, but some things need to take time.

‘People are waiting for you to help them, but you know you only have a certain amount of time. You’re trying to work out how you can balance giving a patient your full attention, the time and support they need, versus a lot of people in a small amount of time.’

She said it was heartbreaking to see patients waiting for hours in the ED, especially older patients who needed an inpatient bed.

‘Older patients have more complex needs and comorbidities. They are stuck in the ED, and it is not the best environment for them,’ Dr Harper said. ‘For example, we don’t get meals delivered because we are not a ward. ED was not designed for the long stay.’

Dr Harper said she had seen an increase in the number of patients being cared for in corridors. Corridors are often the only available physical space, due to limited ED clinical spaces to look after a rising number of patients coming into the ED, as well as a shortage of inpatient beds for those needing to be admitted to a ward.

Dr Harper said older patients were often stuck in hospital when they were medically ready to leave but could not be safely discharged due to a lack of residential aged care beds or community support to return home.

Every ED is different and has its own issues, she said, but the issue affecting every ED in the country is the longstanding underinvestment in primary care, community care and residential aged care.

‘People are often unable to access timely care in the community,’ Dr Harper said. ‘We need to strengthen non-ED contact points for primary, community and residential aged care.’

She said residential aged care was particularly challenging. While some GPs provide services to residents in aged care this is not consistent, as there isn’t adequate government funding to provide this type of care in every community across the country.

‘It’s not a 24/7 service so there are gaps which the ED picks up,’ Dr Harper said.

The lack of after-hours addiction and mental health care services is another pressure point on the hospital, as patients present to the ED, but the ED cannot refer them unless they meet a very high threshold to access these services.

‘We work closely with our local mental health services, and this has improved coordination and care, but it is a work in progress. The ED piloted and continued an Intentional Peer Support team based in the ED which has been hugely successful. Part of the success is that the Peer Support team is already established in the community, so can provide out-of-ED-follow-up and support for people who come to ED.’

Dr Harper added that their flexibility and broad scope means the Peer Support team supports people who are suicidal, anxious as part of cognitive impairment, and people and their whānau who had just been told they have cancer.

Nelson ED has increased senior medical officer FTE and allied health positions following a Nelson Hospital review undertaken by Health New Zealand and funding by the government last year.

'It's been helpful to keep up with the pace of demand. We're in a better position but continue to struggle when other services are short staffed. We're dependent on the rest of the health system working effectively,' Dr Harper said.

She agrees that regional hospitals struggle to recruit more than their urban counterparts, however this has been less of an issue in Nelson.

'The people I work with are committed to living here, they love the lifestyle. It's understood the job will be more challenging because it's a smaller hospital,' she said.

'As a team we have focused on what makes us enjoy work. We decided to put most of our effort into offering a great training and working experience for our trainees. It drowns out the negative stuff and has helped to improve wellbeing.'

While the team has focused on the positives, she said securing an adequate ED workforce to meet rising patient demand is an ongoing challenge.

'This last year has been especially tough. We were short staffed and understaffed – not enough working hours in the team - and every shift was super intense, and you would be reeling for days afterwards,' Dr Harper said. 'We are in a constant surge state so anything that adds extra pressure, such as the peak flu season, takes us beyond the surge state we already work under.'

She can personally relate to emergency medicine physicians increasingly shifting to working part-time.

'I stepped down from my FTE role as head of department recently as work was taking all my energy and bandwidth. It was unsustainable,' she said. 'I needed to rebalance my life. It took a while to make my decision, but I realised there would never be a right time, and it had to be on my own terms.'

Dr Harper believes that offering greater work flexibility is key to growing the emergency medicine specialist workforce, so they can adapt to each stage of life and the commitments this brings, such as parental leave and return to work, and the late career stage.

Despite the challenges EDs and emergency medicine physicians face, Dr Harper said she would not hesitate to recommend the specialty to medical students.

'For those who love diverse challenges, problem solving on a grand scale, and are keen to move the specialty forward as we try to navigate where the specialty sits, it's exciting. Bring your energy but also look after yourself as it's a lot to take on all at once.'

Māori health equity

Achieving equity for Māori in emergency care

The te ao Māori approach to health has long shaped the goal of what good healthcare should look like for everyone in Aotearoa New Zealand. With physical, mental, spiritual and whānau wellbeing viewed together, practices such as whānau-centred models of care and collective approaches to wellbeing are recognised as markers of quality across the system. Quite simply, what is good for Māori is good for everyone, and lifting Māori health outcomes lifts the quality of emergency care as a whole.

The strengths that Māori communities bring to health are real, with whānau as the primary unit of care, whanaungatanga as the foundation of wellbeing and manaakitanga as the practice of caring for one another. Māori providers and communities have already designed models of care that put these values into practice, with these models built on Māori autonomy and leadership. A health system that works for Māori builds on these strengths.

ACEM's analysis is grounded in the principles of Te Tiriti – partnership, options, tino rangatiratanga, active protection, and equity – recognising Māori leadership in the design of models of care that work for Māori. Where the evidence identifies inequitable outcomes for Māori, ACEM presents these as indicators of health system failure and as a breach, where it occurs, of the Crown's active protection obligations under Te Tiriti. Where Māori experience inequity, this pinpoints where the system is failing. Conversely, where Māori leadership and Māori models of care improve outcomes, this shows the system working as it should. This is what ACEM supports.

Through Te Rautaki Manaaki Mana ('Te Rautaki'), ACEM has committed to addressing Māori health equity directly within the College's own control and by advocating for the policy and system settings required to achieve equitable emergency care.[22] ACEM supports Fellows, trainees and ED colleagues translating this commitment into practice through Te Rautaki, the strategic advice of the Māori Manaaki Mana Rōpū and the national Kaikōkiri network. Dedicated roles within ED such as Pou Mātanga (clinical nurse specialists) provide further Māori clinical leadership and support.

However, achieving equity in emergency care cannot rest on ACEM's efforts alone. Māori communities and clinicians have already identified what works. But funding for this work has too often been short-term and project-based, confined to pilots rather than embedded as core service delivery. What is missing is consistent, sustained investment to make this the standard of care rather than the exception.

Before turning to what this means in practice, we should highlight a caveat on the data used to show it. Asked to rate the quality of their Māori ethnicity data, only 25 per cent of ACEM-accredited EDs rated it excellent or very good, 40 per cent good, and 35 per cent fair or poor.[21] Failing to consistently identify Māori patients in ED data obscures the true scale of inequity and undermines the system's ability to monitor and correct it. This gap likely means the inequities reported below understate, rather than overstate, the true experience of Māori patients. A system serious about achieving equity should be equally serious about measuring it, as improving ethnicity data collection is itself part of delivering on Te Tiriti commitments.

With that caveat in mind, this section traces what the funding gap costs in practice; a Māori patient's emergency care journey through the health system, from presentation to discharge, showing where the system's failures compound inequity at each step.

The Māori patient journey

Presentation demand and unmet need

Māori presentations rose 39 per cent between 2015-16 and 2024-25 *(Figure 7),* almost double the 20.8 per cent growth in overall national ED presentations, pointing to unmet need accumulating in EDs rather than any increase in the underlying demand for emergency care. That gap reflects failures earlier in the system, not a change in Māori health needs. Where primary care is hard to access or afford, patients end up in EDs instead of being treated before a crisis develops. Where emergency services are not configured or resourced to match where Māori communities live, that mismatch itself drives presentations.

22 Australasian College for Emergency Medicine. *Te Rautaki Manaaki Mana: Excellence in Emergency Care for Māori 2026–2029.* Melbourne: ACEM; 2026

Māori now account for almost 23 per cent of all ED presentations, up from 20 per cent in 2015–16. The Māori population also grew rapidly over this period, up around 19 per cent (786,000 to 932,000) compared to a 13 per cent increase nationally.[1]

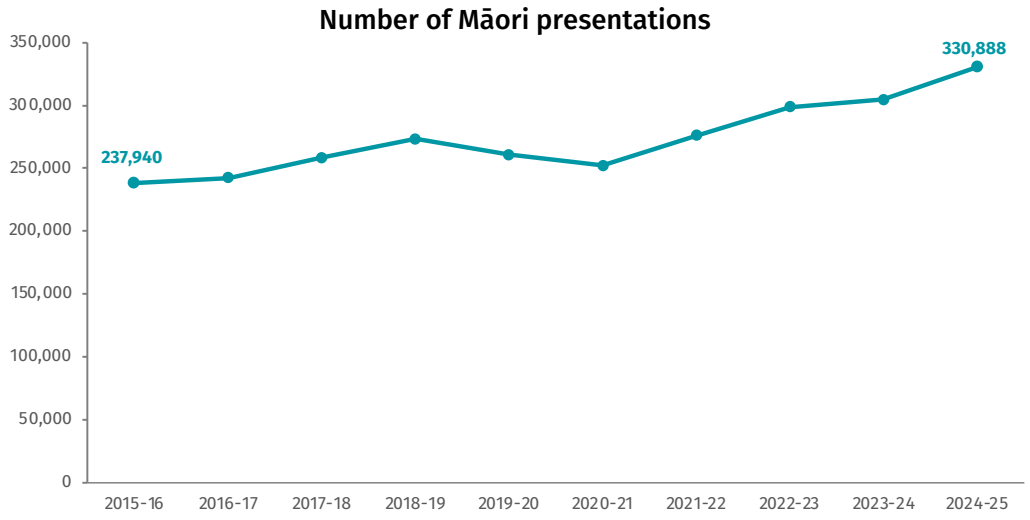

Figure 7: *Annual ED presentations by Māori, 2015–16 to 2024–25.*

The Māori population also skews markedly younger than the national average, with only 12.7 per cent of Māori ED patients aged 65 or over in 2024–25, compared with 30.6 per cent of non-Māori patients (*Figure 8)*. A younger, faster-growing population explains part of this scale but not its direction. Younger patients would typically be expected to use the healthcare system less and fare better through the system when they do go to ED, not worse.

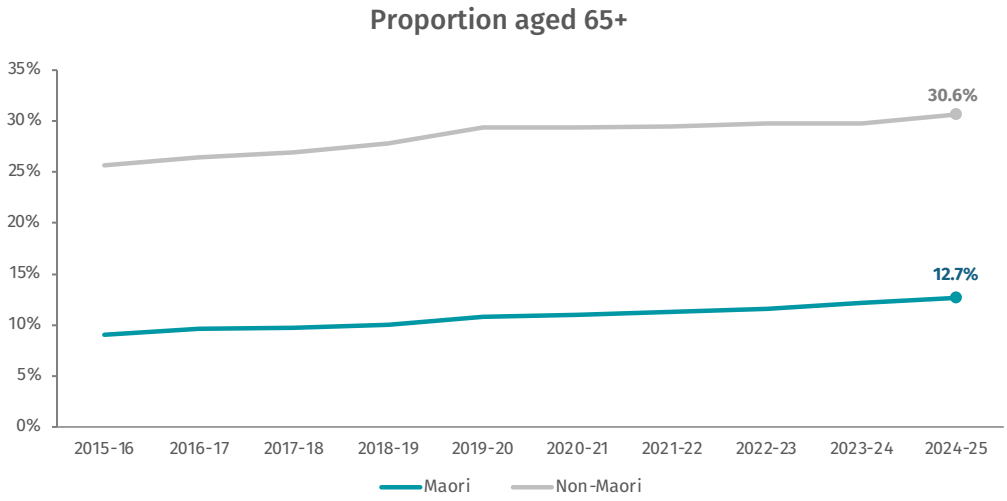

Figure 8: *Proportion of ED patients aged 65 and over, by ethnicity, 2015-16 to 2024-25.*

Māori patients are also less likely to be triaged into more urgent categories *(Figure 9)*, another factor that would typically predict better outcomes. Inequities in triage were not explained by ED process measures or comorbidities, reinforcing the need to investigate health professional bias and institutional racism in health care.[23]

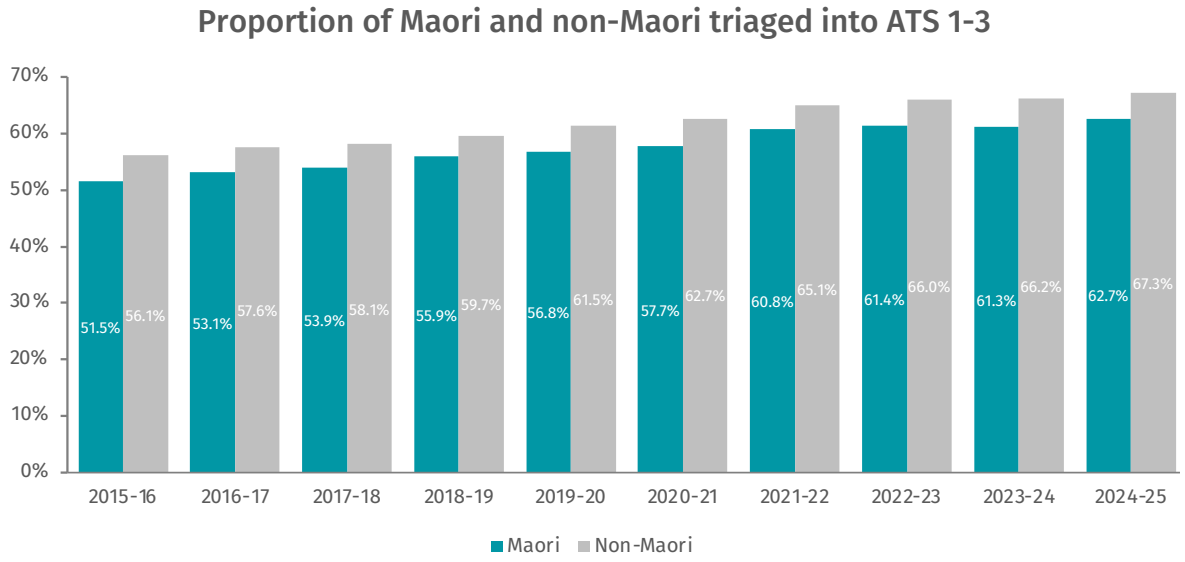

Figure 9: *Proportion of presentations triaged into ATS 1-3, Maori and non-Maori, 2015-16 to 2024-25.*

Emergency department length of stay

How long a patient spends in the ED, from arrival to departure, shows less evidence of a gap than earlier stages of the journey. Performance between Maori and non-Maori patients who are admitted, transferred or discharged, was broadly comparable in 2015-16 but gaps are growing over time *(Figure 10)*. However, this comparison should be read with care. Patients who leave before treatment is commenced or completed, outlined in the next section, fall outside the scope of ED LoS data. This data only reflects the experience of those who stay and is thus not proof of equal treatment overall. These figures are unadjusted. The younger age profile of Maori ED patients shown in Figure 8 is likely to account for some of this difference. The contribution of whānau-centred, Kaikokiri-supported models of care has not been formally evaluated.

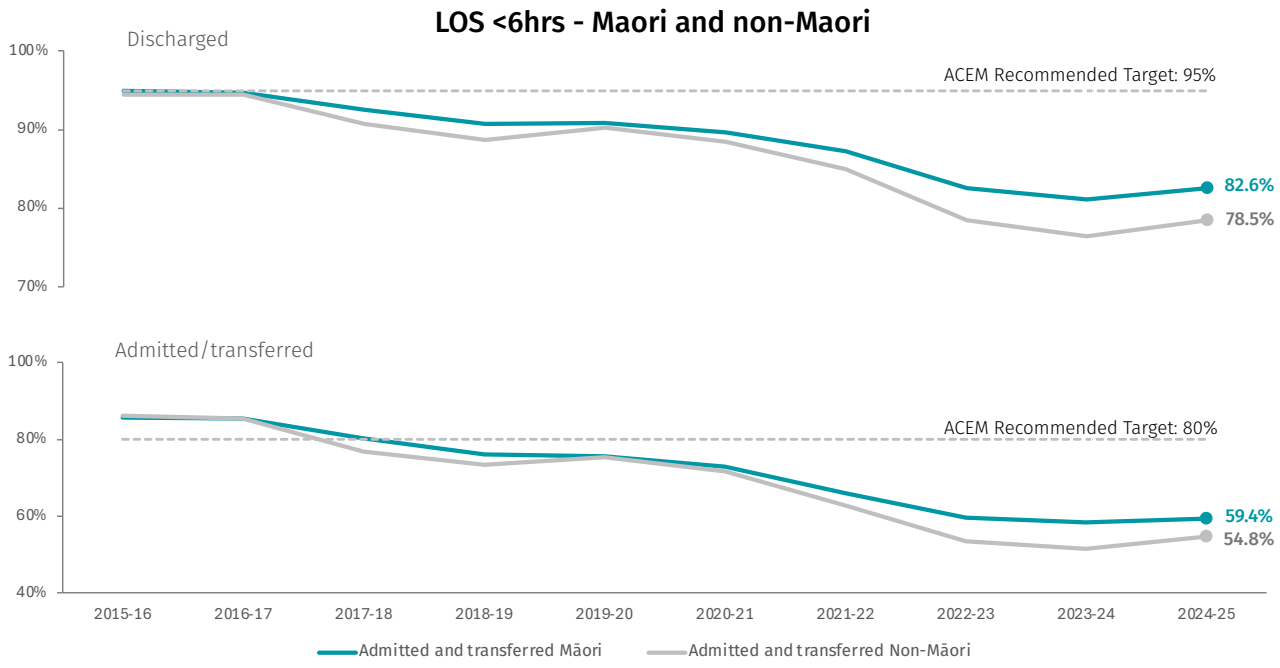

Figure 10: *Proportion of patients with an ED length of stay of six hours or less, by disposition and by ethnicity, 2015–16 to 2024–25.*

23 Curtis E, Paine S-J, Jiang Y, Jones P, Tomash I, Healey O, Reid P. *Examining emergency department inequities in Aotearoa New Zealand: findings from a national retrospective observational study examining Indigenous emergency care outcomes.* Emergency Medicine Australasia. 2022;34(1):16-23. doi:10.1111/1742-6723.13876 (online first 2021).

Leaving before treatment

For a substantial percentage of Māori patients, the ED encounter ends before they are even assessed. Barriers such as long wait times, lack of cultural safety, and poor communication lead some Māori patients to self-discharge before assessment is complete, and a significant number of these patients subsequently experience serious deterioration or leave without ever being formally diagnosed.[23] These are system issues that require system fixes, not an expectation that Māori patients conform to a system that was not designed for them.

Death after discharge

When two patients leave the same ED on the same day with the same condition, they should have the same chance of surviving the next 10 days. In Aotearoa New Zealand, they do not. Māori patients have a 60 per cent higher chance of dying within 10 days of leaving the ED compared to non-Māori patients, even after accounting for age, injury type, triage category, and existing health conditions.[23] This is despite Māori patients being younger and less likely to be triaged into urgent categories, both factors that would typically predict better outcomes, not worse.

Every stage of a Māori patient's journey has too often been ignored or explained away on its own, whether it be a lower-urgency triage category, a longer ED stay, a discharge that happened a little early, or an ED discharge that could have been a hospital admission. Together, their cumulative effect is a substantially higher risk of death for Māori patients, even after age, injury, triage category, and existing health conditions are accounted for. This is what access and flow pressures and an under-resourced workforce costs Māori patients, and why closing that gap is what health equity in emergency care actually means.

Māori workforce equity

Emergency care works best when its workforce reflects the community it serves. ACEM is working towards this for Māori patients, but attracting and retaining Māori doctors and nurses depends on capacity the system does not currently have.[24] The numbers show how wide that gap still is.

Only 3.7 per cent of FACEMs and 6.2 per cent of trainees self-identify as Māori, against a Māori population share of approximately 17.5 per cent.[21, 25] Only 11 of the 20 ACEM accredited EDs report having Māori medical staff, and only 12 report Māori nursing staff.[21] Left unaddressed, this gap is set to widen.

There are currently more Māori trainees close to finishing their training than there are starting it. A number will reach Fellowship soon, but recent recruitment has not kept pace, so today's workforce gains are not being sustained. This shortfall is being driven by three connected pressures. Overcrowded EDs leave supervisors managing flow rather than teaching (see Access and flow section), and burnout is already pushing experienced FACEMs out of supervisory roles (see Workforce section), so the system has less capacity to train the next generation, Māori or otherwise, just when it needs more of them. The third factor runs in the opposite direction. A system not yet safe or equitable for Māori patients will have difficulty recruiting Māori clinicians, which means workforce and equity gaps discussed in this section are self-reinforcing rather than separate problems.

ACEM's figures are themselves likely an undercount. As noted earlier, ACEM's ability to monitor and address these workforce gaps depends on the quality of the ethnicity data it collects, which is why improving this data quality is one of this section's core recommendations.

Alignment with Pae Tū: Hauora Māori Strategy

Pae Tū: Hauora Māori Strategy, the Ministry of Health's current strategy, requires Māori leadership in the workforce, culturally safe care, whānau-inclusive discharge planning, and data that makes Māori experience visible across the system.[26] Delivering on it requires partnership with Māori providers, iwi, and whānau in how emergency care is designed, options that support Māori models of care, and tino rangatiratanga, meaning Māori self-determination and leadership, in the decisions that shape them. ACEM is aware that a new Maori Health Strategy – Whiria Te Ora has recently been released to supersede Pae Tū over the coming five years.

24 Australasian College for Emergency Medicine. *S962 Aboriginal and Torres Strait Islander and Māori Workforce Parity in Emergency Medicine.* 2025.
25 Stats NZ. *Māori population estimates: Mean year ended 31 December 2025.* 2026
26 Ministry of Health, Manatū Hauora, and Te Aka Whai Ora. *Pae Tū: Hauora Māori Strategy.* Wellington: Ministry of Health; 2023. Published 12 July 2023, ISBN 978-1-991075-44-4 (online), HP 8808.

The answers already exist. Māori providers, clinicians, and communities have designed and run models of care that work, evidence that this section has already highlighted. What has been missing is sufficient government funding to make them the standard, not a one-off pilot renewed at the Crown's discretion. Under Pae Ora, Pae Tū, and Te Tiriti, that funding is not a favour. This funding is an obligation; however, it has not yet been met. As a medical college ACEM is doing what it can by embedding Manaaki Mana in ED practice, building the evidence base, and advocating for the system settings this requires. What follows is a set of recommendations to close that gap, as well as one Fellow's knowledge and insights on how to achieve this in practice.

> *"The successes are ours. The barriers are the system's. Our people are innovating, and doing it well, with very little. What stops the work is not a shortage of ideas or commitment. It is permanence and funding."*[27]

Recommendations

- Fund and deliver workforce education in cultural safety and Te Tiriti principles, incorporate Māori health priorities into the emergency medicine training curriculum, and mandate cultural competency training for IMGs across the health sector.
- Align budget and health system performance frameworks explicitly to Te Tiriti o Waitangi obligations and integrate Te Tiriti principles into health sector goals and targets.
- Fund Māori-led models of care already operating in EDs, including Kaikōkiri roles and whānau-centred discharge planning, as core service delivery rather than time-limited pilots.
- Invest in nationally consistent ED data collection with high-quality ethnicity data to support Pae Ora objectives, enable equity-focused monitoring and drive quality improvement.

27 Australasian College for Emergency Medicine. Manaaki Mana Kaikōkiri National Hui; 10–12 August 2026; Tangatarua Marae, Rotorua, New Zealand.

Health equity - ‘culturally safe care is everyone’s responsibility’

‘Your interaction with a patient can become etched into their memory, the story of their life’, reflects FACEM Dr Max Raos (Te Ātiawa), an emergency physician at Auckland’s Middlemore Hospital. ‘Many people’s best stories are about their ED experience.’

‘As a kid I went to Starship Hospital with a broken arm, and I still remember the treatment and interactions. For the doctors I may have been just another kid with a broken arm, but it’s part of my story. We can sometimes take this for granted as a specialty, but the meaning of these interactions for the patient and their whānau is what restores us.’

Dr Raos holds a Bachelor of Medicine and Bachelor of Surgery from Auckland University Medical School. He’s a father of four and his wife Amy is on the cusp of becoming a paediatrician. Max was inspired to study medicine after his older sister trained to be a doctor. A kid of the 1980s, he watched TV shows featuring hospital drama, as well as the series *MacGyver*, ‘where Mac used what was available to fix things against the odds’.

Dr Raos said that emergency medicine was not a focus for him until he began working at Nelson Hospital as a second-year doctor.

‘I started on nights, running the ED as a second-year doctor. It was harrowing, but the FACEMs helped and were really engaged. They provided oversight but also made me feel empowered.

‘I made decisions and could action them and be supported. I would ask, “How do you do this?” and I would be coached through it. And instead of triaging things to various specialties, I was doing a lot of hands-on medicine.’

Dr Raos, who has worked at hospitals in Aotearoa New Zealand and Australia, describes emergency medicine as dynamic and innovative.

‘The ED doctors I work with are receptive to new information - not completely flipping the script, but willing to try new things. As a relatively young specialty, we’re willing to question dogma.’

His advice for medical students deciding on their specialty is the advice he was given: ‘Your life as a registrar is short but your life as a consultant is longer. So, as you train, talk to different specialists that you think are your vibe.’

Emergency medicine offers versatile options outside of the ED, he said, such as pre-hospital, telemedicine, research, Māori health equity, and leadership. This gave him the freedom to carve out the career he wanted and to try new things. ‘Choose what interests you, follow what you like.’

Dr Raos has a strong interest in indigenous health and improving health outcomes for Māori. He is a member of ACEM’s Māori Manaaki Mana Rōpū and was a previous co-chair of ACEM’s Indigenous Health Committee. His commitment to improving Māori health equity was a key reason for returning to practice in Aotearoa New Zealand after years working in Sydney.

‘We know that Māori have a disproportionate need for healthcare across the spectrum and disparities in health outcomes’, Dr Raos said. ‘A key factor is systemic inequity.’

‘I think the architecture of mainstream healthcare provision in Aotearoa New Zealand is structured in a way that makes it more difficult for Māori to access timely and affordable preventative care and early intervention in primary care. The ED sees the downstream effects of that.’

‘Healthcare interaction is not always grounded in Te Ao Māori or mātauranga Māori. For example, the patient comes to the ED, they don’t know you but are expected to share with a stranger all the things that are wrong with you in a public space. It’s very personal and we don’t want to talk about, for example, mental health history.’

He said delivering culturally safe care is everyone’s responsibility: ‘showing empathy and supporting a patient on what may be the worst day of their life.’

‘It is a privilege to help people – they might not know what’s wrong, or their health literacy is low, or they have nowhere else to go.’

How do we put culturally safe care into practice? ‘It requires self-reflection and asking questions like, “What am I bringing to my practice today? How did that interaction with the patient go, and if not so well, why not? Can I collaborate with someone in the ED to bridge, which can be useful as the ED is a team environment?”’

The case for achieving health equity is that it equates to quality healthcare, Dr Raos said, which is backed up by research in Aotearoa New Zealand and internationally.

He believes that Te Rautaki Manaaki Mana, ACEM’s strategy to achieve excellence in emergency care for Māori patients, whānau and staff, is a ‘shining light’ offering practical ways to achieve health equity for Māori in EDs.

He said these include ‘operational steps and best practice that can be implemented nationally over time. Reporting across our KPIs and what we measure in the ED to track progress in Māori health against markers such as wait times, triage rates, or left before treatment completed.’

The need for quality data, and making it mandatory to collect, would mean we are better placed to remedy things, Dr Raos said.

‘In terms of measuring patient-oriented, whānau-centric outcomes and trust in the system - that part is harder to measure, so we don’t, but you could introduce new metrics.’

The quality interface around ethnicity data is also fundamental, Dr Raos said.

‘For Māori, you would have a set of best practices around asking questions on ethnicity, getting quite granular data and having the architecture to ensure you’re respectful of Māori data and sovereignty. You can then measure representation rates or do case-based studies of patients who re-present for care. Instead of framing it as a gap we could frame it as an opportunity.’

Capturing progress is also about having a patient-centred approach, asking patients to share their experiences and insights.

He explains that every ED has different ways of implementing Te Rautaki Manaaki Mana.

‘Most departments have Kaikōkiri (champions) who enable Manaaki Mana to be delivered,’ Dr Raos said. ‘At Middlemore we have Te Amo Huia, a nurse-led clinic within the department and we have a registrar (in Aotearoa New Zealand’s first and only Indigenous Health Special Skills post) to facilitate some medical decision-making for Māori patients, and in Taranaki they have a Pou Mātanga (Manaaki Mana Clinical Nurse Specialist) to lift equity throughout the ED.’

‘These actions uplift the mana of those seeking help and everyone around you. That’s not something you can measure on a dashboard but it’s meaningful.’

Improving Māori health equity also requires an increase in the number of Māori emergency staff to better reflect the population who come to the ED.

‘When your workforce is more aligned to the population seeking care, it leads to better quality care and improved health outcomes for things we measure like lengths of stay, and better adherence to treatment plans,’ Dr Raos said. ‘It also makes improvements we don’t measure like a better memory of their experience in our department, a memory that gets retold into the story of their whānau.’

Summary of recommendations

Priority: Access and flow

Recommendations in this priority area address barriers to patient access and flow. Investment in inpatient and aged care capacity would help relieve the access and exit blocks that drive longer ED stays; digital infrastructure and a national performance framework would make blockages visible and drive accountability across the whole hospital and the entire health system nationally, not just the ED.

Recommendations

- Increase investment in inpatient capacity across the hospital system to ease the effects of access block.
- Expand investment in specialist aged care facilities and community partnerships so older patients with complex needs can remain in the community or be discharged quickly and safely when hospital care is required.
- Continue upgrading digital health infrastructure, including integrated ordering systems for laboratory, radiology and pharmacy, and tools to support efficient clinical documentation.
- Replace the Shorter Stays in Emergency Department targets with ACEMs Hospital Access Targets to expose blockages across all patient streams and drive accountability at a whole-of-hospital level.
- Mandate clinical input in patient flow decision-making at every level so decisions are driven by clinical need.

Priority: Workforce

Recommendations in this priority area address workforce pressures. Investment in training, retention and rural distribution would reduce reliance on international recruitment and close the gap in access to specialist emergency care between urban and rural areas.

Recommendations

- Invest in emergency medicine training and retention to meet national workforce need.
- Support ACEM's commitment to rural FACEM training by increasing and investing in training opportunities outside the cities, including through innovative and flexible delivery models.
- Retain all current and future domestically trained and IMG specialists across their full careers, with long-term investment in the existing workforce being more cost-effective than relying on short-term staffing solutions.
- Streamline recruitment and support for qualified IMGs as an interim measure of increasing human resources while domestic training pipelines are strengthened.
- Set requirements to increase the number of Māori specialists in the health system in line with the parity targets ACEM has committed to through Te Rautaki Manaaki Mana, backed by targeted investment.

Priority: Māori health equity

Recommendations in this priority area address Māori health equity. Cultural safety training, Te Tiriti-aligned policy settings and investment in Māori-led models of care, and improvements in the quality of ethnicity data are needed. These would help collectively address the gaps in triage, mortality and workforce representation documented throughout this report.

Recommendations

- Fund and deliver workforce education in cultural safety and Te Tiriti principles, incorporate Māori health priorities into the emergency medicine training curriculum, and mandate cultural competency training for IMGs across the health sector.
- Align budget and health system performance frameworks explicitly to Te Tiriti o Waitangi obligations and integrate Te Tiriti principles into health sector goals and targets.
- Fund Māori-led models of care already operating in EDs, including Kaikōkiri roles and whānau-centred discharge planning, as core service delivery rather than time-limited pilots.
- Invest in nationally consistent ED data collection with high-quality ethnicity data to support Pae Ora objectives, enable equity-focused monitoring and drive quality improvement.

Conclusion

The commentary in this report, supported by available evidence, is ACEM's diagnosis of the most important structural and systemic issues facing the health system in Aotearoa New Zealand. The recommendations across the priority areas discussed are the actions we urgently need to address these challenges.

What emergency medicine physicians are asking for is a system that is resourced and joined up: enough beds, enough staff, and enough support outside the ED so patients coming to an ED receive the timely, high-quality care they deserve. Importantly, ACEM calls for a system that is truly resourced and supported to deliver on its commitment to Māori health equity.

Delivered together, these recommendations would enable the system to keep the promise it was built on. FACEMs and trainees show up. 24 hours a day, every day. That won't change. These recommendations, effectively delivered, will help the health system show up for the ED workforce, and the patients they serve.

How did we get this data?

The ED presentation data was sourced from the National Non-Admitted Patient Collection (NNPAC) datasets provided by Health New Zealand | Te Whatu Ora to profile the ED demand across all reporting EDs over 10 years between 2015-16 to 2024-25. A total of 40 hospitals across Aotearoa New Zealand reported to NNPAC in 2024-25, a decrease from 43 in 2015-16 as three EDs with a small number of presentations (all located in rural areas) have ceased reporting. ED geographical location in Aotearoa is categorised using the Geographic Classification for Health (GCH)[28], where Urban refers to those located in Urban 1, and Rural refers to Urban 2 and Rural 1-3 areas. The NNPAC data was supplemented by other data sources and reports from government and non-government organisations.

28 University of Otago. Geographic Classification for Health: GCH23. 2026.

References

1. Stats NZ. *Population.* March 2026. https://www.stats.govt.nz/topics/population/
2. Australasian College for Emergency Medicine. G24 *Guidelines on the implementation of the Australasian Triage Scale in emergency departments.* November 2023
3. Australasian College for Emergency Medicine. P02 *Policy on Standard Terminology*. 2025
4. Organisation for Economic Co-operation and Development. *Hospital Beds*. 2024. https://www.oecd.org/en/data/indicators/hospital-beds.html
5. Organisation for Economic Co-operation and Development. *Health at a Glance 2025: OECD Indicators*. 2025. https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en.html
6. Morley C, Unwin M, Peterson GM, Stankovich J, Kinsman L. *Emergency department crowding: a systematic review of causes, consequences and solutions. PLOS One.* August 30, 2018.
7. Jones P, Faure S, Munro A. *Variation in resources and impact on performance: results of the emergency department benchmarking survey. NZ Med J.* 2021;134(1540):64–75.
8. Health New Zealand | Te Whatu Ora. *Health and Independence Report 2024*. Wellington: Health New Zealand; 2025.
9. Health New Zealand | Te Whatu Ora. *Hospital Events Web Tool*.
10. Australasian College for Emergency Medicine. *P51 Policy on Care of Older Persons in the Emergency Department.* April 2021
11. Morre D, Loan J, Rohani M, Trill R et al. *A review of aged care funding and service models.* 16 January 2024
12. Health New Zealand | Te Whatu Ora. *Health Digital Investment Plan*. 2025. https://www.healthnz.govt.nz/news-and-updates/health-digital-investment-plan
13. Figure.nz. *Core Crown spending on health in New Zealand*. 2016
14. Ministry of Health. *Health funding trends. 2026-27 Vote Health funding compared to 2025/26*. 2026
15. Stats NZ. *National population estimates: at 30 June 2026.* 2026. https://www.stats.govt.nz/information-releases/national-population-estimates-at-30-june-2026/
16. *One Million People Aged 65+ by 2028* [Media release]. Wellington: Stats NZ; 2026. https://www.stats.govt.nz/news/one-million-people-aged-65-by-2028/
17. Cumming J, Rosenberg B. *How much funding is needed for Health in the 2026 Budget?* Wellington: Kaitiaki Hauora; 2026.
18. Tenbensel T, Rosenberg B, Cumming J, Lorgelly P. *NZ's health spending isn't enough for current needs, let alone future ones, researchers say.* The Conversation; 24 June 2026.
19. Australasian College for Emergency Medicine. *ACEM Membership and Trainee Demographics and Workforce*. 2025. https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Research-at-ACEM/Demographic-and-Workforce-Report
20. Australasian College for Emergency Medicine. *2025 Sustainable Workforce Survey Report*. 2025. https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Research-at-ACEM/Sustainable-Workforce-Survey
21. Australasian College for Emergency Medicine. *ACEM Annual Site Census*. 2025. https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Research-at-ACEM/Annual-Site-Census
22. Australasian College for Emergency Medicine. *Te Rautaki Manaaki Mana: Excellence in Emergency Care for Māori 2026–2029*. Melbourne: ACEM; 2026

23. Curtis E, Harwood M, Sheridan N, et al. Examining emergency department inequities in Aotearoa New Zealand. *Emergency Medicine Australasia*. 2022; 34(1):16–23.

24. Australasian College for Emergency Medicine. *S962 Aboriginal and Torres Strait Islander and Māori Workforce Parity in Emergency Medicine*. 2025.

25. Stats NZ. *Māori population estimates: Mean year ended 31 December 2025*. 2026. https://www.stats.govt.nz/information-releases/maori-population-estimates-mean-year-ended-31-december-2025/

26. Ministry of Health, Manatū Hauora, and Te Aka Whai Ora. *Pae Tū: Hauora Māori Strategy*. Wellington: Ministry of Health; 2023. Published 12 July 2023, ISBN 978-1-991075-44-4 (online), HP 8808.

27. Australasian College for Emergency Medicine. *Manaaki Mana Kaikōkiri National Hui*; 10–12 August 2026; Tangatarua Marae, Rotorua, New Zealand.

28. University of Otago. *Geographic Classification for Health: GCH23*. 2026. https://www.otago.ac.nz/centre-for-rural-health/research/geographic-classification-for-health

Definitions

Terms used throughout this report are defined below for readers who want a plain-language reference.

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.[3]

Australasian Triage Scale

The five-category scale, commonly abbreviated to ATS, is used to prioritise ED patients by clinical urgency. Categories 1–3 warrant assessment within 30 minutes and are used in this report as a measure of high-acuity demand.[2]

Bed Block

Bed block is used to describe a situation when patients are unable to move from one area of the healthcare organisation to another or leave hospital. 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).

Did Not Wait

A measure, commonly abbreviated to DNW. Patients who present for care to the ED and subsequently fail to wait for care, or who leave after commencement of care, may be at some risk after leaving.

Fellow of the Australasian College for Emergency Medicine

A specialist emergency physician, commonly abbreviated to FACEM. FACEMs are the most senior clinicians working in an ED.

He Korowai Oranga (the Māori Health Strategy)

The New Zealand Government's national strategy for Māori health frames wellbeing (oranga) as encompassing the whole person and their connections to whānau (family), hapū (subtribe), iwi (tribe) and the natural world, rather than clinical outcomes alone. The full strategy is available at www.health.govt.nz/publications/he-korowai-oranga-maori-health-strategy.

Kaitakawaenga (Māori Health Liaison Officer)

A role within a hospital providing cultural support and advocacy for Māori patients and whānau (family).

Organisation for Economic Co-operation and Development

An intergovernmental organisation, commonly abbreviated to OECD, of mostly high-income countries. The member average is used in this report as a benchmark for Aotearoa New Zealand's hospital bed capacity.

Te Tiriti o Waitangi

The founding agreement between the Crown and Māori places an obligation on the Crown to protect Māori health and actively reduce health disparities.

Trainee pipeline

The multi-year sequence of training stages a doctor moves through between entering emergency medicine training and being credentialled as a Fellow of the Australasian College for Emergency Medicine. A pipeline is described as back weighted when more trainees sit near the end of training than at the beginning, indicating a shortfall in new entrants.

Regional health snapshot

Northern Te Tai Tokerau *(the northern tide)*

Te Tai Tokerau covers four districts – Northland, Waitematā (North Shore, Waitākere and Rodney), Auckland and Counties Manukau – and carries the largest population base of the four Health New Zealand regions. The region is home to 38 per cent of the Aotearoa New Zealand population. Of the eight emergency departments (EDs), six are ACEM-accredited EDs.

Access and flow profile **as of 2024–25**

Demand

Increased 17% from 2015-16.

Patient profile

25% of patients aged 65+,
20% of patients identified as Māori.

ED length of stay

Only **75% of discharged** patients and **61% of admitted or transferred** patients met the ED six-hour benchmark target.

Access

69% of patients triaged into the more urgent triage categories (ATS^ 1-3);
6% of patients left before the commencement or completion of treatment.

Workforce profile **as of 31 December 2025**

Total FACEMs	Full-time (38+ hrs per week)	More than one workplace	Workplace(s) in RRR*
159	**55%**	**33%**	**16%**

Equity: Cultural support for Māori

Two out of six ACEM-accredited EDs reported that the quality of the Indigenous status data collected is very good or excellent.

Five out of six ACEM-accredited EDs reported that they have a dedicated Māori health unit.

One out of six ACEM-accredited EDs reported that the Kaitakawaenga/Māori Health Liaison Officer or equivalent sees more than 25% of Māori patients.

^ Australasian Triage Scale
* Regional, rural and remote, encompassing Urban 2 and Rural 1-3 areas as defined by the Geographic Classification for Health.
Workforce profile refers to self-reported ACEM Portal data; FACEM totals include members with workplace details only.

Regional health snapshot

Midland
Te Manawa Taki *(the heartbeat)*

Te Manawa Taki covers five districts – Bay of Plenty, Tairāwhiti, Lakes, Taranaki and Waikato. The region is home to 29 per cent of the Aotearoa New Zealand population, with 29 per cent of people living in rural areas – the highest rural share of any Health NZ region. Of the 12 emergency departments (EDs), six are ACEM-accredited EDs.

Access and flow profile **as of 2024–25**

Demand
Increased 22% from 2015-16.

Patient profile
27% of patients aged 65+,
35% of patients identified as Māori.

ED length of stay
Only **85% of discharged** patients and **55% of admitted or transferred** patients met the ED six-hour benchmark target.

Access
63% of patients triaged into the more urgent triage categories (ATS^ 1-3);
10% of patients left before the commencement or completion of treatment.

Workforce profile **as of 31 December 2025**

Total FACEMs	Full-time (38+ hrs per week)	More than one workplace	Workplace(s) in RRR*
96	**52%**	**10%**	**53%**

Equity: Cultural support for Māori

Two out of six ACEM-accredited EDs reported that the quality of the Indigenous status data collected is very good or excellent.

Five out of six ACEM-accredited EDs reported that they have a dedicated Māori health unit.

Three out of six ACEM-accredited EDs reported that the Kaitakawaenga/Māori Health Liaison Officer or equivalent sees more than 25% of Māori patients.

^ Australasian Triage Scale
* Regional, rural and remote, encompassing Urban 2 and Rural 1-3 areas as defined by the Geographic Classification for Health.
Workforce profile refers to self-reported ACEM Portal data; FACEM totals include members with workplace details only.

Regional health snapshot

Central Te Ikaroa *(the Milky Way)*

Te Ikaroa region is home to 18 per cent of the Aotearoa New Zealand population across five health districts – Whanganui, Hawke's Bay, MidCentral (Manawatū, Horowhenua and Tararua), Wairarapa, and Wellington, Kāpiti and Hutt Valley (Capital, Coast and Hutt). Rural areas are home to 18 per cent of the region's population. Of the seven emergency departments (EDs), four are ACEM-accredited EDs.

Access and flow profile as of 2024–25

Demand

Increased 11% from 2015-16.

Patient profile

28% of patients aged 65+, **24% of patients** identified as Māori.

ED length of stay

Only **71% of discharged** patients and **47% of admitted or transferred** patients met the ED six-hour benchmark target.

Access

67% of patients triaged into the more urgent triage categories (ATS^ 1-3); **11% of patients** left before the commencement or completion of treatment.

Workforce profile as of 31 December 2025

Total FACEMs	Full-time (38+ hrs per week)	More than one workplace	Workplace(s) in RRR*
75	**71%**	**16%**	**50%**

Equity: Cultural support for Māori

Zero out of four ACEM-accredited EDs reported that the quality of the Indigenous status data collected is very good or excellent.

Four out of four ACEM-accredited EDs reported that they have a dedicated Māori health unit.

Zero out of four ACEM-accredited EDs reported that the Kaitakawaenga/Māori Health Liaison Officer or equivalent sees more than 25% of Māori patients.

^ Australasian Triage Scale
* Regional, rural and remote, encompassing Urban 2 and Rural 1-3 areas as defined by the Geographic Classification for Health.
Workforce profile refers to self-reported ACEM Portal data; FACEM totals include members with workplace details only.

Regional health snapshot

South Island
Te Waipounamu

(the waters of greenstone)

Te Waipounamu covers five districts – Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern (Otago and Southland) – and is home to 24 per cent of the Aotearoa New Zealand population across 56 per cent of the country's land mass. Of the 13 emergency departments (EDs), four are ACEM-accredited EDs.

Access and flow profile as of 2024–25

Demand

Increased 33% from 2015-16.

Patient profile

27% of patients aged 65+,
13% of patients identified as Māori.

ED length of stay

Only **85% of discharged** patients and **57% of admitted or transferred** patients met the ED six-hour benchmark target.

Access

65% of patients triaged into the more urgent triage categories (ATS^ 1-3);
6% of patients left before the commencement or completion of treatment.

Workforce profile as of 31 December 2025

Total FACEMs	Full-time (38+ hrs per week)	More than one workplace	Workplace(s) in RRR*
107	**58%**	**12%**	**43%**

Equity: Cultural support for Māori

One out of four ACEM-accredited EDs reported that the quality of the Indigenous status data collected is very good or excellent.

One out of four ACEM-accredited EDs reported that they have a dedicated Māori health unit.

Zero out of four ACEM-accredited EDs reported that the Kaitakawaenga/Māori Health Liaison Officer or equivalent sees more than 25% of Māori patients.

^ Australasian Triage Scale
* Regional, rural and remote, encompassing Urban 2 and Rural 1-3 areas as defined by the Geographic Classification for Health.
Workforce profile refers to self-reported ACEM Portal data; FACEM totals include members with workplace details only.

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