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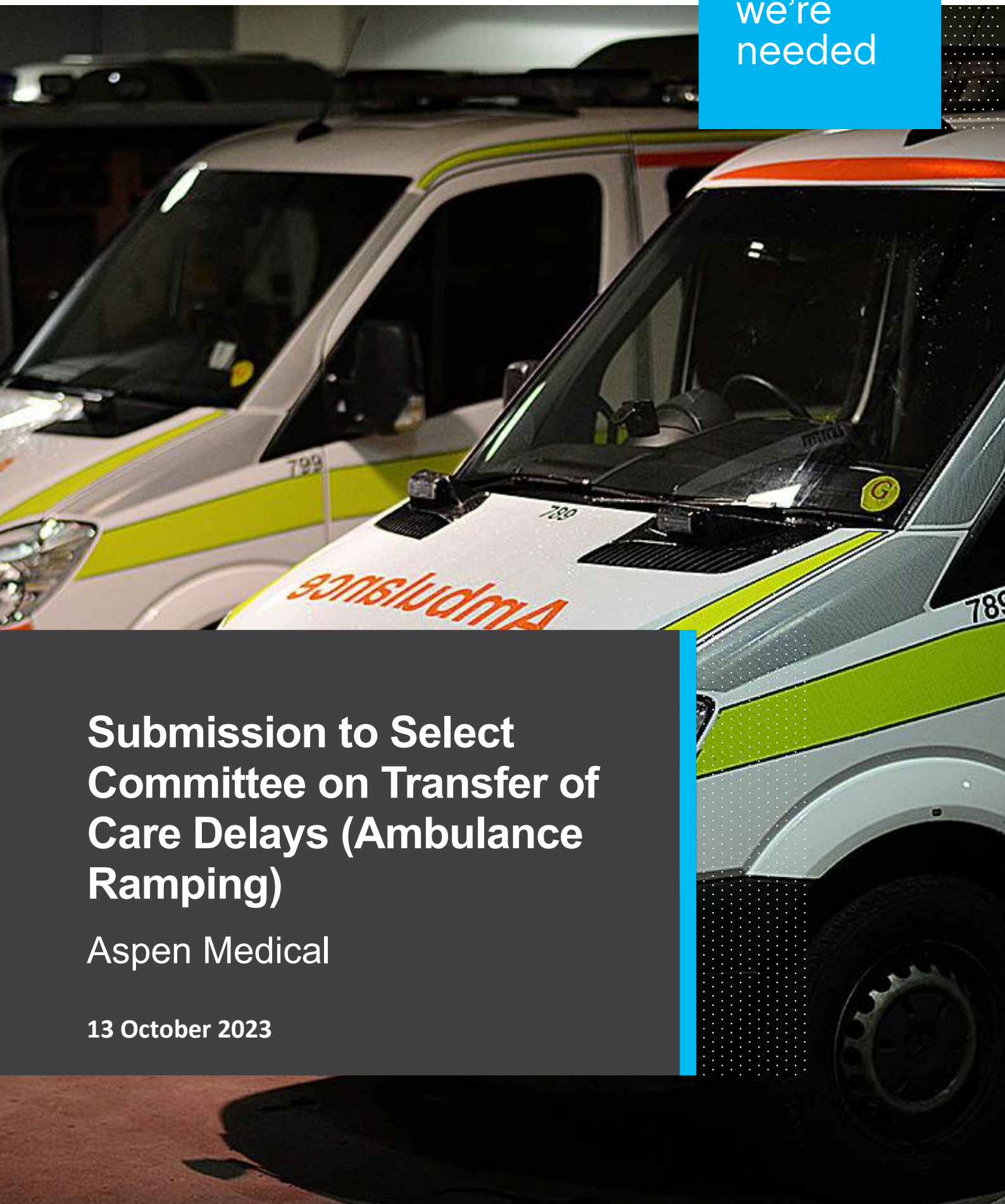

Submission to Select Committee on Transfer of Care Delays (Ambulance Ramping)

Aspen Medical

13 October 2023

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13 October 2023

The Secretary
Select Committee on Transfer of Care Delays (Ambulance Ramping)
Parliament of Tasmania
Parliament House
HOBART TAS 7000

Dear Secretary

The Select Committee's terms of reference asks the Committee to consider the forces shaping Tasmania's t**ransfer of care delays (ambulance ramping)** and the challenges to their resolution.

The Australian and Tasmanian health systems function well overall, but reducing transfer of care delays would ensure more Tasmanians get the care they need, when they need it.

As a global provider of innovative health care solutions with operational experience in the delivery of ambulance, hospital and health care services across a number of jurisdictions and contexts, Aspen Medical is uniquely placed to provide suggestions to improve Tasmania's response to transfer of care delays.

We hope this submission is of use to the **Select Committee on Transfer of Care Delays (Ambulance Ramping)** and we will follow the Inquiry with interest. Aspen Medical has substantial experience and insights on many of the issues relevant to the current inquiry. This is a topic of great public concern where there is substantial scope for improved performance.

We would be happy to expand on the points in the attached submission, or to provide further information if this would assist the Select Committee.

Yours sincerely,

Robyn Hendry
General Manager
Aspen Medical Advisory Services
[redacted]

Executive summary

Aspen Medical welcomes the opportunity to provide a written submission to the Tasmanian House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping).

Aspen Medical was invited to submit a response with reference to an Ambulance Ramping Issue Paper developed by Aspen Medical Advisory Services (Advisory Services, please see appendix in addition to our submission). Aspen Medical is unique as a private health care provider as we are not only a provider of ambulance services and paramedic staff globally (with experience in Australia, the Middle East and USA), but also a provider of broader hospital and healthcare solutions. As such our submission is based not only on our operational, but also our advisory, experience.

Founded in 2003, Aspen Medical is a multi-award-winning global provider of innovative healthcare solutions across a diverse range of clients in the government, resource and extractives, humanitarian and private sectors. In the past 20 years, Aspen Medical has become a world leader in the rapid delivery of healthcare solutions in any setting**,** particularly those that are remote, challenging or under-resourced. Aspen Medical operates across Australia, the Pacific, the USA, Europe, Africa and the Gulf Region and we currently employ approximately 4,500 dedicated, experienced and highly trained professionals globally.

Our health care operations offer our clients a tailored and flexible service wherever it is needed. This can range from a single paramedic to a full spectrum solution involving a multidisciplinary team of healthcare professionals, ambulances, medical facilities, equipment, consumables, pharmacy products, procedures and road and aeromedical evacuation services. This allows development of a tailored solution which meets client requirements whilst taking into consideration local health infrastructure and supply chain arrangements.

Aspen Medical has provided ambulance services in the United States, Middle East and Australia including aeromedical evacuation services. This includes providing emergency response services, pre-hospital patient care, specialised transport services, coordination of aeromedical services and interhospital transfers.

Our virtual health business supplies experienced clinical, non-clinical and allied healthcare staff to provide health services to the community, government and non-government agencies via omnichannel means (i.e. voice, text, IM, video or email). It augments traditional care models using interoperable networked devices and software platforms. We are a service provider to the national and state health departments via Healthdirect Australia.

As a part of Aspen Medical, Advisory Services partners with our clients to bring together a seasoned, multidisciplinary expert team to assist in reviewing and revising plans and addressing issues. Using a co-design methodology, we work in partnership with our clients to select the best team to tailor the right solution. By fully understanding client priorities, we are well positioned to develop practical health solutions to overcome complex issues and support operations.

Re-shaping of the ambulance service model

We are hopeful that the Committee's determinations will result in a service system that recognises the strengths that exist and seeks to ameliorate the challenges faced by service providers and patients experiencing transfer of care delays.

Aspen Medical encourages the Select Committee to consider the following suggestions presented in this submission:

- Suggestion 1: Create improved data analytics within the hospital EDs and Tasmanian Ambulance Service to assist in driving productivity improvements including advocating and implementing a national ambulance dataset.
- Suggestion 2: Undertake a system audit and identify short-, medium- and long-term implementation options to address ambulance ramping and associated issues at a local, regional and national level. This includes status updates on previous health review recommendations, particularly with respect to ambulance, mental health and patient flow.
- Suggestion 3: Collaborate with the wider Tasmanian Health network to ensure that all urgent and emergency care services are connected and integrated. This includes access to digital records across systems and clinical hubs within call centres to assist with referral to non-hospital care pathways.
- Suggestion 4: Fast-track virtual health options to enhance health service provision. This includes virtual emergency departments linked to the main Tasmanian acute hospitals and additional telehealth support for secondary triage to provide care as 'close to home' as possible.
- Suggestion 5: Develop and implement frequent user pathways and patient management plans for key frequent users and key frequent disease profiles, such as mental health.

- Suggestion 6: Launch a targeted campaign to encourage retired clinicians (and those nearing retirement) to work on a more flexible basis in virtual health or secondary triage rather than leaving the workforce altogether.
- Suggestion 7: implement scope of practice innovations identified through the Scope of Practice Review or successful pilot programs. This might include extended care paramedics being scaled across the system or seeking to further innovate through embedding them in urgent care or GP centres.

We hold great hope that the Final Report will provide a clear pathway to implementation across a 5–10 year outlook for transfer of care delays.

The overall problem

When an ambulance is ramped, patients receive care from paramedics, either in the ambulance or the hospital corridor, until there is a free bed and available emergency department staff to handover care to. This results not only in ambulance callout delays, but also paramedic staff attempting to provide either hospital or primary care services when ideally this care should have been handed over. Providing more ambulances will only compound what is essentially a series of bottlenecks. The bottleneck at entry into the Emergency Department (ED), the bottleneck to discharge from the ED and lastly the bottleneck to discharge from hospital to transitional care or home (including aged care).[1]

Magnitude of the problem

Literature reviews,[2] national performance data[3] and recent news coverage have demonstrated agreement on that:

- the problem is getting worse
- it is associated with poor health outcomes
- there are three main categories of factors associated with the problem:
  - patient-centred issues, such as willingness to pay or support networks
  - hospital/system issues, such as bed capacity and bed block, staffing mix, financial incentives or disincentives
  - clinical factors, such as disease complexity and prevalence.

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[1] Ambulance Ramping Issues Paper v1.2 13092022 for web publication _0.pdf (aspenmedical.com)
[2] Access block and emergency department overcrowding CC9998-Forero.indd (nih.gov)
[3] 11 Ambulance services - Report on Government Services 2023 - Productivity Commission (pc.gov.au)

The patients most affected by ambulance ramping, access block and overcrowding are those who, because of their medical conditions, require unplanned admission to hospital. Providing increased ambulances and paramedic staff will not alleviate, but instead likely exacerbate, the problem of ambulance ramping.[4]

The role of systemic reform

In the long term, there is no evidence that suggests any specific funding models routinely deliver a better health care system than any other. In fact, what tends to differentiate performance of health systems is the level of investment rather than underlying model of funding.[5] There is, however, a widely agreed recognition that there is underinvestment in hospital funding that is causing some of the hospital access challenges underpinning ambulance ramping and transfer of care delays[6]. This has worsened in the current high inflation environment as the Australian Government does not increase funding based on CPI, but funds 45 per cent of growth in activity, with increases capped at 6.5 per cent a year.[7]

There is, however, consistency in suggestions from various reviews and Royal Commissions. The Strengthening Medicare Taskforce and several recent Royal Commissions into aged care, mental health, disability and veteran suicide all highlighted the major issues facing public health and care sector reform in Australia. Supporting our workforce to provide care more effectively and to improve the productivity of the health and care sector is critical.[8] They all point to solving this conundrum through pursuit of a transformation journey, including but not limited to:

- person-centred models of care
- flexible, multidisciplinary and integrated configurations of service delivery
- digitalisation, data analytics and artificial intelligence
- remodelling of occupational contours and job design optimisation.

Australian healthcare system performance

Australian healthcare is globally acknowledged to perform at the highest level, both in terms of quality and access.[9]

Outcomes

Australia performs well compared to most countries, having lower rates for both preventable and treatable mortality than its peers.[10]

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[4] Paramedics left shaking their heads as ambulance ramping debate misses the point | Danny Hill | The Guardian
[5] The NHS in crisis – evaluating the radical alternatives | The King's Fund (kingsfund.org.uk)
[6] AMA Submission to mid-term review of the National Health Reform Agreement Addendum 2020-25 | Australian Medical Association
[7] Microsoft Word - FINAL NHRA 2020-25 Addendum (consolidated version) - May 2020.DOCX (federalfinancialrelations.gov.au)
[8] Workforce productivity pathways discussion paper | Aspen Medical
[9] Mirror, Mirror 2021: Reflecting Poorly | Commonwealth Fund
[10] How does the NHS compare to the health care systems of other countries (kingsfund.org.uk)

Unfortunately, contemporary and comparable data is less readily available on waiting times for important services, including mental health crisis services, accident and emergency (A&E) departments and ambulance services.[11]

Health systems effectiveness and health outcomes often use the rate of avoidable admissions for long-term conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD) and congestive heart failure. Effective monitoring, management and treatment of these conditions, particularly in primary care, can reduce the need for ambulance service response and hospitalisation. Australia has below average performance on these indicators for avoidable hospital admissions.[12]

Beds and diagnostic technologies

As with capital investment overall, there is no 'right' level of diagnostic equipment. The OECD (2021) notes that too few scanners can lead to longer waiting times or underdiagnosis of health conditions, while too many scanners could lead to overuse of costly equipment for little clinical benefit.[13] Again, Australia compares well internationally, with 44.5 CT and MRI units per million head of population; this is well above the United Kingdom (UK, 16.1), Canada (24.7) and New Zealand (NZ, 30.5).[14]

Australia also has a relatively higher average of another key resource – hospital beds. We have 3.8 beds per 1,000 people, compared to the average in key comparable countries of 3.2 beds per 1,000. The UK, Canada and NZ have 2.5.[15]

Workforce

Australia has (on average) higher numbers of practising doctors and nurses per person, including compared to the UK, Canada and NZ.

Doctor-to-nurse ratios can reflect different models of care. Only two countries of those surveyed had more nurses per 1,000 population, and eight European countries had more doctors per 1,000 population than Australia. However, Australia relies heavily on foreign-trained doctors and nurses, similar to NZ and the UK.[16]

Key insights from the Australian Institute of Health and Welfare

The number of beds per 1,000 population in Australian public hospitals has fallen by an average of 0.9 per cent every year since 2015–16. There were 2.5 public hospital beds per 1,000 population in 2019; this still compares favourably internationally when private hospital beds are included.

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[11] How does the NHS compare to the health care systems of other countries (kingsfund.org.uk)
[12] How does the NHS compare to the health care systems of other countries (kingsfund.org.uk)
[13] How does the NHS compare to the health care systems of other countries (kingsfund.org.uk)
[14] How does the NHS compare to the health care systems of other countries (kingsfund.org.uk)
[15] How does the NHS compare to the health care systems of other countries (kingsfund.org.uk)
[16] How does the NHS compare to the health care systems of other countries (kingsfund.org.uk)

Over time, ED activity has grown faster than population growth, both in terms of the number of presentations to EDs and the number of hours each person spends in ED. This growth has been concentrated within the working age populations, which suggests a growing demand for ED services that does not appear to be driven by factors such as population ageing.

Over the last five years, the performance of EDs with regard to measures of waiting times has declined: 61 per cent of presentations were completed within 4 hours and 67 per cent within expected timeframes (2021–22).[17]

Patients are now waiting longer in EDs before being seen: 90 per cent of patients were seen within 1 hour and 57 minutes. This was markedly higher than the previous 4 years, which varied from 1 hour and 32 minutes in 2019–20 to 1 hour and 42 minutes in 2020–21.

Patients are staying longer in ED and fewer ED visits are completed in four hours. The time in which 90 per cent of ED visits for patients subsequently admitted to the hospital has increased by almost 4.5 hours in recent years.

The rate of mental health presentations at EDs has risen by about 70 per cent over the past 15 years, in part due to the lack of community-based alternatives and people with mental illness are nearly twice as likely to arrive at the ED by ambulance.[18]

Key insights from the Tasmanian experience

Tasmania has a target of 85 per cent of cases being transferred from the ambulance to the ED within 15 minutes and 100 per cent within 30 minutes. Tasmania's patient transfer performance has been deteriorating year-on-year since at least 2015–16, where 92.1 per cent of patients were transferred within 15 minutes and 95.2 per cent were transferred within 30 minutes. This represents a 26.2 per cent deterioration, and 15.6 per cent deterioration in performance for the 15- and 30-minute targets respectively, compared to 2020–21.

The proportion of all ED patients whose length of stay was 4 hours or less (2021–22) was 55.2 per cent in Tasmania, which was the second worst of all states and territories and well below the Australian average rate of 60.9 per cent.[19]

Nationally, an estimated 67 per cent of patients were seen within the expected triage category timeframe. This rate was 53 per cent in Tasmania (the second worst after the ACT) but more concerningly saw the biggest decrease across all states since 2012, with an 18 per cent decline.[20]

The Tasmanian Government has recognised the challenge of bed block as a system issue across the patient care journey and established the *Statewide Access and Patient Flow Program*. As part of this, a review of access and flow in all four Tasmanian EDs was completed this year, delivering a set of recommendations for

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[17] Emergency department care - Australian Institute of Health and Welfare (aihw.gov.au)
[18] Inquiry report - Mental Health - Productivity Commission (pc.gov.au)
[19] 12 Public hospitals - Report on Government Services 2023 - Productivity Commission (pc.gov.au)
[20] 12 Public hospitals - Report on Government Services 2023 - Productivity Commission (pc.gov.au)

each ED and identifying opportunities to introduce statewide patient flow consistency where practicable. Similar reviews are occurring with Statewide Mental Health Services exploring access and flow concerns for patients experiencing mental health issues.[21]

Ambulance Tasmania's Secondary Triage service commenced in 2021 and it continues to have increased utilisation at 21.5 per cent over the last year, ensuring a median of 362 emergency ambulance callouts are not required.

The Tasmanian Department of Health and Human Services undertook a review of Ambulance Tasmania Clinical and Operational Services, with a final report in 2017[22] providing short-, medium- and long-term recommendations to the state government to assist with the causes and effects of transfer of care delays.

Urgent Care Clinics (UCCs) have been a key Australian Government measure to help reduce ED pressure and ambulance ramping. By the end of 2023, 58 Medicare clinics will be established to increase access to doctors and nurses when urgent, but non-life threatening, care is required.[23] There will be four Medicare UCCs in Tasmania.[24] It should be noted that ED attendance continues to become more complex and that appropriate attendance at EDs reflects some success in secondary triage but that UCCs will not be a panacea for ambulance ramping and ED blockages.

Nationally, total expenditure on ambulance service organisations was $190 per person in 2021–22, an increase of 8.8 per cent from the previous year, with Tasmania highest of all states and territories at $262.11.[25] Whilst efficiency should be treated with caution given population dispersal etc., there is room for improvement. This is especially so when considering Tasmanian ambulance response times to code 1 emergencies in comparison to other states.[26]

Nationally, the proportions of respondents who indicated a slower than expected wait time for call connection (8 per cent) and ambulance arrival (14 per cent) have risen to their highest levels over the six years of reported data. Whilst this has improved in Tasmania, this was because it came off a very low base.[27]

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[21] Department of Health Annual Report 2021-22
[22] RATCOSFR_v3_LR.pdf (health.tas.gov.au)
[23] About Medicare Urgent Care Clinics | Australian Government Department of Health and Aged Care
[24] Medicare Urgent Care Clinics | Tasmanian Department of Health
[25] 11 Ambulance services - Report on Government Services 2023 - Productivity Commission (pc.gov.au)
[26] 11 Ambulance services - Report on Government Services 2023 - Productivity Commission (pc.gov.au)
[27] 11 Ambulance services - Report on Government Services 2023 - Productivity Commission (pc.gov.au)

Lessons from other jurisdictions

Digitalisation, data analytics and artificial intelligence

The Queensland Audit Office (QAO) published a performance audit report on measuring emergency department patient wait times[28] and has a scheduled a QAO report on minimising potentially preventable hospitalisations. This will also investigate the issues of ambulance ramping at hospitals.[29]

The use of improved data analytics is recognised as a key ingredient to productivity improvements. The National Ambulance Data Set integrates existing and developing data sets across the urgent and emergency care system in hospitals and community health, such as the National Ambulance Surveillance System (NASS). It is a world-first public health monitoring system for ambulance attendance data suicidal and self-harm behaviours.[30]

Virtual emergency departments staffed by a mixture of GP and emergency medicine fellows have developed across Australia.[31] They provide a digital offering that can help reduce ambulance ramping and encourage the productivity gains required to address ED blockages. In Victoria, the virtual ED pilot showed 87 per cent of people referred to the virtual service avoided a trip in an ambulance to the hospital ED.[32] Tasmania could benefit from investing in virtual health offerings, specifically virtual ED and expanding secondary triage and nurse on call services.

A range of new digital health technologies can aid triage improvements in EDs. This can also include increased adoption of technology opportunities, such as wearable technologies to improve triage and monitoring in both EDs and ambulances.[33,34] As an example, since 2016 Copenhagen Emergency Medical Services have trialled the use of artificial intelligence to improve detection of cardiac arrests and strokes. Call handlers have a digital assistant that listens to the conversation and compares that to historical emergency calls. The system then sends its predicted clinical severity to the dispatcher.[35]

Flexible, multidisciplinary and integrated configurations of service delivery

Lord Carter published *Operational Productivity and Performance in NHS Ambulance Trusts* in 2018[4], highlighted that reducing avoidable conveyances to hospital could release capacity in the acute sector. However, the report also acknowledged that alternative services that better meet patients' needs were required. The new models of care are:

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[28] Measuring emergency department patient wait time (Report 2: 2021–22) (qao.qld.gov.au)
[29] Acquittal of Queensland Audit Office prior published work plans – June 2023 (qao.qld.gov.au)
[30] Ambulance attendances - Australian Institute of Health and Welfare (aihw.gov.au)
[31] Step inside the virtual emergency department • The Medical Republic
[32] Virtual Service Expanding To Relieve Hospital Pressures | Premier of Victoria
[33] How Digital Innovations Can Transform Emergency Medical Triage | Center for Digital Health | Medical School | Brown University
[34] Sensors | Free Full-Text | Wearable Bluetooth Triage Healthcare Monitoring System (mdpi.com)
[35] Artificial intelligence in Emergency Medical Services dispatching: assessing the potential impact of an automatic speech recognition software on stroke detection taking the Capital Region of Denmark as case in point | Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine | Full Text (biomedcentral.com)

- resolving calls over the phone or by virtual consultations (known as 'hear and treat')
- treating patients at the scene, including through virtual ED (known as 'see and treat')
- taking patients to non-hospital destinations.

The Australasian College of Paramedicine has highlighted the need to expand the role of paramedics in the new UCCs being rolled out nationwide and including them as part of multidisciplinary teams. This is especially critical as paramedics as a health profession comparatively fewer shortages.[36] Internationally, ambulance services are transforming their model of care from treat and transport to acute mobile healthcare services, where care is delivered at the scene in an integrated model by accessing alternative pathways.[37]

Person-centred models of care

Ambulance clinicians often find themselves responding to patients with very limited information of the person's history, condition, preferences and wishes. They may have to make very difficult and time critical decisions, often in isolation. Developing information systems, care pathways and policy advice for ambulance clinicians in easily accessible manner (such as for end of life, dementia or mental health patients) is essential to ensuring good person-centred care and optimal outcomes, including preventable hospitalisation.

The NHS has developed advice to assist ambulance clinicians.[38,39] In consultation with patients, community providers and experts, Ambulance Care Victoria Care Connect is co-designing alternative care pathways for vulnerable patients. These include aged care, palliative care, frequent and complex care needs and mental health patients and seeks to keep them in their home environment and avoid unnecessary transport to hospital EDs.[40]

Measures of quality and response time need to reflect the patient's whole episode of care and be developed with patients.[41] Performance indicators should shift away from activity-based indicators to outcome indicators with patient reported outcome measures (PROMS) and patient reported experience measures (PREMs).

Remodelling of occupational contours and job design optimisation

Redesigning workflows and occupational contours are essential to improving service quality and being open to transformation. The future can't just be about responding when someone wants an ambulance, but instead about playing an active role in supporting local communities to help prevent illness and keep

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[36] The Australasian College of Paramedicine (paramedics.org)
[37] The Alternative Pre-hospital Pathway team: reducing conveyances to the emergency department through patient centered Community Emergency Medicine | BMC Emergency Medicine | Full Text (biomedcentral.com)
[38] End-of-Life-Care-Route-to-Success-ambulance-services.pdf (england.nhs.uk)
[39] SAS Self Care Booklet (scottishambulance.com)
[40] Patient Care Academy - Ambulance Victoria
[41] easc.nhs.wales/publications/amber-review/

people out of hospitals. A good comparative example is fire services and their work on prevention, including smoke alarm installation.[42]

The *Operational Productivity and Performance in NHS Ambulance Trusts* report also found that when staff spend more time at the scene with patients, they convey fewer patients to hospital and are therefore able to see and treat more people.[43] This highlighted the need to increase the clinical capacity of paramedics and to shift to new combinations of clinical staff to enhance ambulance clinical service models. The Australian Government is undertaking a Scope of Practice Review - Unleashing the Potential of our Health Workforce, which is primarily focused on exploring opportunities and innovations in primary care.[44]

The development of the extended care paramedic (ECP) has expanded the scope of practice of paramedics to provide:

- patient assessment
- recognition and management of minor illness and minor injury presentations
- provision of definitive care
- referral to community-based health services for a range of presentations.

ECPs have successfully reduced the number of patients being unnecessarily transported to EDs by 60 per cent compared to usual care.[45] The College of Paramedicine suggests a new era of a primary health paramedicine is one that doesn't focus on paramedics in an ambulance. Instead, it focuses on chronic conditions, long-term health goals and looking after the whole wellbeing of a patient.

This does require systemic changes, including the Australian Government creating and funding an MBS item number for paramedics.[46]

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[42] Ambulance services and integrated care systems: lessons for effective collaboration | NHS Confederation
[43] on-the-day-briefing-carter-ambulance-report.pdf (nhsproviders.org)
[44] Scope of Practice Review - Terms of Reference (health.gov.au)
[45] Ambulance NSW (Digital Health) - SNPHN Partnership (sydneynorthhealthnetwork.org.au)
[46] The Australasian College of Paramedicine (paramedics.org)

Conclusion and suggestions for action

The findings described above show the significant challenges and barriers to resolving transfer of care delays (ambulance ramping), both globally and nationally. Aspen Medical has several suggestions to help improve systems, service delivery models and other supports to help reduce ambulance ramping and the myriad of complex interdependent issues arising from this bottleneck. These will not only benefit the health system, but also the individual Tasmanians confronted with this issue on a day-to-day basis.

Systemic improvements

- Suggestion 1: Create improved data analytics within the hospital EDs and Tasmanian Ambulance Service to assist in driving productivity improvements including advocating and implementing a national ambulance dataset.
- Suggestion 2: Undertake a system audit and identify short-, medium- and long-term implementation options to address ambulance ramping and associated issues at a local, regional and national level. This includes status updates on previous health review recommendations, particularly with respect to ambulance, mental health and patient flow.
- Suggestion 3: Collaborate with the wider Tasmanian Health network to ensure that all urgent and emergency care services are connected and integrated. This includes access to digital records across systems and clinical hubs within call centres to assist with referral to non-hospital care pathways.

Service delivery model improvements

- Suggestion 4: Fast-track virtual health options to enhance health service provision. This includes virtual emergency departments linked to the main Tasmanian acute hospitals and additional telehealth support for secondary triage to provide care as 'close to home' as possible.
- Suggestion 5: Develop and implement frequent user pathways and patient management plans for key frequent users and key frequent disease profiles, such as mental health.

Workforce improvements

- Suggestion 6: Launch a targeted campaign to encourage retired clinicians (and those nearing retirement) to work on a more flexible basis in virtual health or secondary triage rather than leaving the workforce altogether.
- Suggestion 7: implement scope of practice innovations identified through the Scope of Practice Review or successful pilot programs. This might include extended care paramedics being scaled across the system or seeking to further innovate through embedding them in urgent care or GP centres.

Image credits: *The Examiner*, Launceston, *The Mercury* Hobart and Ambulance Tasmania

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Ambulance Ramping Issues Paper

Aspen Medical Advisory Services
September 2022

Executive summary

Ambulance ramping predates COVID-19, but the pandemic has placed unprecedented demand on healthcare systems. After a reduction in ambulance and general hospital activity in 2020, a rebound is now seeing ambulance ramping getting worse, leading to poor health outcomes. It requires both systemic and structural solutions.

Australian healthcare is globally acknowledged to perform at the highest levels both in terms of quality and access.[1] It is, however, not immune to the pressures exposing cracks globally in healthcare systems. Australia's universal healthcare system is a blend of federal and state jurisdictional finances and operations, with a mix of public and private sector providers. To date, it responded exceptionally well by global standards during the COVID-19 pandemic and its adaptations through the pandemic provide opportunities to respond to these ongoing pressures.

A review of Australian and globally published research and grey literature[2] highlights numerous pressures on our healthcare system that have led to ambulance ramping and its associated impact, including:

- over-reliance on emergency departments as a gateway into the health system
- bed block and constraints to discharging from hospital
- patient flow and variation management
- COVID-19 pandemic impact on health system capacity
- focus on sickness, not a 'wellness' model of care
- tendency toward fragmentation in the health system
- poor health outcomes associated with ramping.

Ensuring ambulances and EDs are available for time critical life-threatening emergencies is essential to ensuring good health outcomes and this will not be achieved unless root causes of ramping are addressed.

Whilst the issues associated with ambulance ramping are complex, and at the moment seemingly intractable, there are a range of solutions being pursued both locally and globally that provide a roadmap towards systemic change. These should not be seen in isolation, but instead as a chance to establish a variety of holistic projects and policy reforms that could cement Australia as a model 'learning health system'.

Key solutions to assist with resolving the national ambulance ramping crisis include:

- the establishment of urgent care centres and increasing utilisation of GPs for urgent assessment to reduce ambulance arrivals at emergency departments

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[1] *Mirror, Mirror 2021: Reflecting Poorly | Commonwealth Fund*

[2] Grey literature is information produced on all levels of government, academia, business and industry in electronic and print formats not controlled by commercial publishing i.e. where publishing is not the primary activity of the producing body.

- continuous review of systems to ensure process optimisation, including agreed ‘demand escalation’ plans in each state, together with appropriate clinical staffing to maintain throughput from ED to hospital to discharge into lower-level care
- keeping the digital, telehealth and virtual healthcare solutions that have assisted greatly through COVID-19; they should not replace face to face consultation but reimagine the healthcare experience
- out-of-hospital transitional care, demand management strategies and improved community support. These will align with community expectations to have care delivered within the community that is adapted to patient needs.
- national policy reform and implementation that is widely accepted as necessary to resolve structural health issues, including removing barriers to virtual health care provision and relieving bed block in acute care settings. The success of National Cabinet during COVID-19 provides a significant springboard for coordinating policy reform.
- investment in implementation science for health and creating a national framework to promote the systematic uptake of evidence-based practices into routine practice
- the use of private sector capacity for surge responses, as already demonstrated during COVID-19.

This paper, prepared by Aspen Medical Advisory Services, provides a brief synopsis of the key issues posed by ambulance ramping. It goes on to present recommendations for the development of the range of solutions suggested above, including surge response models for discussion with governments and local health districts.

Background

Purpose of this document

This issues paper identifies some of the specific issues around ambulance ramping and associated solutions as a contribution to current policy discussions. It also seeks to outline potential roles of the public and private sector in supporting the resolution of ambulance ramping within the Australian health system and a call for a wider engagement across the health policy landscape.

The ambulance ramping problem

Ambulance ramping occurs when ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital emergency department (ED) within a clinically appropriate timeframe, specifically due to lack of an appropriate clinical space in the ED. In some jurisdictions, ambulance ramping is also referred to as 'off-stretcher time delays' or 'ambulance turnaround delays'.[3]

Ambulance ramping ties up crews, meaning there are fewer ambulances available to respond to other emergencies. It can see paramedics doing the work of emergency departments due to staff shortages and leads to poor patient experiences.[4] Ambulance ramping is a national issue, as illustrated in Figure 1.[5]

Magnitude of the problem

Literature reviews[6] and recent news coverage have demonstrated agreement on the following:

- the problem is getting worse
- it is associated with poor health outcomes
- there are three main categories of factors associated with the problem:
  - patient-centred issues, such as willingness to pay or support networks
  - hospital/system issues, such as bed capacity and bed block, staffing mix, financial incentives or disincentives
  - clinical factors, such as disease complexity and prevalence.

The patients most affected by ambulance ramping, access block and overcrowding are those who, because of their medical condition, require unplanned admission to hospital. Providing increased ambulances and paramedic staff will not alleviate, but likely exacerbate, the problem of ambulance ramping.[7]

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[3] *S347-Statement-on-Ambulance-Ramping-Nov-13.aspx (acem.org.au)*
[4] *'Health system in distress': how ambulance ramping became a major problem | Health | The Guardian*
[5] *AMA Ambulance Ramping Report Card | Australian Medical Association*
[6] *Access block and emergency department overcrowding CC9998-Forero.indd (nih.gov)*
[7] *Paramedics left shaking their heads as ambulance ramping debate misses the point | Danny Hill | The Guardian*

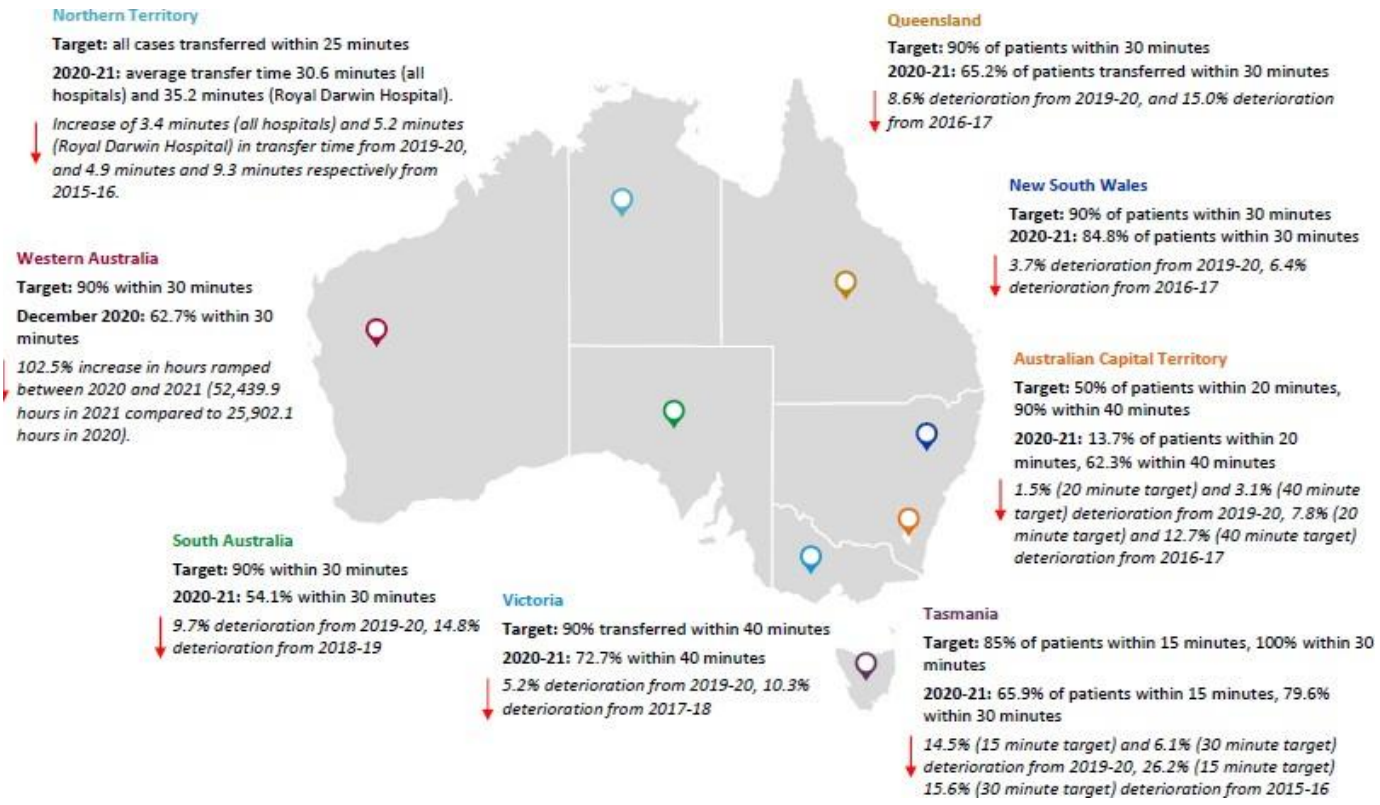

Figure 1. Illustration of the extent of ambulance ramping across Australia

The Australian health system

Australia's health system performs well globally, as illustrated in Figure 2. Australia has a universal public health insurance program (Medicare) that is financed and administered through a complex mix of federal and state regulations and bodies (see Appendix *1*). Citizens receive free public hospital care and substantial coverage for physician services, pharmaceuticals and certain other services. Approximately half of Australians buy supplementary private insurance to pay for private hospital care and dental and other services. The major drivers of cost growth are the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS).

Beyond direct state and federal budget control measures, health costs are controlled mainly through capacity constraints, such as workforce supply. Demand and funding pressures are being driven by an ageing population, increasing consumer expectations and the resulting growth in per capita use of health services, more expensive technology, and the growing burden of chronic conditions. All governments are facing health workforce pressures.[8]

Australia's hospital network is comprised of public hospitals operated by state and territory governments and private hospitals (for profit and not for profit). In 2013, there were around 750 public hospitals and

[8] Reform of the Federation White Paper - Roles and Responsibilities in Health ISSUES PAPER 3 December 2014

almost 600 private hospitals. Around 65 per cent of beds were in public hospitals.[9] Emergency medicine was once exclusively provided in public hospitals in Australia, but now over half a million consultations per annum are in private (7 per cent total emergency consultations).[10] A major barrier to private ED attendances is out-of-pocket costs: insurers deem private EDs outpatient services and therefore do not contribute any funding to these attendances.[11]

The private sector contributes significantly to funding healthcare in Australia primarily through out-of-pocket costs and private health insurance premiums. Individuals accounted for 17.8 per cent of total health expenditure in 2012–13, which has remained relatively stable since 2002–03.[12]

Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**3**	**10**	**8**	**5**	**2**	**6**	**1**	**7**	**9**	**4**	**11**
Access to Care	8	9	7	3	1	5	2	6	10	4	11
Care Process	6	4	10	9	3	1	8	11	7	5	2
Administrative Efficiency	2	7	6	9	8	3	1	5	10	4	11
Equity	1	10	7	2	5	9	8	6	3	4	11
Health Care Outcomes	1	10	6	7	4	8	2	5	3	9	11

Data: Commonwealth Fund analysis.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 – Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021).

The Commonwealth Fund

Figure 2. The top performing countries in overall healthcare performance rankings are Norway, the Netherlands and Australia.

The Australian healthcare system as whole has been repeatedly tested through the COVID-19 pandemic. This has exposed not only systemic and structural flaws in the system, but also opportunities for reform.

Ambulance ramping is symptomatic of these deeper issues. It shows the 'access block' within the system both for admission into inpatient care and discharge from inpatient care to lower acuity, transitional or residential and community care. Hospital bed shortages are not always due to physical capacity, but often a reflection of the need to ensure there are adequate nursing staff and appropriately trained specialists to allow for prompt admission and discharge. All of these symptoms are correlated directly to the blunt levers that both the Australian and state governments have to reduce ever-growing healthcare expenditure in a time of fiscal constraint.

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[9] *Health Issues Paper (ahha.asn.au)*
[10] *Choosing public or private emergency departments in Australia Katherine Walker,Michael Ben-Meir*
[11] *Choosing public or private emergency departments in Australia Katherine Walker,Michael Ben-Meir*
[12] *Health Issues Paper (ahha.asn.au)*

Issues and pressures on the system

There are numerous pressures on our healthcare system. As with any complex system, any change can lead to unpredictability and unintended outcomes. These pressures are beyond the scope of any one government to fix. It is critical to ensure that the allocation of roles and responsibilities in healthcare is not holding back the health system's performance and delivering better outcomes for Australians.[13]

Overreliance on EDs as a gateway into the health system

At times, residential care facilities are overly ready to call an ambulance and transfer residents to ED. Factors may include staff shortages or lack of willingness to care for residents who have had a minor downturn, or lack of ready access to same day medical assessment in the facility.

Similarly, the Mental Health Productivity Commission Inquiry Report[14] highlighted the impact of the national mental health crisis affecting ED and ambulance ramping, with the rate of mental health presentations at EDs rising by about 70 per cent over the past 15 years. This is, in part, due to the lack of community-based alternatives to ED, particularly in the evenings and on weekends. A recent Queensland report cited the mental health crisis that accounts for 13 per cent of all ambulance emergencies in Queensland.[15] The Royal Commission into Victoria's Mental Health recommended improving access to community mental health and wellbeing services, crisis responses and a community-based model of care where people receive the most appropriate treatment, care and support for their needs at any given point, close to where they live.[16]

Bed block and constraints to discharging from hospital

It can be a challenge for acute hospitals to find aged care and disability residential care placements for patients.[17] An actual or perceived lack of appropriate nursing care in aged care and disability facilities means these facilities are unable to accept patients discharged from hospital or admit patients that should ideally be treated in the residential facility.

The significant reform that occurred in the wake of the closure of stand-alone psychiatric institutions is often referred to as deinstitutionalisation. The subsequent mainstreaming (acute mental health in general hospital) and community care have not kept up with the pace of deinstitutionalisation. Numerous mental health reviews point to the difficulty in accessing suitable support and accommodation as a key factor preventing discharge. This represents substantial numbers of patients remaining in inpatient care, effectively blocking throughput.[18]

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[13] *Reform of the Federation White Paper - Roles and Responsibilities in Health ISSUES PAPER 3 December 2014*
[14] *Inquiry report - Mental Health (pc.gov.au)*
[15] *Queensland parliamentary inquiry highlights dramatic rise in ambulance call-outs for mental health emergencies - ABC News*
[16] *Royal Commission into Victoria's Mental Health System - Home (rcvmhs.vic.gov.au)*
[17] *Disabled Victorians forced to wait in hospital beds due to NDIS delays (smh.com.au)*
[18] *Chapter 8 - Inpatient and crisis services – Parliament of Australia (aph.gov.au)*

Patient flow and variation management

The 'problem' of patient flow is essentially one of uncontrolled variation, with multifaceted issues. Patient flow is an ongoing challenge, but broad consensus suggests process improvements will alleviate some bed block and ambulance ramping problems across Australia.[19] The Emergency Foundation of Australia and Queensland Health are collaborating on a large research program to find effective, evidence-based solutions to improve patient flow in Queensland's public hospitals and the Queensland Ambulance Service. They also envisage a funded implementation program.[20]

COVID-19 pandemic impact on health system capacity

The COVID-19 pandemic has increased the burden on the health system, not only through COVID-19- related hospitalisations and care but also through deferred care. This is care that has been postponed or exacerbated due to hospital restrictions; a prime example is the postponement of elective surgery that now needs to be addressed and actioned.[21] This has created unusually high demand and is combining with ongoing COVID-19 hospitalisations and a seasonal influenza outbreak to increase ambulance ramping.

Workforce shortages to cover the increase in healthcare demand during COVID-19 were exacerbated by necessary COVID-19 furloughing rules. There are now worsening shortages as nursing, medical staff and paramedics are leaving the system due to burnout[22] and ongoing systemic shortages.

Australians' willingness and ability to adopt digital health has been accelerated by the COVID-19 pandemic. The healthcare system needs to capitalise on this momentum and the significant investments that have already been made. But these ambitions will not be realised if healthcare providers and workers are unable to adopt and engage with integrated virtual solutions.[23]

Focus on sickness, not a 'wellness' model of care

The funding system skews the focus of governments to acute care episodes. This leads to limited or delayed funding for preventive healthcare that would ultimately reduce acute pressures in the longer term. The most glaring recent example is the delayed provision of free influenza vaccines to prevent costlier inpatient admissions and ED presentations.[24]

Tendency toward fragmentation in the health system

The size and complexity of Australia's state-federal health system inevitably produces centrifugal and centripetal forces, seeking to integrate disparate knowledge and policies but simultaneously splitting away to spur exploration and creativity.[25] These lead to inherent contradictions, such as between control and collaboration (that result in a lack of coordination between different sectors) and the structure and

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[19] *Access block and emergency department overcrowding - PMC (nih.gov)*
[20] *Request-for-Submissions_Patient-flow-study_May2022.pdf (emergencyfoundation.org.au)*
[21] *Waitlist-Surgery-Report-Final-web.pdf (mq.edu.au)*
[22] *Deadly ambulance ramping at Victorian hospitals was on the rise before COVID-19, study finds - ABC News*
[23] *Australia's health reimagined The journey to a connected and confident consumer March 2022 Deloitte*
[24] *RACGP - Free flu vaccination campaigns expand across the country*
[25] *Quo vadis, paradox? Centripetal and centrifugal forces in theory development (sagepub.com)*

financing of primary care. This can lead to use of the ED as a 'free' service to avoid out-of-pocket costs in primary care, as well as cost-shifting throughout the wider health, aged care and disability sectors.

Any discussion on cost-shifting must address its cause and required structural reforms i.e. the haphazard division of responsibilities within the federal system and greater reform towards models of care to better streamline health service delivery.

It should be noted that the states and territories are essentially the providers of 'last resort care' i.e. people will be admitted to hospital when they are too sick for alternative care. This means that, where cost-shifting is a problem, the states and territories eventually bear the cost of an inefficient system.[26]

Poor health outcomes

Poor health outcomes caused by ambulance ramping and bed block have been well documented, with a recent study by Ambulance Victoria, Monash University, Royal Melbourne Hospital, Alfred Health and the Baker Heart Research Institute finding that when an ambulance took longer than 17 minutes to offload a patient at a hospital, the patient faced a higher risk of dying within the next 30 days.[27]

Opportunities for lasting change

Whilst the issues associated with ambulance ramping are complex and seemingly intractable, there are a range of opportunities being pursued both locally and globally that provide a roadmap towards systemic change. These opportunities should not be seen in isolation but instead as a chance to establish a variety of holistic projects and policy reforms that are guided by implementation science frameworks. Australia could be a model 'learning health system'.

1. Urgent care centres and increasing GP utilisation

The average cost for a non-admitted ED presentation is $533, which rises to $969 if the patient is admitted to ED[28]. The cost of a GP consultation is approximately $50 (bulk billed). Research has estimated 10–12 per cent of all ED presentations may have been suitable for general practice, and the Australian Institute of Health and Welfare (AIHW) suggests that up to 25 per cent of ED presentations could have been managed by general practice.[29]

Provision of financial inducements to patients to use GP care can provide an effective and efficient model:

- Wellington region hospitals in New Zealand have offered GP vouchers to ease emergency department pressure (a cause of ambulance ramping)[30]
- In Auckland, Counties-Manukau DHB is paying GP surgeries $350 per patient to offer free appointments, to help ease pressure on Middlemore Hospital's ED.

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[26] *Health Issues Paper (ahha.asn.au)*
[27] *Ambulance ramping associated with 30-day risk of death | The Medical Journal of Australia (mja.com.au)*
[28] *round_22_nhcdc_infographics_emergency.pdf (ihpa.gov.au)*
[29] *Economic-evaluation-of-the-RACGP-vision.pdf*
[30] *Wellington region hospitals offer GP vouchers to ease emergency department pressure | RNZ News*

A 2007 Healthcare for London report[31] strongly recommended establishing a network of polyclinics, with a far greater range of services than those currently offered in GP practices, and more accessible and less medicalised than hospitals. The incoming Australian Government has pledged to create Medicare Urgent Care Clinics that are located close to hospital emergency departments and will bulk bill, with extended hours.[32] These are based on the New Zealand experience such as Pegasus Health[33] that has left the country with the "the lowest level of emergency department presentations in the developed world".[34]

2. Process optimisation, including agreed 'demand escalation' plans and appropriate clinical staffing

In the event of ambulance ramping, hospitals could benefit from following detailed and benchmarked procedures. These could use, or be based on, the Australasian College of Emergency Medicine and St John Ambulance in New Zealand[35] joint guidelines.

A strong clinical component is required in both the problem and the solution. Safe, efficient and sustainable patient flow requires the right levels of clinical decision-making at the right time in the patient journey – for every patient. This, in turn, depends on good clinical practice and the appropriate staffing mix and level to support the care model. Figure 3 shows the agreed six essential actions to improve unscheduled care for the NHS in Scotland:[36]

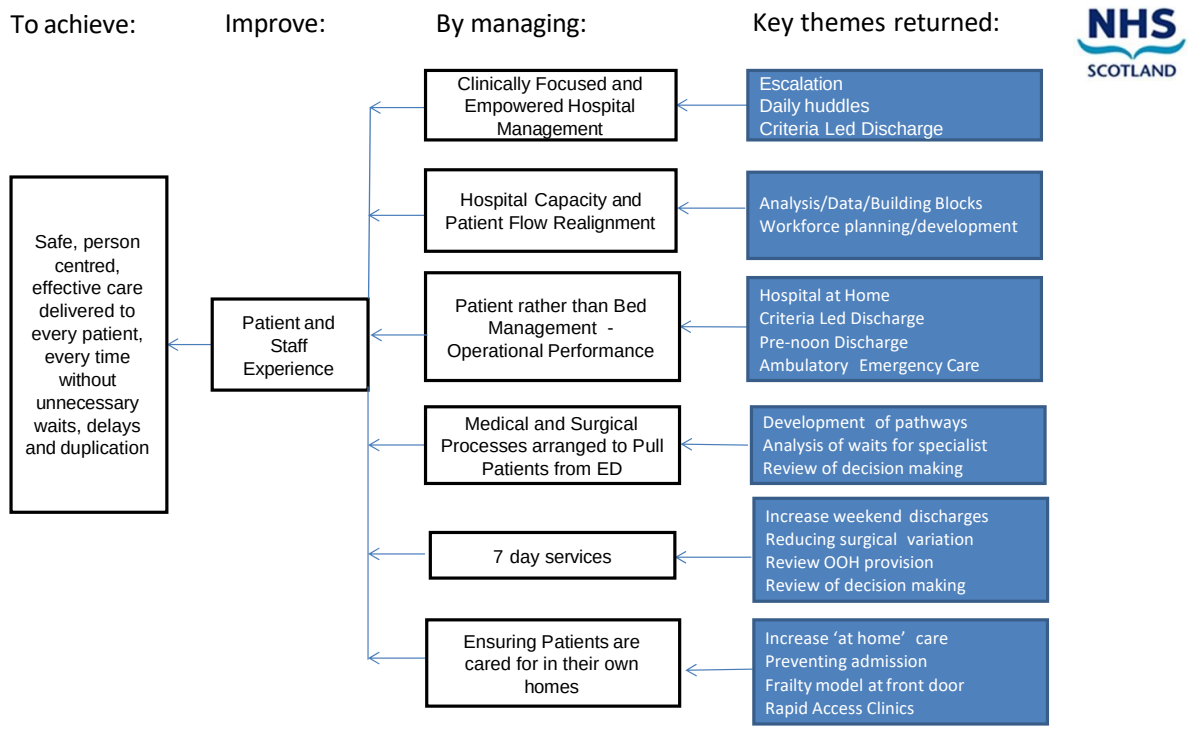

Figure 3. Six essential actions to improve unscheduled care for NHS Scotland

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[31] *Healthcare for London: A Framework for Action (2007). NHS London*
[32] *Medicare Urgent Care Clinics | Policies | Australian Labor Party (alp.org.au)*
[33] *About Pegasus Health - Pegasus Health | Primary Health Services*
[34] *Election 2022: Labor's Medicare urgent care clinics 'won't fix hospital crisis' (smh.com.au)*
[35] *Joint-Guidelines-int-the-event-of-ambulance-ramping-in-A-NZ (acem.org.au)*
[36] *NHS Scotland: Improving unscheduled care – six essential actions*

3. Use of digital, telehealth and virtual healthcare solutions

The health system of the future is expected to provide care virtually outside its walls, and function as a part of the larger care ecosystem. Hospitals will focus only on complex care in their emergency departments, operating rooms and intensive care units. All other care will move to patients' homes or into the community.

Perhaps the greatest opportunity to arise from the disruption caused by COVID-19 was increased access to health services via virtual and telehealth. Virtual care enables health services to provide care delivery to areas that are remote or experience a skills shortage. The technology-enabled model allows and enables doctors and associated hospital staff to provide remote assessment, triage, care and monitoring to patients. The CEO of Medibank said, "virtual care, whether it be hospital in the home, specialist mental health services or primary care support, is the next frontier for healthcare in Australia. It's a way to reduce pressure across the public and private health system, as well as an opportunity to design care around the needs and preferences of patients and their families".[37]

Virtual health options include:

- expanding access to virtual emergency services such as the Victorian Virtual Emergency Department - Northern Health. This service allows people to access ED staff virtually for non-life-threatening emergencies rather than using 000, ambulances or waiting in ED. This program has been doubled in Victoria in response to the increasing strain of the current COVID-19 and influenza surges to free up ambulances and hospitals.[38]
- expanding telehealth solutions such as My Emergency Doctor. This service provides 24/7 consultation with Australian-qualified senior emergency specialist doctors (Fellows of the Australasian College for Emergency Medicine or FACEMs). Likewise, expanded ambulance secondary triage (as per the Healthdirect 24-hour Ambulance Secondary Triage service below).
- specialist services such as the Child and Adolescent Virtual Urgent Care Service.[39] Specifically aimed at supporting GPs, this is a virtual assessment and referral option which allows children and young people (aged between 6 months and 17 years) with non-life-threatening conditions to be assessed virtually by a team of highly skilled emergency doctors and nurses, potentially reducing the need to visit the ED.

4. Ensuring ambulances and ED's are available for time critical life-threatening emergencies

Expanded use of ambulance secondary triage can help manage 000 calls and redirect non-emergency call to the appropriate part of the health system. Healthdirect Australia delivers a 24-hour Ambulance Secondary Triage Service on behalf of the New South Wales Health and Western Australian health departments[40] and in Victoria through the Ambulance Victoria Referral Service.

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[37] *Calvary-Medibank using AI and remote monitoring to support more than 130,000 COVID patients so far | Medibank Newsroom*
[38] *Victoria doubles virtual emergency department capacity to cope with COVID and flu surge - ABC News*
[39] *Women's and Children's LHN South Australia: Virtual Urgent Care Service*

Deployment and operation of outdoor treatment tents (as for the COVID-19 surge)[41] can allow ambulances to offload ambulatory patients and provide surge capacity for ED for non-admitted patients. Caring for patients in the ED who have been admitted as an inpatient but are awaiting handover represents over a third of the ED workload in Australian hospitals.[42] Having a dedicated surge capacity looking after patients waiting for beds or transfer to another facility would allow ED staff to focus on critical patients and timely triage of new patients.

5. Out of hospital (transitional care), demand management strategies and improved community support

US studies have shown that long stays in EDs and delays in inpatient discharge are related to two key groups: psychiatric and geriatric patients. This occurs due to a shortage of psychiatric and assisted living beds[43]. Australia faces similar issues with inpatient discharge and unnecessary ED admission, where early identification of high-risk patients and strengthening relationships with community-based services with a more integrated approach are necessary.[44]

The Canterbury District Health Board in New Zealand has long operated an acute demand management system. It provides both a means for general practice to support patients so that they do not need to go to hospital, and a means for the hospital to discharge patients from the emergency department (or from medical and surgical admission wards) without the need for a hospital stay. They estimate that in the winter of 2012, some 40 per cent of chronic obstructive pulmonary disease (COPD) patients who would previously have been taken to the emergency department were diverted to other forms of care.[45] In a review of the Canterbury District Health system, it was judged to be achieving the 'holy grail' of moving resources from acute care to arranged care and to have had a systematic rebalancing of health resources for the people of Canterbury.[46]

The recently funded adult mental health service model 'Head to Health' provides a successful model to divert people with significant levels of distress or suicidal crisis from less appropriate emergency department attendance. It also promotes better outcomes where urgent ED care is not required.[47]

6. National policy and implementation reform

Ambulance ramping in Australia has become extremely politicised. South Australian Premier Peter Malinauskas called on the Australian Government to play a bigger role in addressing ramping issues

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[40] *Ambulance Secondary Triage | healthdirect*
[41] *Deployment and Operation of Outdoor Treatment Tents During the COVID-19 Pandemic (nih.gov)*
[42] *Statement_on_Emergency_Department_Overcrowding (acem.org.au)*
[43] *Barriers to Discharge in Geriatric Long Staying Inpatient and Emergency Department Admissions: A Descriptive Study - PMC (nih.gov)*
[44] *Access block and emergency department overcrowding - PMC (nih.gov)*
[45] *The quest for integrated health and social care: A case study in Canterbury, New Zealand (kingsfund.org.uk)*
[46] *The quest for integrated health and social care: A case study in Canterbury, New Zealand (kingsfund.org.uk)*
[47] *Microsoft Word - CLEAN REVISED FINAL Service Model for Head to Health centres and satellites - June 2021.docx*

across the country, saying, "This is a national crisis and I don't think that just throwing more resources at a state level alone will be enough".[48]

The formation of National Cabinet to deal with the pandemic provides a real opportunity to push forward critical governance and policy reform. The current environment is ideal for adjusting governance and funding through reallocating some of the 6.5 per cent funding increase each year and putting it into creating something different i.e. a model of integrated health and social care.[49]

Systemic change that includes bold fiscal options is required to address the wicked problems of Australian healthcare. One such example of a bold idea was the recent Royal Commission of Victoria into Mental Health Services proposal for a mental health and wellbeing surcharge. It explored the reform approaches governments, both in Australia and internationally, have used to overcome structural complexities in healthcare systems.[50] An exploration of the issues confronting after-hours care including potentially establishing a nationalised funding system for after-hours care is one example of a potential bold policy implementation reform.

7. Investment in implementation science

It is suggested that evidence-based practices take, on average, 17 years to be incorporated into routine general practice in healthcare.[51] Implementation science is the use of scientific methods to promote the systematic uptake of evidence-based practices into routine practice (Figure 4). It is a critical tool to creating a 'learning healthcare system' to ultimately improve the quality and effectiveness of health services.[52] The ongoing challenges of access block or ambulance ramping over the last 20 years shows that without a national operational research framework, resolving these issues could take many years.

8. Role of the private sector

During the COVID-19 pandemic, the Australian government partnered with the private health sector to ensure more than 30,000 hospital beds (and 105,000 people in its skilled workforce) were available alongside the public hospital sector.[53] This unprecedented move saw private hospitals integrating with state and territory health systems in the COVID-19 response. In the wake of this historic move, it is essential to include the private sector as a valued partner in any discussions seeking to resolve the bed block, ED overcrowding and ambulance ramping issues. The use of private sector capacity for surge response is an ideal solution.

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[48] *SA ambulance statistics reveal ramping delays have reached record high - ABC News*
[49] Reforming our health care system: time to rip off the band-aid? MJA 215 (7) ▪ 4 October 2021
[50] *Final Report – Volume 1 – A new approach to mental health and wellbeing in Victoria (rcvmhs.vic.gov.au)*
[51] *An introduction to implementation science for the non-specialist (nih.gov)*
[52] *Australia's health reimagined: The journey to a connected and confident consumer March 2022, Deloitte*
[53] *Australian Government partnership with private health sector secures 30,000 hospital beds and 105,000 nurses and staff, to help fight COVID-19 pandemic | Health and Aged Care Portfolio Ministers*

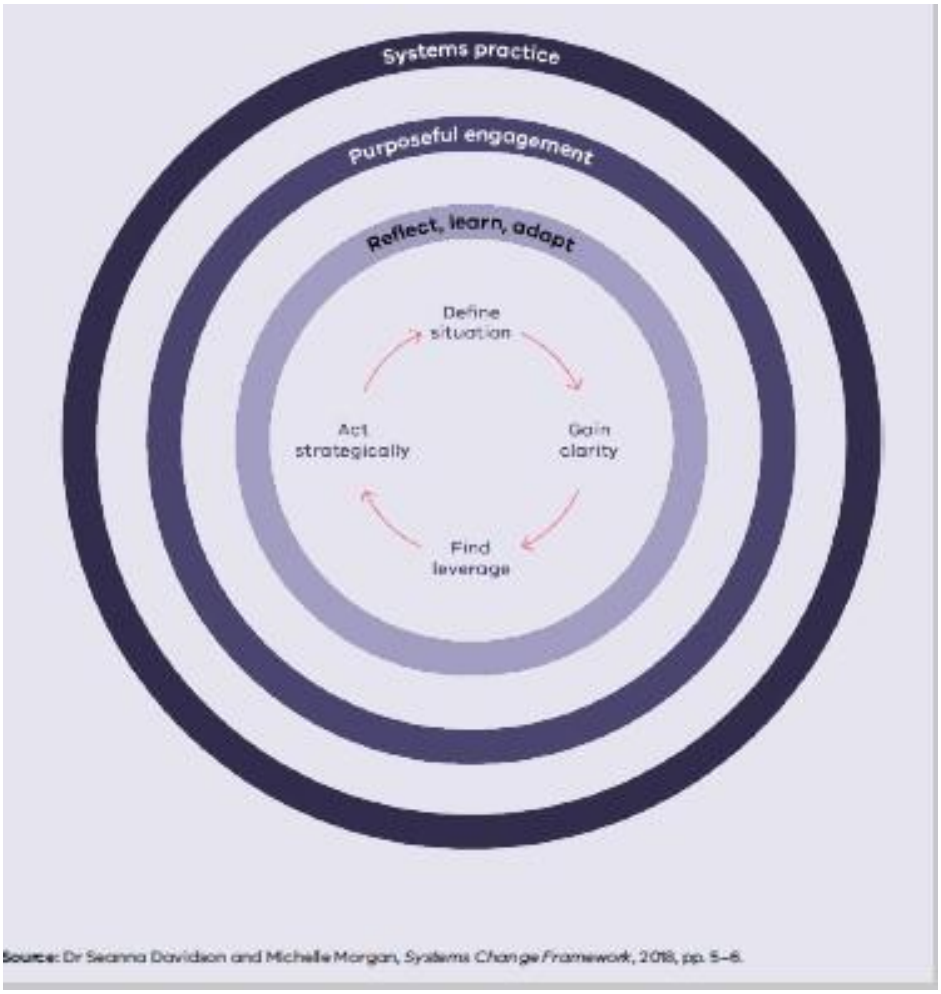


Figure 4. Systems change framework

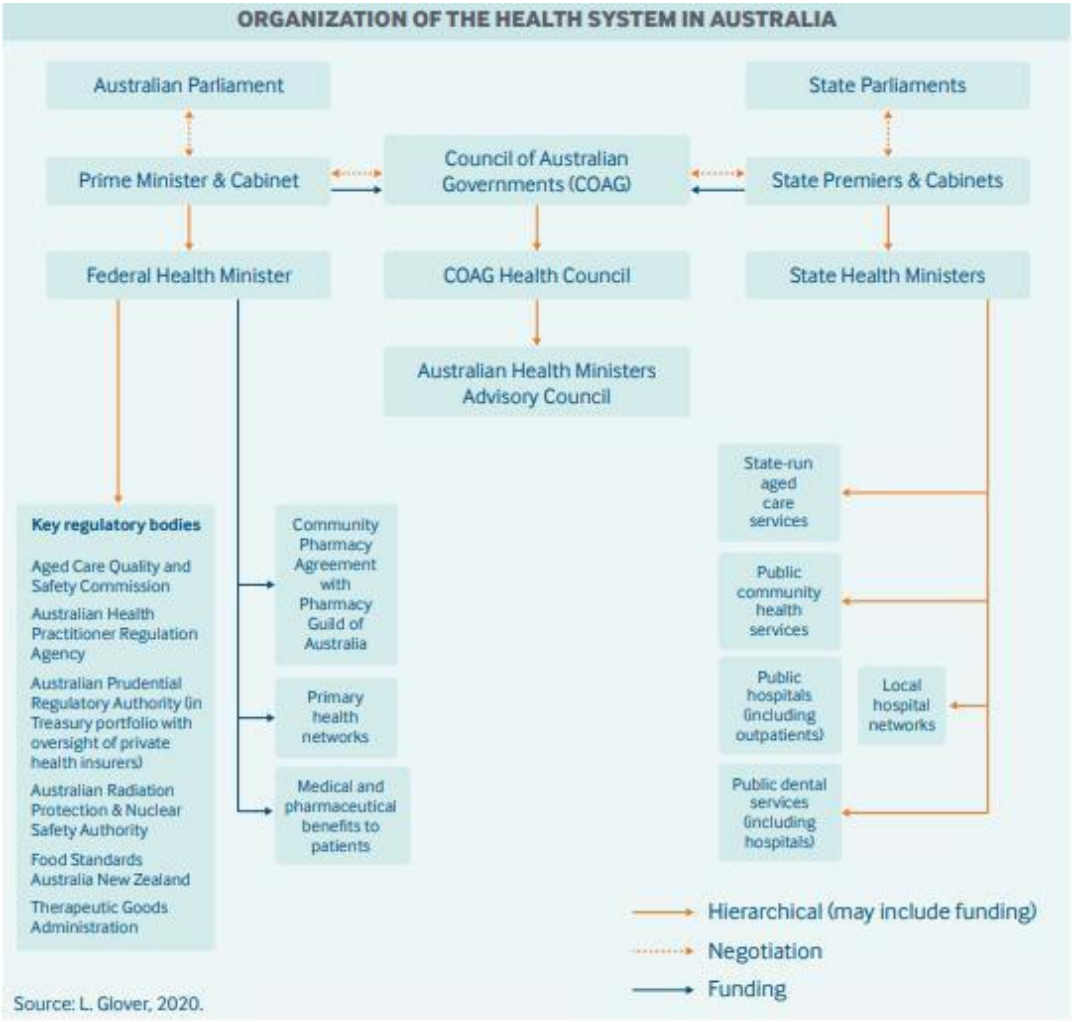
Summary

The issues underlying ambulance ramping are complex and multifaceted, and large-scale solutions are required to address them. This Issues Paper is not exhaustive in its analysis and is by no means the first to consider this issue. However, there are repeated and urgent calls for action across the health landscape and political spectrum.

The current fiscal situation necessitates securing greater value from the allocation and use of healthcare resources; this is greater than ever during the recovery from COVID-19. The role of the private sector during COVID in providing surge capacity and fast-tracking digital solutions has been essential. Direct requests like that of the Tasmanian government for surge capacity support for ambulance ramping are likely to continue, whilst indirect opportunities through telehealth tenders will also continue to develop.

Aspen Medical seeks to be part of the solution and will actively pursue partnerships to deliver innovative models that address the underlying issues and symptoms of ambulance ramping outlined in this report. For example, the development of an Aspen Medical surge model offering for governments and local health districts (with a mixed 'boots on the ground' surge response in an ED, ambulances or urgent care clinics combined with a virtual health solution) has the potential to offer surge opportunities.

Appendix 1. Organisation of the Australian health system



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The contents of this document are time-sensitive and specific to the situation as at 13 September 2022.

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