# 2023 Public Hospital Report Card

AMA

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# PRESIDENT'S INTRODUCTION

**Professor Steve Robson**

Federal AMA President

The AMA has been publishing the Public Hospital Report Card since 2007 with health data going back to 2002. We started the report card as a way to both monitor the performance of our public hospitals and propose solutions to improve performance and reduce wait times.

As the eighth AMA President to introduce a report card, it's disappointing to see that 16 years after the first report hospital performance is at its lowest ever. Wait times have continued to blow out and the solutions put forward by the AMA over successive years continue to be ignored.

The decline in performance is represented in the numbers. Over the last 30 years, the number of public hospital beds available for people aged over 65 has dropped by more than half — from 32.5 beds per 1,000 people to only 14.7. This is happening while our demographics are shifting. In just over 10 years, Australia is expected to have more than 1 million people who will be over 85 years of age. We know that older patients are more likely to require an admission to a public hospital, and we should be planning for this. Instead, we are deliberately setting our public hospitals, and with them our patients, on the path to failure.

This year we saw emergency departments (ED) face their toughest year since the AMA began tracking ED performance. Only 58 per cent of patients triaged as urgent were seen within the recommended 30 minutes, with one in three patients staying longer than four hours in EDs, often because there aren't beds available in hospitals to safely admit them.

We also saw wait times for planned surgeries continue to blow out in the last financial year, with only 63 per cent of patients referred for semi-urgent planned surgery treated within the recommended 90 days. That's more than one in three patients waiting longer than the clinically indicated time for essential surgeries, often in terrible pain and unable to work.

I use the term 'planned surgery' here because this better reflects what it is as opposed to the term 'elective surgery.' We will use this term throughout the report card. Planned surgery better reflects the medical necessity of a surgery that will improve a patient's health and wellbeing or diagnose a potentially life-threatening illness. These surgeries are planned and scheduled in accordance with a triage scale and the health system's capacity. We are doing this to avoid any potential misunderstanding of the term "elective" by the broader public. These surgeries are essential.

Meanwhile, access to specialists in the public hospital system — the 'hidden waiting list' for outpatient appointments — continues to be a huge problem. Without these appointments, people can't be assessed and added to the actual surgical waiting list. As a result, around 100,000 fewer people were added to the planned surgery waiting list in 2021–22. This shows our hidden wait list is continuing to grow.

These are significant problems, but there are solutions. We need a new funding agreement to support hospitals to expand their capacity and improve their performance — to clear the hospital logjam.

We need a health budget in May, that includes additional funds to address the elective surgery backlog. Longer term we need a new national hospital funding agreement — one that has a fair 50–50 funding split at its heart, but also provides the resources our hospitals need to grow, improve, and keep you healthy.

Professor Steve Robson

# PERFORMANCE INDICATORS AND TERMINOLOGY USED IN THIS REPORT CARD

The AMA uses following indicators to measure the performance of Australian public hospitals:

- Public hospital capacity — the number of available public hospital beds relative to the size of the Australian population, including available public hospital beds per 1,000 people aged 65 years and over.
- Emergency department waiting and treatment times:
    - Proportion of patients seen within the clinically recommended timeframes set by the Australian Triage Scale,[1] maximum waiting time for medical assessment and treatment:
        - Category 1 Immediate treatment
        - Category 2 10 minutes
        - Category 3 30 minutes
        - Category 4 60 minutes
        - Category 5 120 minutes
    - Length of stay for emergency department care - the proportion of presentations where the length of the emergency department stay is 4 hours or less.
- Planned Surgery Waiting and Treatment times:
    - The median waiting time for planned surgery — number of days within which 50 per cent of patients were admitted for their planned surgical procedure; and
    - The percentage of Category 2 patients — clinically indicated to be treated/receive surgery within 90 days, treated within the clinically recommended timeframe.
- Hidden waiting list — the period between the General Practitioner's or other health practitioners' referral and the patient seeing a specialist in the public hospital system and being officially added to the planned surgery list.
- Funding for public hospitals
    - Public hospital expenditure per person (constant prices).

Previous AMA Public Hospital Report Cards used 'Elective Surgery' as a term to describe surgeries that are planned in the public hospital system, and where the admission of patients did not go via Emergency Department. Australian Institute of Health and Welfare (AIHW) defines elective surgery as "planned surgery that can be booked in advance as a result of a specialist clinical assessment. Elective surgery is considered medically necessary, and may be required urgently, but is not conducted as a result of an emergency presentation."[2]

**Due to the potential misunderstanding of the term 'Elective" in the broader public, from this Report Card, the AMA will use the term "Planned Surgery" instead of Elective Surgery to highlight the medical necessity of the surgery that is required to improve the patient's health and wellbeing and is planned in accordance with the triage scale and the health system's capacity, as opposed it being something that is patient's choice and may not be seen as necessary.**

[1] Australian College of Emergency Medicine. Australasian Triage Scale (ATS) https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Triage
[2] Australian Institute of Health and Welfare 2023. Reports and Data. Hospitals. Elective Surgery https://www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery

# NATIONAL PUBLIC HOSPITAL PERFORMANCE

## Public hospital capacity

The number of available public hospital beds relative to the size of the Australian population is a broad indicator of whether a person will receive a timely admission when required. In 2020–21 there were on average 2.46 public hospital available beds per 1,000 population.[3] Even though the number of available public hospital beds has increased by 1,536 beds since 2017–18, this has not matched the growth of the Australian population.[4] The bed ratio to population has been in constant decline since 2016–17, with average decline of 0.8 per cent per year.[5]

The availability of public hospital beds per 1000 people over the age of 65 is an important indicator of public hospital capacity, as the older patients are more likely to require an admission, either via an emergency department or for planned surgery. In 2020–21, 16.8 per cent of the Australian population were aged 65 years and over,[6] an increase of 0.8 per cent compared to the year before. This cohort represented 42.7 per cent of total public hospital separations, an increase of 2.8 per cent compared to the year before.[7] Once admitted, people aged 65 years or over utilised almost half of all patient hospital days (49 per cent).[8] They also tend to spend longer in hospital, 31 per cent longer than all other age cohorts.[9] The average number of days spent in hospital for all people under 65 was 2.7 in 2020–21. For those aged 65 and over it was 3.9 days. The number of days increases as the person gets older:

| Age group (years) | Average no of patient days in public hospital |
|---|---|
| 65–69 | 2.3 |
| 70–74 | 2.5 |
| 75–79 | 2.8 |
| 80–84 | 3.3 |
| 85–89 | 4.5 |
| 90–94 | 5.4 |
| 95+ | 6.2 |
| Average 65+ | 3.9 |

With the number of Australians aged 85 and over expected to exceed one million by 2035,[10] and with the hospitals already operating at capacity, Australia's public hospital system is at risk of becoming unsustainable. In the year between 2019–20 and 2020–21, the number of hospital separations for 65 and older cohort increased by 260,337, with number of patient days increasing by 440,518.

[3] Source: Australian Institute of Health and Welfare (AIHW) 2022, Australian Hospital Statistics: Hospital Resources 2020–21 data tables, Table 4.5, https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients
[4] Ibid.
[5] Ibid.
[6] Australian Bureau of Statistics, 2022 National State and territory population, Data downloads – data cubes, Population by age and sex – national: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/jun-2022
[7] Australian Institute of Health and Welfare 2022. Australian hospital statistics. Admitted patient care 2020–21: Who used these services, Table 3.1: Separations and patient days, by age group and sex, all hospitals, 2020–21 https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients
[8] Ibid.
[9] Australian Institute of Health and Welfare 2021.Australian hospital statistics. Admitted patient care 2020–21: Who used these services, Table 3.1: Separations and patient days, by age group and sex, all hospitals, 2020–21 https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients
[10] Parliament of Australia 2008. Department of the Parliament Library – Publications. Population projections 2007 to 2057 https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook43p/ageingpopulationfigure

This means that a 0.8 per cent increase in the population 65 and over resulted in 5.43 per cent increase in hospital separations and 2.87 per cent increase in patient days.

It is also important to note that this happened in the year where there were minimal number of COVID-19 related hospital separations: in 2020–21 reporting period there were total 4,718 separations with COVID-19 diagnosis according to AIHW, vast majority of which were in Victoria.[11]

The AMA research paper from 2021 that looked into the performance of public hospitals predicted sustained growth in ED presentations as well as sustained growth in the share of patients presenting who are then admitted to hospital. The Figure below displays actual growth to 2019–20, and trended age-specific growth rates thereafter.

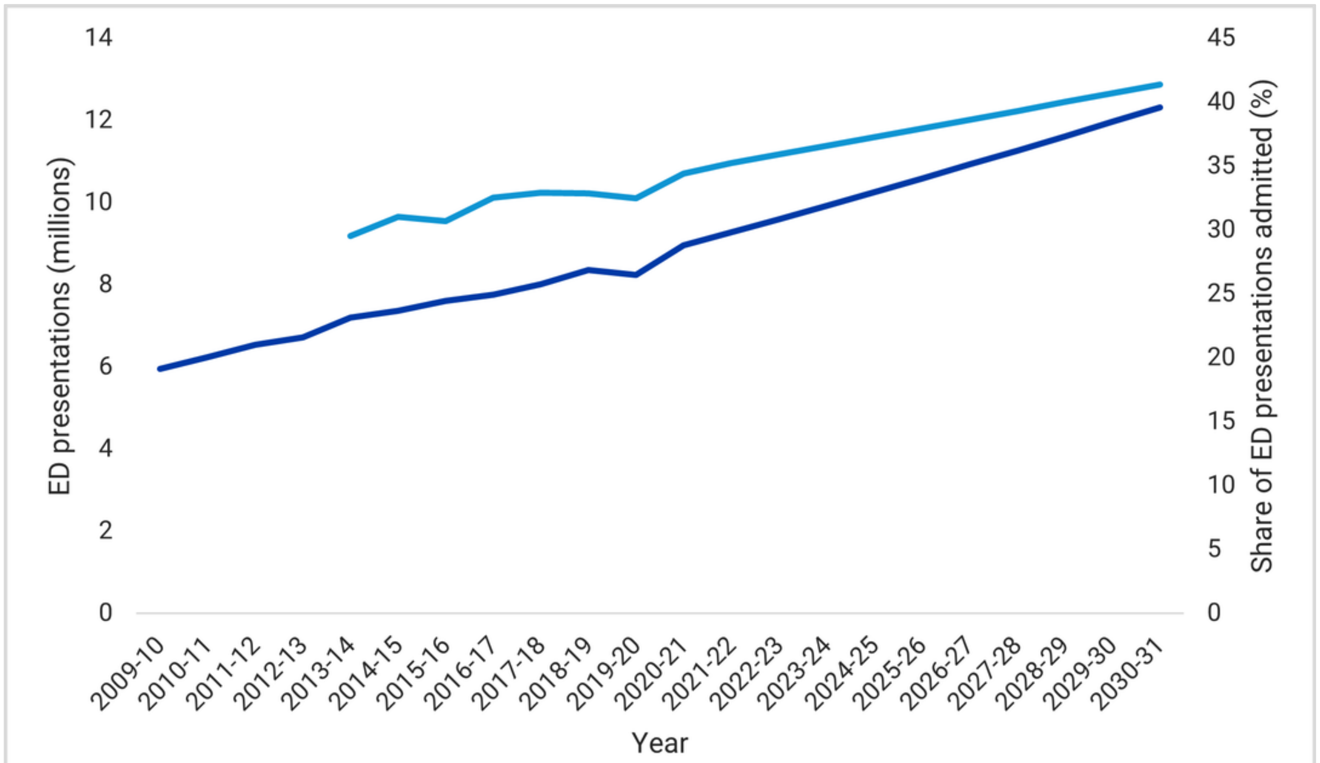



Figure 1: Actual and projected growth in ED presentations and share of ED presentations admitted to hospital, 2009–10 to 2030–31[12]

[11] AIHW 2022. Admitted patient care 2020–21, Table 1: Separations with COVID-19 diagnosis, states and territories, Australia, 2020–21

[12] Australian Medical Association 2021. Public Hospitals Cycle of Crisis. https://www.ama.com.au/sites/default/files/2022-10/Public%20hospitals%20-%20cycle%20of%20crisis.pdf

Furthermore, the AMA estimates that over the next 10 years the number of admissions from EDs will exceed all other hospital admissions, including for planned surgery.

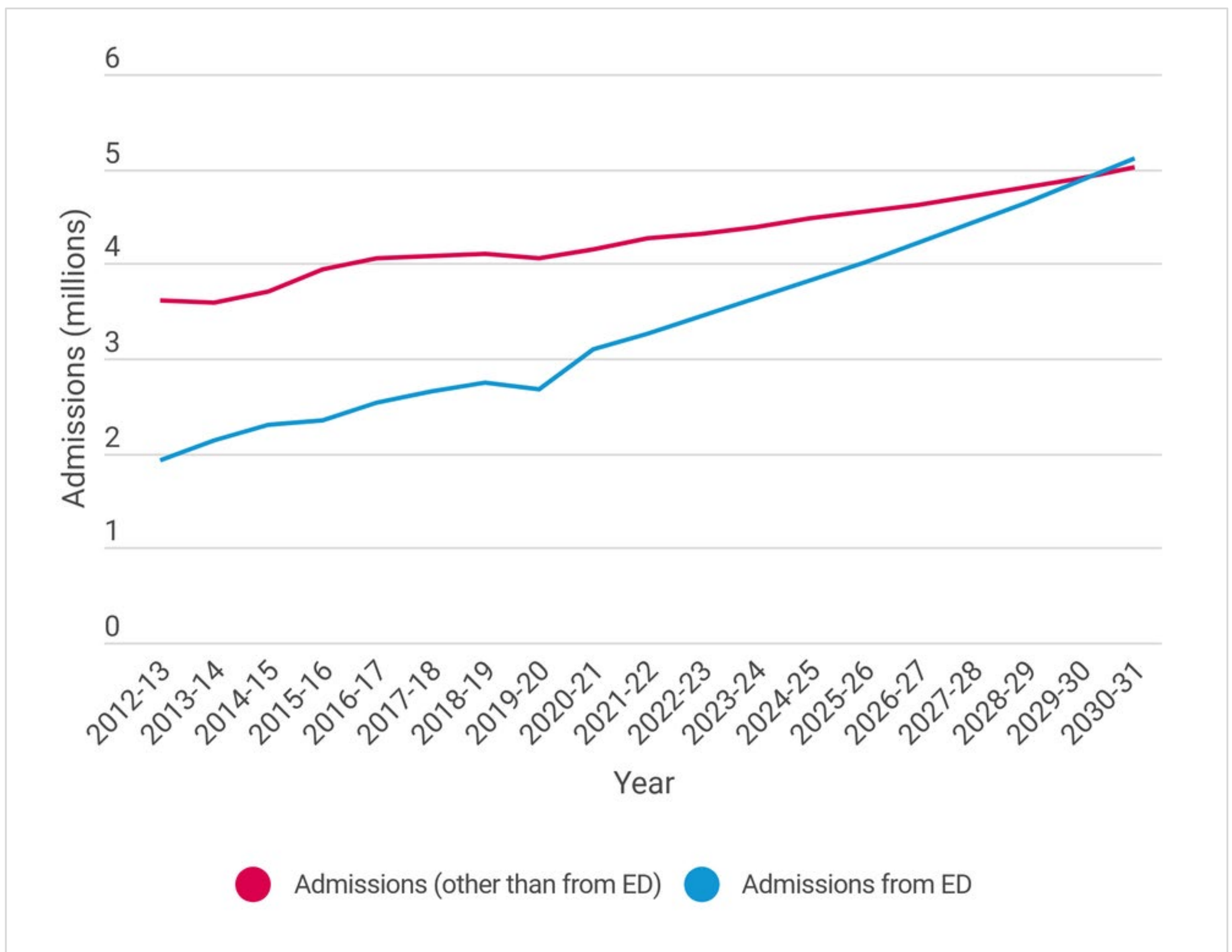



Figure 2: Actual and projected growth of hospital admissions from ED and other (non-ED) admissions, 2012–13 to 2030–31[13]

[13] Australian Medical Association 2021. Public Hospitals Cycle of Crisis. https://www.ama.com.au/sites/default/files/2022-10/Public%20hospitals%20-%20cycle%20of%20crisis.pdf

These numbers show that Australia's shifting demographics are having a significant impact on the public hospital system. Australia needs a broader discussion at the national level on whether Australia's public hospital policy and funding settings are still adequate to provide the level of care Australians expect.

**Number of approved/available public hospital beds per 1000 population aged 65 and over -all States and Territories**

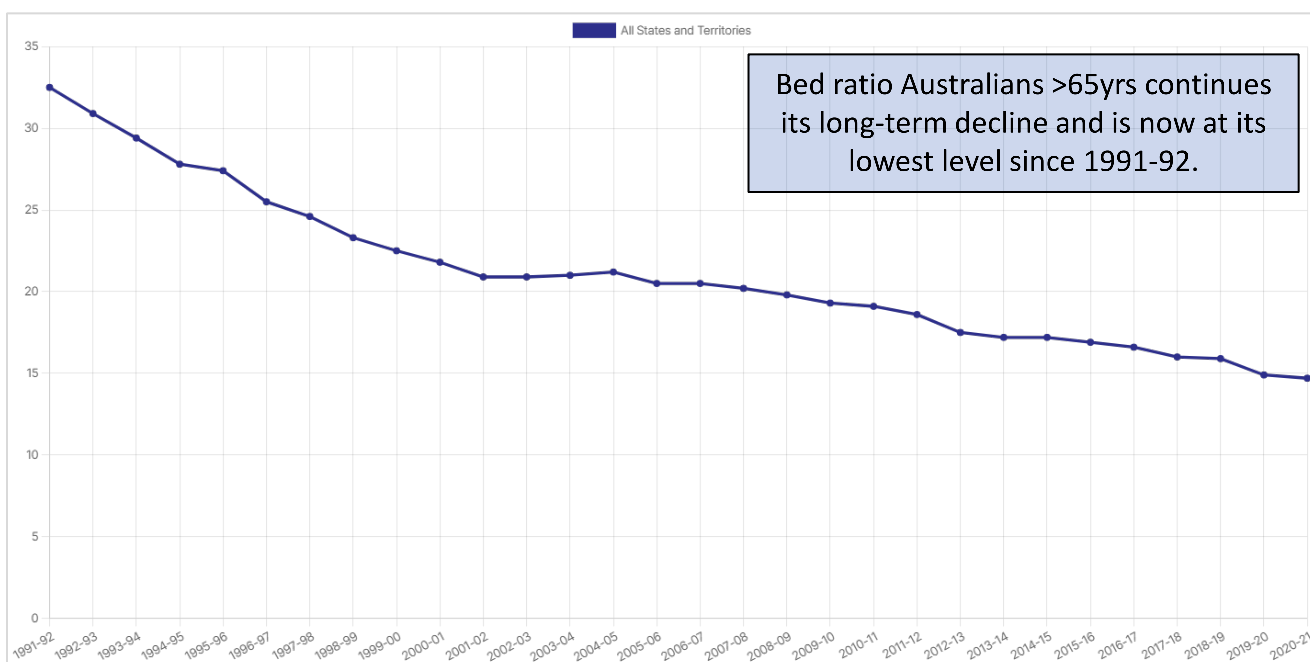



Figure 3: Australian Bureau of Statistics, national, state and territory population, https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-download

Figure 3 shows that in 2020–21 the ratio of total public hospital beds for every 1,000 people aged 65 years and older was 14.7 — a decrease of 0.2 per cent from the previous year (2019–20).[14] This is in spite of the fact that overall number of public hospital beds increased by 1.2 per cent in 2020–21 compared to the year before.[15] This ratio has now been on a downward trend for 27 years and is a major cause of public hospital over-crowding and long waiting times for emergency and planned surgery treatments.

Unsafe or unsuitable discharge destinations for vulnerable patients at risk of readmission also keeps public patients admitted longer than is necessary once their acute phase of hospital treatment has ended.[16]

[14] Australian Institute of Health and Welfare (AIHW) 2022 Australian Hospital Statistics: Hospital Resources 2020–21, Table 4.5 https://www.aihw.gov.au/getmedia/fb227d5e-0084-487d-b921-0ac5c6f65803/Hospital-resources-2019-20-data-tables-17-August-2021.xlsx.aspx; https://www.aihw.gov.au/reports-data/myhospitals/content/data-downloads

[15] Ibid.

[16] Australian Medical Association 2023. Hospital exit block: a symptom of a sick system report. https://www.ama.com.au/articles/hospital-exit-block-symptom-sick-system

As an illustration, in 2020–21, 19,631 public hospital separations were attributed to patients waiting for aged care services nationally (either a place in a residential aged care facility or an appropriate home care service).[17] Of these patients, around one in 10 waited more than 35 days. The number of separations, and therefore the number of patients waiting for aged care services, has been overall increasing since 2011–12.

Delayed access for patients who require an admission, either from the emergency department or for planned surgery, will almost certainly continue unless these multi-morbid, vulnerable, often elderly patients, can be safely discharged to the care of a multidisciplinary service team. This is a team who can manage their condition in the community or within a residential aged care facility.

With the lack of access to multidisciplinary community and primary care (due to geographical and/or socioeconomic factors), many multi-morbid patients will continue to seek public hospital emergency care and rely on public hospital admitted beds.

Unless the Commonwealth, State and Territory governments co-invest in additional community service solutions that fully support these vulnerable patients outside of the hospital, our hospital log jam will continue; wait times in emergency will continue to increase and the planned surgery waiting lists will only blow out further.

[17] Australian Government Productivity Commission (2023). Report on Government Services 2023: Chapter 14 aged care services. Retrieved 24/01/2023 from: https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/aged-care-services

## Emergency department waiting and treatment times

The public hospital system's ability to cope with Category 2 and Category 3 cases is a crucial measure of public hospital performance.

Under the Australian Health Performance Framework, two of the public hospital emergency department performance measures are:

- Proportion of patients seen within the clinically recommended timeframes set by the Australian Triage Scale; and
- Length of stay for emergency department care, proportion of patients staying for four hours or less.

**Percentage of triage category 3 emergency department patients seen within recommended time (< 30 minutes)**

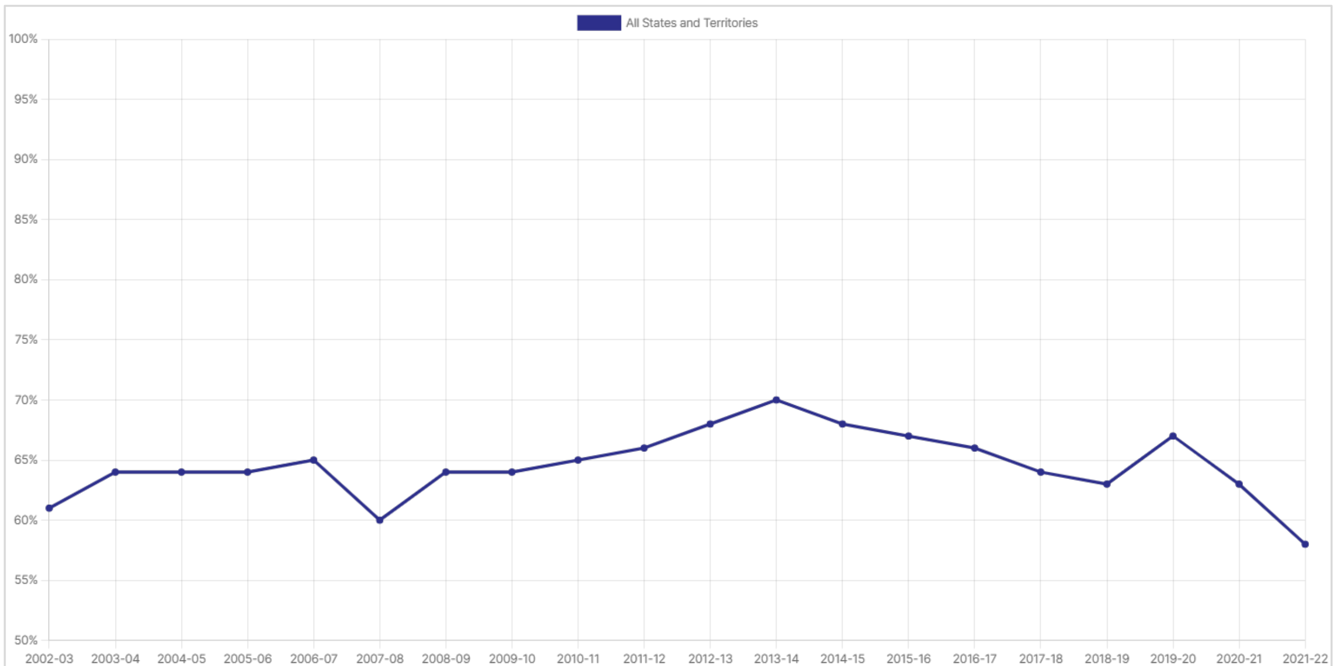



Figure 4: Source: The State of Our Public Hospitals (DoHA 2004 to 2010); Australian Institute of Health and Welfare (AIHW) Emergency department care (2010–11 to 2021–22): Australian hospital statistics.

Note: National Emergency Admission targets were abolished with effect from 1 July 2015.

In 2021–22 the proportion of Triage Category 3 Emergency Department patients seen within recommended 30 minutes dropped to 58 per cent nationally. This is the lowest number since the AMA started tracking ED performance in 2002–03.

## Patients leaving emergency within four hours

The proportion of emergency department presentations completed within four hours is one important indicator of whether Australians receive appropriate high quality and affordable hospital care. Patients are considered to have completed their visit to the emergency department when they physically leave (regardless of whether they were admitted to the hospital, were referred to another hospital, were discharged, or left the hospital at their own risk).

Figure 5 shows that in 2021–22, the proportion of people in all triage categories who completed their emergency presentation within four hours or less was 60.9 per cent. This is a decline of 5.8 per cent compared to the previous year and a further decline of 9 per cent compared to the pre-pandemic levels — in 2018–19, 70 per cent of patients completed their emergency department stay within four hours or less.[18,19] This is also the lowest number since 2011.

Translated into hours, this meant that nationally, in the 90th percentile[20] patients left the emergency departments 9 hours after presenting in 2021–22 reporting year. For patients whose visit to emergency departments ended in hospital admission, the 90th percentile length of emergency department stay was over 15 hours (15 hours 37 minutes), ranging from 12h 22min in Queensland to 23h 49 min in Tasmania.[21]

Although it is likely that the emergency department performance in 2021–22 was influenced by COVID-19, the proportion of public hospital emergency patients leaving within four hours has been in decline since 2014–15.

[18] Australian Institute of Health and Welfare (AIHW) 2021. Australian hospital statistics: Emergency Department Care 2019–20 viewed 8 August 2021 https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

[19] Australian Institute of Health and Welfare 2021, Australian hospital statistics: Emergency department care 2018–19, Table 6.4 viewed 31 July 2021 https://www.aihw.gov.au/getmedia/6f15c095-e669-428c-9cef-a887cb65f3b0/Emergency-department-care-2018-19.xlsx.aspx

[20] The 90th percentile number expression means that among 90 per cent of patients there will be those whose stay at Emergency Department will be 9 hours. According to AIHW, the 90th percentile is the maximum amount of time which 90% of patients spent in the emergency department. For the remaining 10% of patients, the length of stay was longer. More information available here: https://www.aihw.gov.au/reports-data/australias-health-performance/australias-health-performance-framework/national/all-australia/access/accessibility/2_5_8

[21] Australian Institute of Health and Welfare (AIHW) 2023. Australian hospital statistics: Emergency Department Care 2021-22, Table 6.1 viewed 14 February 2023 https://www.aihw.gov.au/getmedia/0d0d6cbf-e764-4a89-a71a-b03c5156235d/Emergency-Department-Care-2020-21.xlsx.aspx https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

**Percentage of emergency department visits completed in four hours or less – all states and territories**

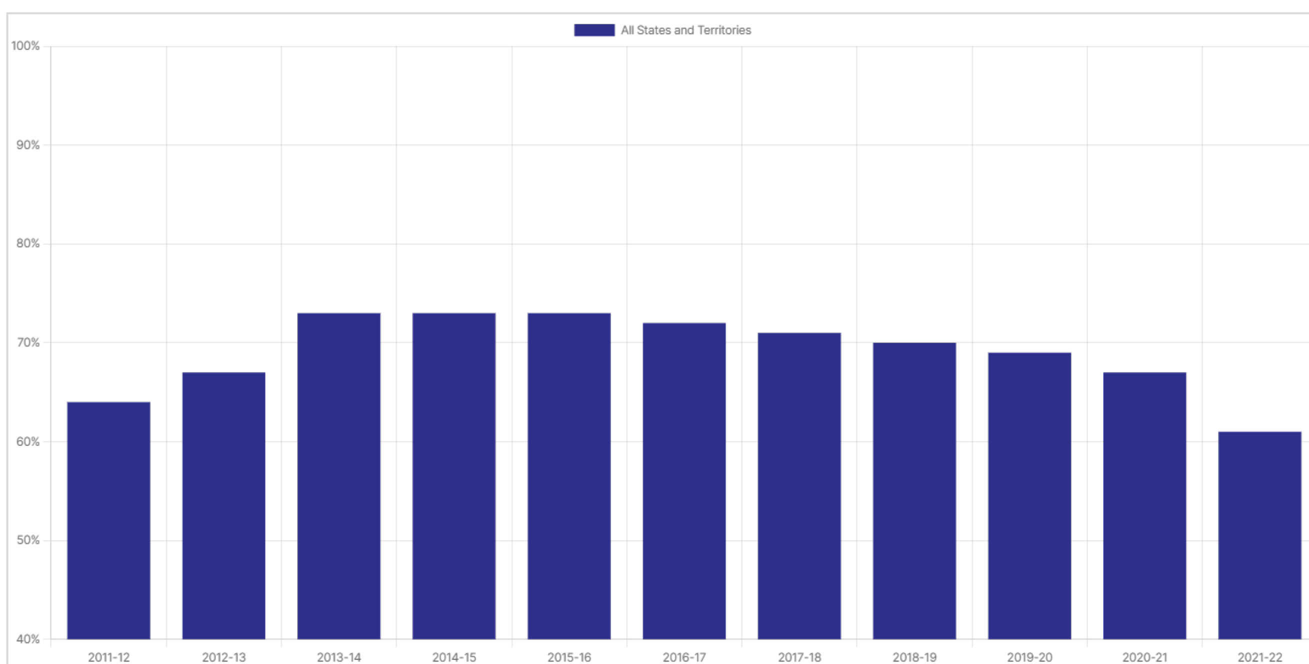



Figure 5 Source: Australian Institute of Health and Welfare (AIHW) Emergency department care (2011–12 to 2020–21): Australian hospital statistics.

Note: National Emergency Admission targets were abolished with effect from 1 July 2015

## The effect of COVID-19 on emergency department activity

Throughout 2021–22 financial year, COVID-19 continued to impact the performance of public hospitals differentially around Australia, but as this Report Card shows, the overall performance of public hospitals declined.

AIHW data indicates that in 2021–22, there were 53,593 admissions from emergency departments for COVID-19 (Emergency use of U07) out of 268,975 presentations. COVID-19 was the third most common principal diagnosis in emergency department and third principal diagnosis for patients who were subsequently admitted.[22]

[22] Australian Institute of Health and Welfare (AIHW) 2023. Australian hospital statistics: Emergency Department Care 2021–22, Table 4.9 and Table 4.10 https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

## Planned Surgery Waiting and Treatment times

Planned surgery is any form of surgery considered medically necessary, but which can be delayed for at least 24 hours. These surgeries are essential and include lifesaving procedures, diagnostic procedures and procedures which will restore basic functions for someone.

Diagnostic Imaging (DI) radiology tests (such as X-ray, ultrasounds, CT, MRI and nuclear medicine scans that are interpreted and reported by radiologists) that lead to planned surgery are often a critical element of the patient treatment process. AMA members report that access to radiology for patients in the public hospital system is also in decline, with many accounts of patients experiencing distressing delays in accessing public DI services when requested by their General Practitioners and specialist referrers. They cite examples of requests for DI referrals that are clinically urgent but can take up to months for patients to access, for conditions such as breast lumps suspected to be cancer requiring X-ray mammography, or painful and debilitating musculoskeletal disorders requiring ultrasound or MRI assessment.

AMA members also report that escalation in demand for radiology due to delays caused by COVID-19 and the 'hidden waiting list' have outstripped workforce availability for diagnostic imaging staff, including radiologists. According to the Australian Institute of Health and Welfare, the volume of diagnostic imaging services dropped significantly in the June quarter 2020, down to 5.6 million from approximately 6.5 million in previous quarters, after the COVID-19 lockdowns were introduced. The volume of imaging services bounced back and reached 7.1 million in the June quarter 2021.[23]

The shortages in workforce availability relative to escalating DI volumes are detrimental to providing timely radiologist reporting of DI studies to referrers, further delaying patient treatment or preparation for future surgery. Although measures such as engaging off-site teleradiology services may alleviate on-site demands, they are not able to replicate the quality of on-site radiologists, who collaborate with referrers and "value-add" in multidisciplinary meetings to enhance quality patient care.[24]

For the planned surgery that is provided in public hospitals, the Australian Health Performance Framework includes the following two performance indicators that measure the provision of timely planned surgery:

- The median waiting time for planned surgery; and
- The percentage of patients treated within the clinically recommended times.

[23] Australian Institute of Health and Welfare (AIHW) 2022. Diagnostic services. Pathology, imaging and other diagnostic services https://www.aihw.gov.au/reports/diagnostic-services/pathology-imaging-and-other-diagnostic-services

[24] Note: Due to lack of quantitative data, this Report Card and the future AMA Public Hospital Report Cards will rely on AMA members to provide qualitative feedback.

## The effect of COVID-19 on public hospital planned surgery activity during 2021–22 reporting period

At the start of the COVID-19 pandemic in 2020, an agreement was reached at the national level to pause public and private hospital planned surgeries from 1 April 2020, except for Category 1 and high priority Category 2 patients. Shortly after, the Commonwealth announced a partnership with the private hospital sector to ensure their viability during the private planned surgery pause.[25] This agreement also allowed state and territory governments to enter into private hospital COVID-19 partnership agreements to purchase capacity for public patients, with 50 per cent of the cost covered by the Commonwealth. State and territory governments have pursued different paths to reaching these agreements.

Following the decline in planned surgery in 2020, during 2020–21, planned surgery admissions from the surgery wait lists increased by 10.7 per cent[26] across all jurisdictions, with some jurisdictions exceeding 2019 pre-pandemic volumes. The greatest increase occurred in Category 3 admissions.

The increases are the result of planned surgery recuperation that was initiated after the first wave of COVID 19 in several jurisdictions in 2020–21[27,28,29] specifically with the aim of clearing the backlog.

AIHW data shows 754,600 admissions to hospital from the public planned surgery waiting lists in 2020–21, and a subsequent drop in 2021–22 to 618,546, lower even than in 2019–20, the first year of the pandemic and about 135,000 admissions less than in 2018–19.[30]

At the same time, 783,715 people were added to the planned surgery waiting list in 2021–22. This is the lowest number of additions since 2017–18, indicating that the number of patients on the hidden waiting list — those waiting to see a specialist to be added to the planned surgery list — is growing.

[25] Hunt, G. MP 2020. Minister's Hunt Media – Media Release: Australian Government partnership with private health sector secures 30,000 hospital beds and 105,000 nurses and staff, to help fight COVID-19 pandemic https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/australian-government-partnership-with-private-health-sector-secures-30000-hospital-beds-and-105000-nurses-and-staff-to-help-fight-covid-19-pandemic
[26] Australian Institute of Health and Welfare (AIHW) 2022. Hospital activity planned surgery https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/eswt
[27] NSW Health Annual Report 2020–21. Response to the COVID pandemic https://www.health.nsw.gov.au/annualreport/Publications/2021/a-pandemic-emerges.pdf
[28] Andrews, D. Premier of Victoria 2020. Media Statement: COVID-19 Capacity Boost As Planned Surgery Blitz Starts https://www.premier.vic.gov.au/covid-19-capacity-boost-planned-surgery-blitz-starts
[29] Queensland Government Deputy Premier and Minister for Health and Minister for Ambulance Services The Honourable Steven Miles Media Statement June 2020. Quarter of a billion dollar planned surgery blitz https://statements.qld.gov.au/statements/90009
[30] Australian Institute of Health and Welfare (2022) AIHW Media Releases Public hospitals worked to clear planned surgery backlog during 2020–21 https://www.aihw.gov.au/news-media/media-releases/2021/january-1/public-hospitals-worked-to-clear-planned-surgery#:~:text=There%20were%20893%2C000%20patients%20added,number%20added%20in%202018%E2%80%9319.&text=Information%20on%20Emergency%20department%20care,the%20AIHW%20in%20December%202021.

## Median waiting time

The median waiting time indicates the number of days within which 50 per cent of patients were admitted for their planned procedure. This means half of the patients had a shorter wait time than the median, and half had a longer waiting time.

With increases in admissions from planned surgery waiting lists and additional investment by State and Territory health departments, nationally in 2021–22, the median wait time for planned surgery was 40 days. This is an improvement of 8 days compared to the year before.

The ratio of additions to the wait list and removals from wait lists due to admissions, plays an important role in the ability of the system to provide timely medical procedures to patients on the lists. The data show that over a number of years, the volume of patients being added to the list is greater than the number who are taken off the list.[31] These data reflect the hospital system's surgical provision capacity. Such capacity needs to be commensurately scaled up to be able to meet the demand of a population that is increasing in size, age and in people living with multiple chronic health issues.

**Median waiting time for planned surgery (days) — national**

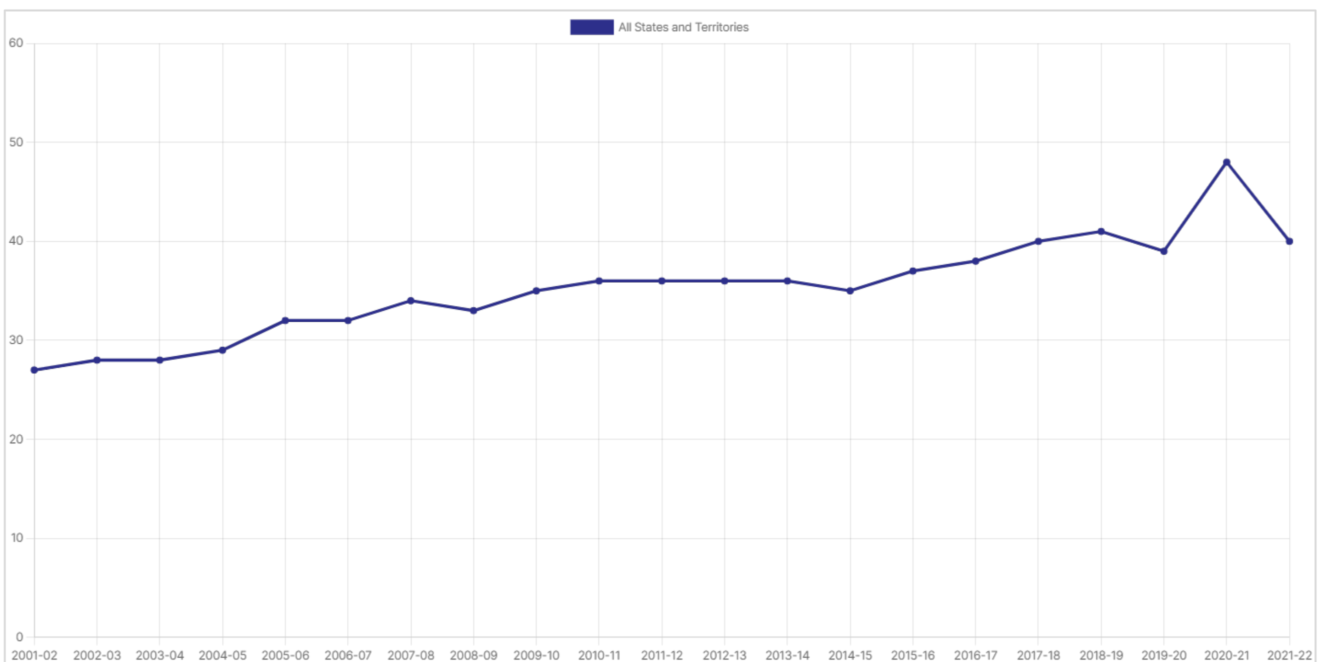



Figure 6 Source: Australian Institute of Health and Welfare (AIHW), Australian Hospital Statistics: Planned surgery data cubes (2001–02 to 2006–07): Australian Institute of Health and Welfare (AIHW), Australian Hospital Statistics: Planned surgery waiting times (2007–08 to 2021–22).

[31] Australian Government. Productivity Commission 2022. Report on Government Services 12. Public Hospitals Table 12A.33 https://www.pc.gov.au/research/ongoing/report-on-government-services/2022/health/public-hospitals

## Planned surgery within clinically recommended timeframes

There are three planned surgery clinical urgency categories:

- Category 1 — procedures that are clinically indicated for completion within 30 days;
- Category 2 — clinically indicated for completion within 90 days; and
- Category 3 — clinically indicated for completion within 365 days.

Even with additional efforts and programs implemented by States and Territories to support planned surgery provision, and increases in in admissions, nationally, the percentage of Category 2 planned surgery that was provided within the recommended 90 days dropped to 63 per cent in the 2021–22 reporting period. This is 7 per cent below the 2020–21 levels[32] and 17.5 per cent down on pre-pandemic 2018–19 levels.[33]

**Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) All States and Territories**

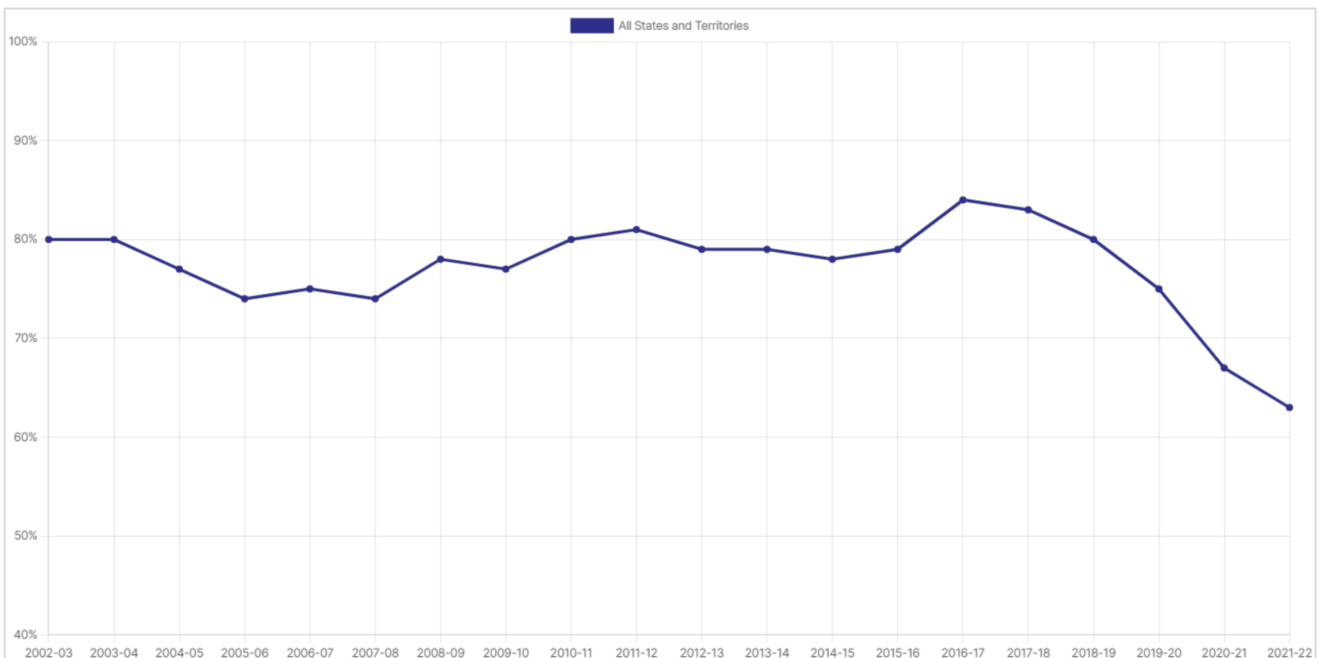



Figure 7 Source: Australian Institute of Health and Welfare (AIHW), Australian Hospital Statistics: Planned surgery data cubes (2001–02 to 2006–07): Australian Institute of Health and Welfare (AIHW), Australian Hospital Statistics: Planned surgery waiting times (2007–08 to 2021–22).

[32] Australian Institute of Health and Welfare 2021. Australian hospital statistics: Planned surgery waiting times 2020–21 Tables 4.11–4.18 https://www.aihw.gov.au/getmedia/f72949da-cba8-4f36-a47d-2c5bbcccd55a/Planned-surgery-waiting-times-2019-20.xlsx.aspx

[33] Australian Institute of Health and Welfare 2020. Australian Hospital Statistics: Planned surgery waiting times 2018–19 Tables 4.11-4.18 https://www.aihw.gov.au/getmedia/5042f8a8-4711-455a-9c6d-60650f954fbe/Planned-surgery-waiting-times-2018-19.xlsx.aspx

During 2021–22 reporting period, more than one in three patients (37 per cent) waited longer than the clinically indicated 90 days for Category 2 planned surgery.

Although the increase in wait times can, to some extent, be explained by the COVID-19 impact, the long-term pressure on public hospital beds and operating theatres pre-dates the pandemic. With an ageing population and hospital capacities not keeping up with population growth, the cumulative public hospital planned surgery demand will continue to grow from an already high baseline of patients on long waiting lists.

The majority of States and Territories reintroduced suspensions of planned surgeries in early 2022 to free up public hospital capacity to manage growing numbers of COVID-19 patients.[34,35,36,37,38] The impact of these suspensions and the States trying to catch up can still be felt across the system.

As a result, the cumulative public hospital planned surgery demand will continue to surge. This is on top of an already high baseline of patients on long waiting lists, surgeries delayed during the multiple planned surgery cancellations over the past three years, delayed diagnoses and referrals due to the impact on health seeking behaviour as a result of the pandemic, and natural growth to the planned surgery waiting list.

[34] Andrews, D. Premier of Victoria 2022. Media statement: Pandemic Code Brown To Support Hospitals https://www.premier.vic.gov.au/pandemic-code-brown-support-hospitals
[35] Victorian Government Department of Health 2022. Media statement: Changes to non-urgent surgery settings helping hospitals respond to Omicron https://www.health.vic.gov.au/media-releases/changes-to-non-urgent-surgery-settings-helping-hospitals-respond-to-omicron
[36] D'Ath, Y. Minister for Health and Ambulance Services 2022. Media statement: Non-urgent planned surgeries postponed https://statements.qld.gov.au/statements/94231
[37] Stevens, G. 2022. Emergency Management (Appropriate Surgery During COVID-19 Pandemic No 6) Direction 2022 https://www.covid-19.sa.gov.au/__data/assets/pdf_file/0011/584309/Emergency-Management-Appropriate-Surgery-During-COVID-19-Pandemic-No-6-Direction-06012022.pdf
[38] NSW Government 2022. Media release: Support measures for hospitals, community https://www.nsw.gov.au/media-releases/support-measures-for-hospitals-community

## Hidden waiting list

Specialist clinics in public hospitals provide planned, non-admitted services to patients. To attend a specialist clinic, patients must have a referral from their general practitioner, hospital doctor or other health professional. These specialist attendances often result in patients being added to the planned surgery waiting lists.

The available data shows that by the time a patient is added to the official planned surgery waiting list, they have already waited the period between referral from their general practitioner to the date of a consultation with an out-patient specialist to assess their surgery urgency or need. This period between the referral and the patient being officially added to the planned surgery list is known as the 'hidden waiting list'.

Similar to the planned surgery urgency categorisation, the outpatient urgency categories are classified as:

- Category 1 — specialist consultation recommended within 30 days of being added to the outpatient wait list
- Category 2 — specialist consultation recommended within 90 days of being added to the outpatient wait list
- Category 3 — specialist consultation recommended within 365 days of being added to the outpatient wait list.[39]

In 2022 the AMA published a report that looked specifically at the hidden waiting lists and the numbers of patients that were waiting to see specialists in the public hospital system.[40] The Report found that many patients were waiting months and even years for an outpatient appointment, to only be put on another waiting list to receive surgery. Patients are therefore not fully informed of the actual waiting time for planned surgery, and the system cannot be resourced properly as the scale of the problem is unknown.

In addition to this, the way in which the public hospital funding system is set up has direct implications for the ability of the system to cope with the increasing burden of disease. At the moment, only the cost of delayed surgery resulting from the overdue time in the actual waiting list is factored in into the pricing model, i.e., only the wait time after seeing a specialist in the public system.

The AMA argues for and has been calling on the Independent Hospital and Aged Care Pricing Authority to consider factoring in the cost of delayed access to specialists in the outpatient clinics.[41] This is particularly relevant for States like Tasmania where the data available through Tasmanian Health Service indicates that patients who are assessed as Category 1, for example needing to see a neurosurgeon 30 days from the referral by their GP, can wait up to 880 days.[42]

Delayed access to a specialist often results in delayed access to planned surgery, leading to patients presenting at emergency departments, having more complex health conditions, and requiring longer recovery.

[39] Queensland Government Queensland Health 2022. Queensland Reporting Hospitals – Outpatient Indicators http://www.performance.health.qld.gov.au/Home/SpecialistOutpatientIndicators/99999?Indicator=Category1
[40] Australian Medical Association 2022. Planned Surgery Hidden Waiting List https://www.ama.com.au/planned-surgery-hidden-waiting-list
[41] Australian Medical Association 2022. IHPA Pricing Framework 2023–24. AMA submission to Independent Hospital Pricing Authority Consultation https://www.ama.com.au/articles/2023-24-public-hospital-pricing-framework
[42] Tasmanian Health Service 2023. Estimated Outpatient Waiting Times – Southern Region. https://outpatients.tas.gov.au/clinicians/wait_times/wait_times

The planned surgery data available via AIHW for 2021–22 indicate that about 100,000 fewer people were added to the planned surgery waiting list in 2021–22 than the year before, or any year since 2017–18.[43] The likely explanation for the drop is the impact of COVID-19 on specialists working in public hospitals and the redeployment of hospital resources to manage COVID-19 patients. Because they are unable to access specialists in the public system following a GP or other health practitioner referral, a number of patients spend time languishing on the hidden waiting list, before they are added to the 'official' planned surgery waiting list.

What this means in practice is that around 100,000 people without private health insurance or who have limited access to private hospitals in areas where they live, will be waiting significantly longer to access the surgery that may relieve them of pain or help them live a more fulfilling life.

Loss of health impacts on productivity and results in increased societal cost. Every delayed surgery has an impact, leading to loss of quality of life and further deterioration of health. Delaying a minor surgical intervention to improve the hearing of a child may mean they miss crucial time for physical and mental development. This is likely to incur much larger costs throughout their life than the cost of surgery. Or a delayed orthopaedic surgery, for example a hip replacement, will incur further costs to the health system through more consults with the patient's General Practitioner, more medicine subsidised by the pharmaceutical benefits scheme, and through income support from the Government due to an inability to work. This could also lead to further health issues, including mental health issues, for an individual due to their limited ability to participate in work, physical and social activities.

If Australia is truly aiming towards creating a framework and measuring the wellbeing of its citizens[44] using the indicators such as premature mortality and life satisfaction,[45] then the health outcomes of its citizens must be considered. Both of those are directly linked with access and availability of affordable healthcare, which this report demonstrates is declining.

Through the Clear the Logjam campaign, the AMA continues to call for significant investment in public hospital resourcing not just to overcome delays further exacerbated by COVID-19, but also to restore the capacity of public hospitals to provide access to surgery to all those who require it within the clinically indicated time frames.

[43] Australian Institute of Health and Welfare 2022. Australian hospital statistics: Planned surgery waiting times 2021–22 Table 2.1: Additions and removals from public hospital planned surgery waiting lists, 2017–18 to 2021–22.
[44] Australian Government The Treasury 2022. Measuring what matters: https://treasury.gov.au/consultation/measuring-what-matters-2022
[45] Australian Government The Treasury 2022. OECD Framework Indicators. https://treasury.gov.au/sites/default/files/inline-files/OECD_framework_indicators.pdf

## Funding for public hospitals[46]

The latest Addendum to the National Health Reform Agreement 2020–25 continues the Commonwealth commitment to fund 45 per cent of the efficient growth in public hospital activity, capped at 6.5 per cent per annum. States and Territories must fund all public hospital expenditure over and above this amount.

In response to COVID-19, a National Partnership on COVID-19 Response Agreement was signed between the Commonwealth and the States that allowed for 50–50 funding share of the costs incurred, to provide states funding to respond to the COVID-19 outbreaks.[47] This Agreement ended on 31 December 2022.

**Public hospital expenditure per person (constant prices)**

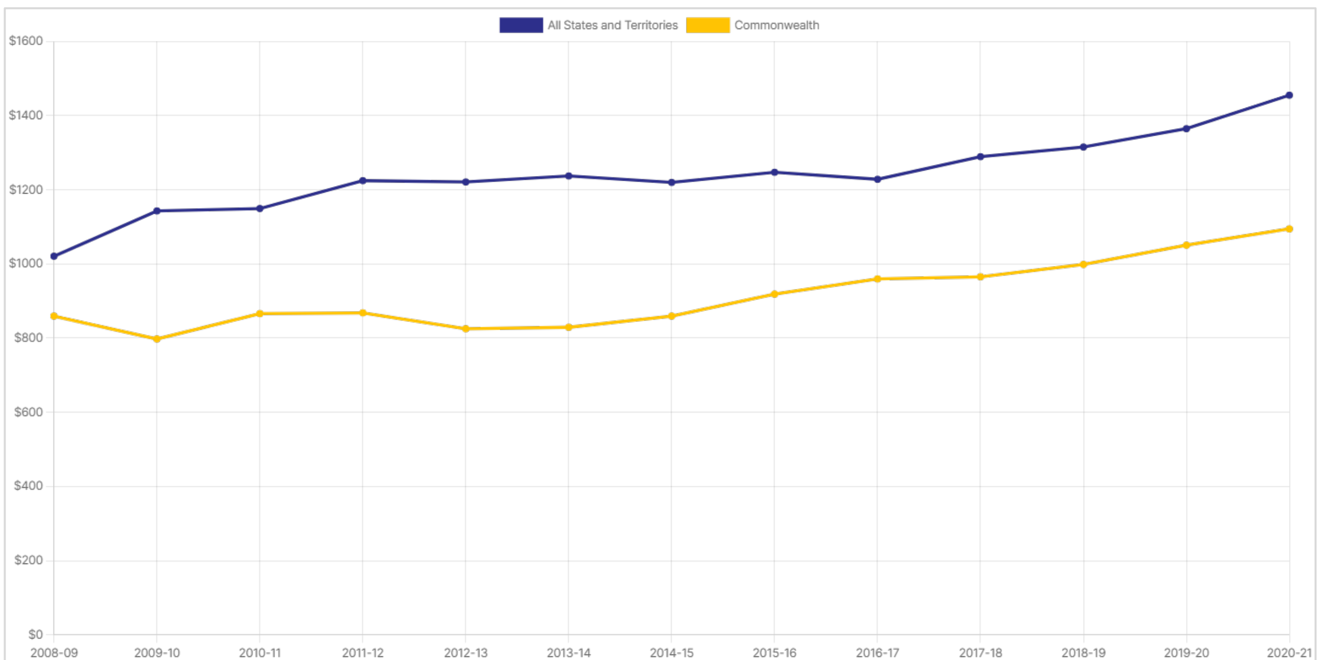



Figure 8 Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 9 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

[46] Note that the most recent public hospital funding data available via AIHW is 2020–21, to the end of the financial year in June 2021, whereas the data on planned surgeries and emergency department activity covers 2021–22 financial year
[47] Federal Financial Relations 2020. National Partnership on COVID-19 Response. https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-04/covid-19_response_vaccine_amendment_schedule.pdf

Figure 8 shows that State and Territory Governments have, on average over the last ten years, allocated substantially higher levels of public hospital growth funding per person each year than has the Commonwealth. The table below compares the rate of growth in per person Commonwealth public hospital funding in each five-year period over the last decade.

**Per person average annual per cent increase in public hospital funding by government source (constant prices)**

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **Commonwealth** | -1.0% | 3.9% | 4.7% | 2.04% |
| **All States and Territories** | 4.6% | 1.0% | 5.2% | 3.00% |

This rate of per person funding growth from the Commonwealth and State governments falls well short of that needed to cover annual public hospital input increases (including wages growth), plus a higher volume of services to provide timely patient treatment.

**Significant effort will be required from both the Commonwealth and the State and Territory governments to improve public hospital performance. While the Commonwealth will need to increase its share by a greater amount, the States and Territories must also invest to improve hospital performance.**

The AMA is calling for the Commonwealth to increase its contribution to 50 per cent for activity-based funding. This increase would require the States and Territories to reinvest the 5 per cent into public hospitals. Furthermore, the removal of the Commonwealth's annual growth cap would allow public hospitals to meet community demand, meaning an indirect increase in funding from all governments due to increased activity. Funding to address demand and expand capacity would be partnership funding, shared between the Commonwealth and States and Territories. Commonwealth funding for pay-for-performance targets would only be paid if States and Territories improved their public hospital performance.[48]

[48] Australian Medical Association 2021. Public Hospitals – Cycle of Crisis https://www.ama.com.au/sites/default/files/2021-10/Public%20hospitals_Cycle%20of%20crisis_online%20%281%29.pdf

# STATE BY STATE PUBLIC HOSPITAL PERFORMANCE

This section includes performance information for each State and Territory using available data sources. A summary of State performance is shown in Table 1. It represents 2020 21 compared to the previous year. The funding section of the Table 1 reflects the 2019–20 data.

**Table 1: State and Territory performance 2021–22 compared to the previous year. Latest hospital per person funding data are for the year 2020–21**

| State/Territory | Improved access to emergency treatment – Category 3 (within 30 mins) 2021–22 | Improvement in proportion of patients leaving emergency within 4 hours 2021–22 | Improvement in median wait time for planned surgery (all categories) 2021–22 | Improvement in Planned Surgery Category 2* – patients seen on time 2021–22 | Commonwealth public hospitals per person funding (constant prices) 2020–21 (latest data) | State public hospitals per person funding (constant prices) 2020–21 (latest data) |
|---|---|---|---|---|---|---|
| **NSW** | ✗ | ✗ | ✓ | ✗ | ✓ | ✗ |
| **VIC** | ✗ | ✗ | ✓ | ✗ | ✓ | ✗ |
| **QLD** | ✗ | ✗ | ✓ | ✗ | ✓ | ✗ |
| **WA** | ✗ | ✗ | ✓ | ✗ | ✓ | ✗ |
| **SA** | ✗ | ✗ | ✓ | static | static | ✗ |
| **TAS** | ✗ | ✗ | ✗ | ✓ | static | ✓ |
| **ACT** | P | ✗ | ✓ | ✗ | ✗ | ✓ |
| **NT** | ✗ | ✗ | ✗ | ✗ | static | ✓ |

Source: Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times 2019–20 to 2021–22: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Emergency department care 2020–21 to 2021–22: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Health Expenditure Australia 2020–21, data visualisation.

*Treating patients within clinically recommended time – Category 2 (within 90 days)

✓or ✗ indicates a change in performance of at least 1 per cent compared to 2019–20. In the case of per person public hospital funding the ✓or ✗ shows a change of 1 per cent or more between 2019–20 and 2020–21. Median wait time for planned surgery expressed in days.

✓or ✗ indicates a change of at least 1 day compared to 2019–20.

# NEW SOUTH WALES

**Dr Michael Bonning**

President AMA NSW

During COVID, the NSW Government dedicated the necessary funding and resources to ensure the health system was adequately equipped to deal with the evolving challenges associated with the pandemic. The response was demonstrative of the State's capacity to respond to the crisis at hand.

Whilst the COVID threat has waned, the State faces new challenges — ambulance ramping, hospital log jams, and long elective surgery waitlists. The pressure from a growing and ageing population with complex, chronic health conditions is pushing the system to its limits.

The statistics in this report reveal a clear trend — our public hospitals are falling behind on the Government's performance measurements. Quarter on quarter our ability to meet patients' health care needs is worsening — it is a crisis in slow motion.

The NSW Government needs to apply the same political will to finding solutions to these current challenges as it did to the COVID pandemic.

The NSW Government has dedicated significant funding to building new infrastructure, but there hasn't been the same resourcing dedicated to bolstering workforce numbers. Operating theatres sit empty while wait lists grow longer because we do not have enough doctors, nurses, and other health workforce staff.

The current health workforce is exhausted due to chronic understaffing. AMA (NSW) is calling on the NSW Government to create 1750 new, permanent positions for doctors, as well as modernise contractual and employment arrangements to reflect modern service delivery, contemporary models of care, and more efficient ways of working.

NSW doctors are among the lowest paid in the country with conditions dating back to the 1980s. The Government's failure to address Award conditions is demoralising. Award and contract conditions must be updated to attract and retain the best and brightest in our public hospital system. It is frustrating to see NSW hospitals train experts in clinical care and then witness the best of these trainees leave — attracted by better remuneration packages and administrative support by interstate hospitals where their skills and training are highly valued.

We're also calling on the State Government to apply comprehensive and sustained funding to improve elective surgery wait times. The health system should set a goal of 15% increase in elective surgery over the next two years, and a plan to reduce the wait list to be under 25,000 by 2028, with a 10-year plan to achieve 'back to zero' on elective surgery waitlists.

If we are to build a world-class health system, then we need a government that is willing to invest in health staff.

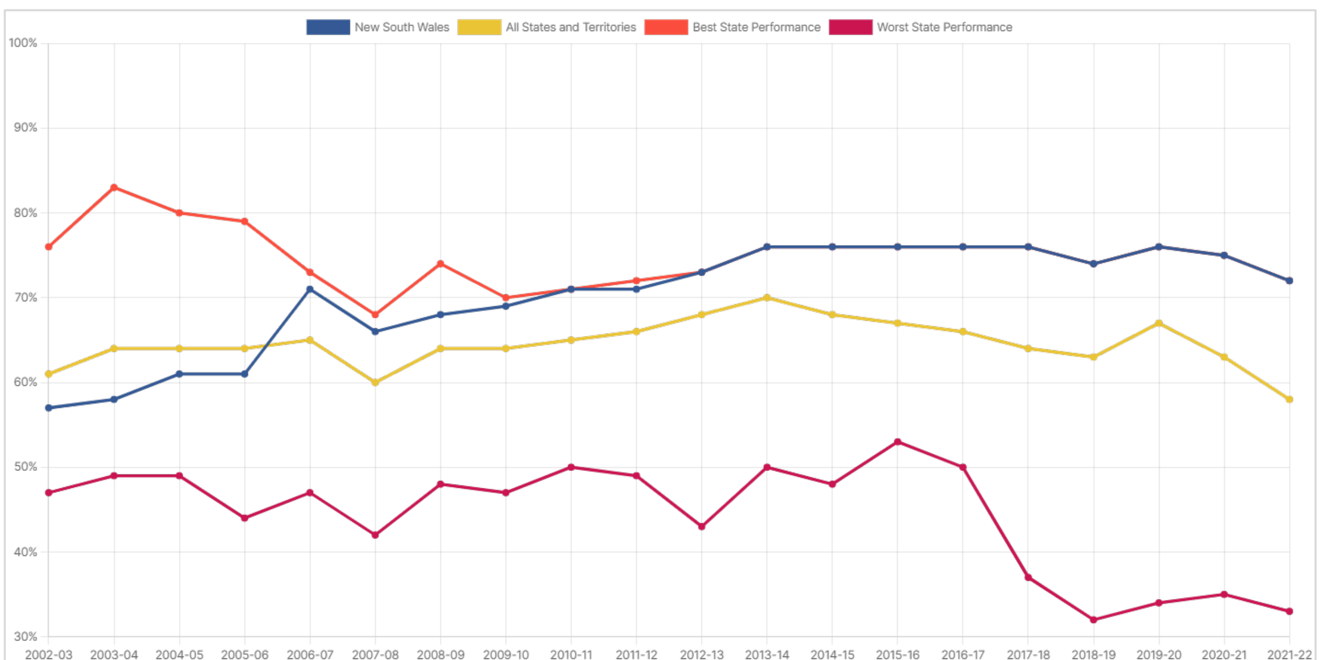
## Emergency department

**New South Wales — COVID-19 impact on public hospital emergency department patient volumes**

During 2021–22 reporting period, NSW emergency department public hospital performance declined compared to the year before. Percentage of Triage Category 3 Emergency department patients seen within recommended time (<30 minutes) dropped by three per cent compared to the year before. However, NSW continues to be the best performer nationally on this important indicator, and 14 per cent above the national average of 58 per cent. Note that the 2021–22 reporting period was heavily influenced by COVID-19 after Australia removed many COVID-19 public health measures in late 2021.

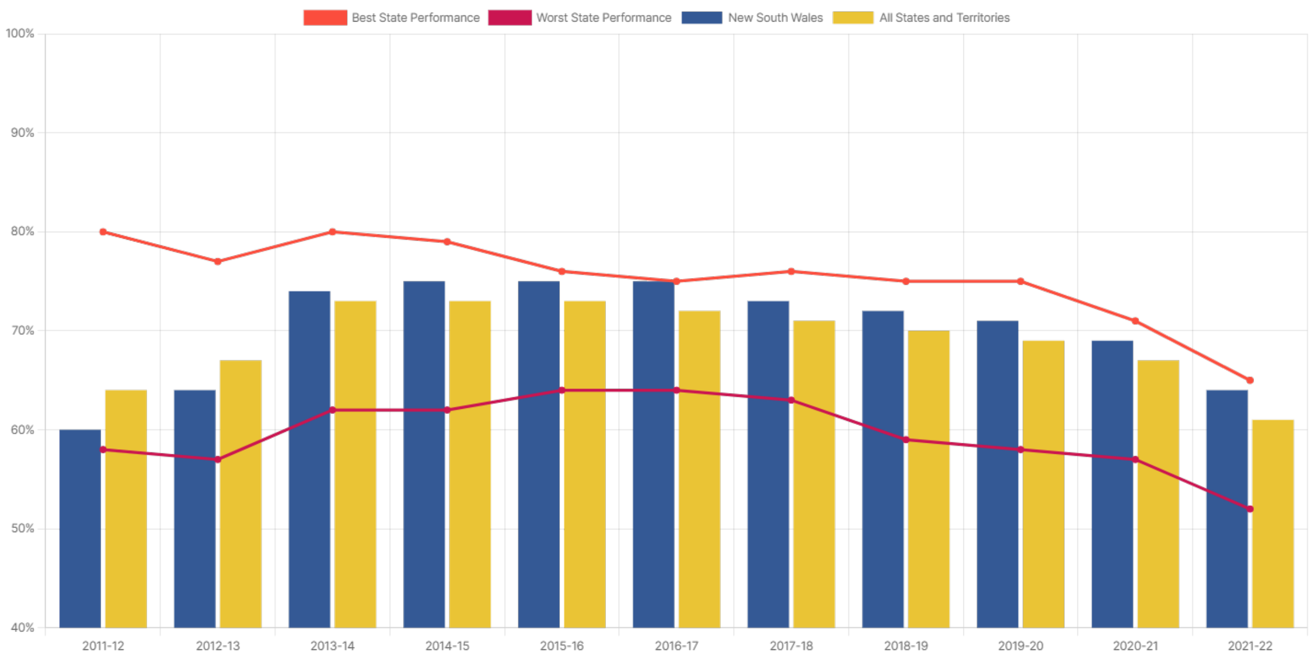
**Waiting times**

**Percentage of Triage Category 3 emergency department patients seen within recommended time (<30 minutes) — New South Wales**




Source: The State of our Public Hospitals (DoHA 2004 to 2010). Australian Institute of Health and Welfare (AIHW). Emergency department care 2010 to 2021–22

**Percentage of emergency department visits completed in four hours or less — New South Wales**




Source: Australian Institute of Health and Welfare (AIHW). Emergency department care (2011–12 to 2020–21): Australian hospital statistics.

Note: National emergency access targets were abolished with effect from 1 July 2015

## Planned surgery

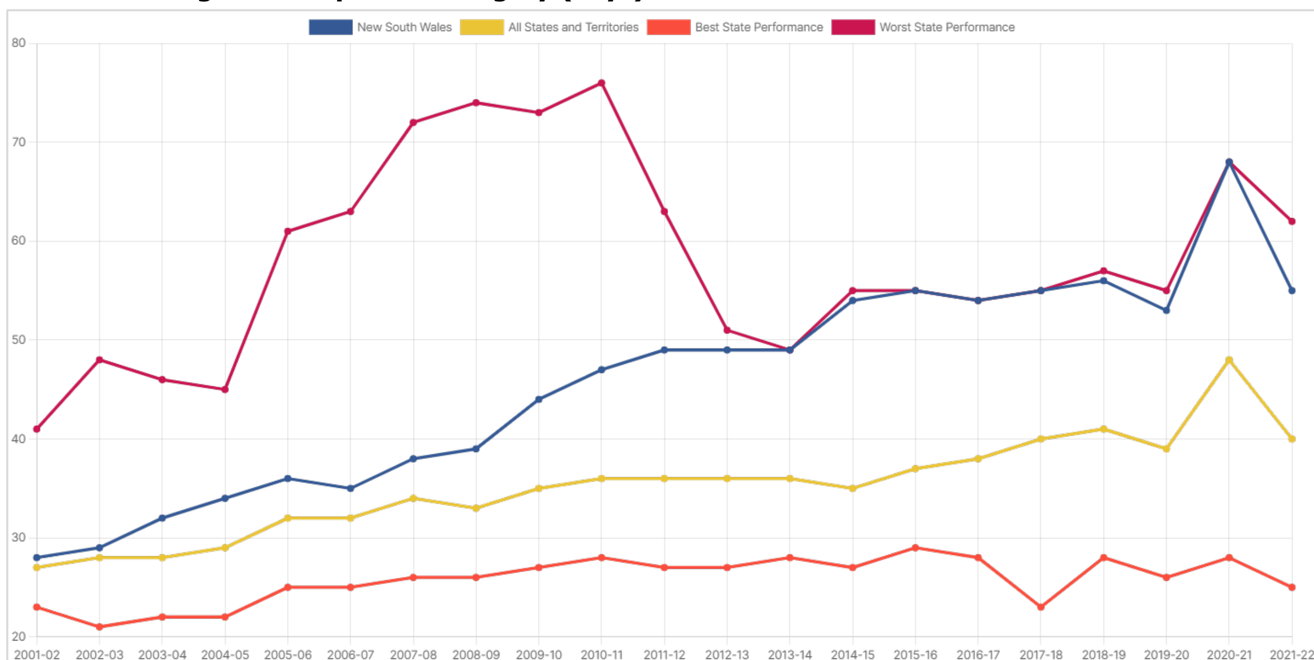
Although in 2020–21 reporting period NSW recorded significant increases in planned surgeries compared to the same period the year before,[49] most of this was offset in 2021–22, with the State recording a significant drop in the numbers of planned surgeries performed, on average around 30 per cent per quarter compared to the year before.[50]

**Waiting times**

**New South Wales — COVID-19 impact on public hospital planned surgery volumes**

After the increase in the median wait time for planned surgery in NSW from 53 days in 2019–20 to 68 days in 2020–21,[51,52] in 2021–22, the median wait time improved to 55 days. Still, in NSW median wait time was 30 days longer than the best performing State (Victoria).[53]

**Median waiting time for planned surgery (days) — New South Wales**



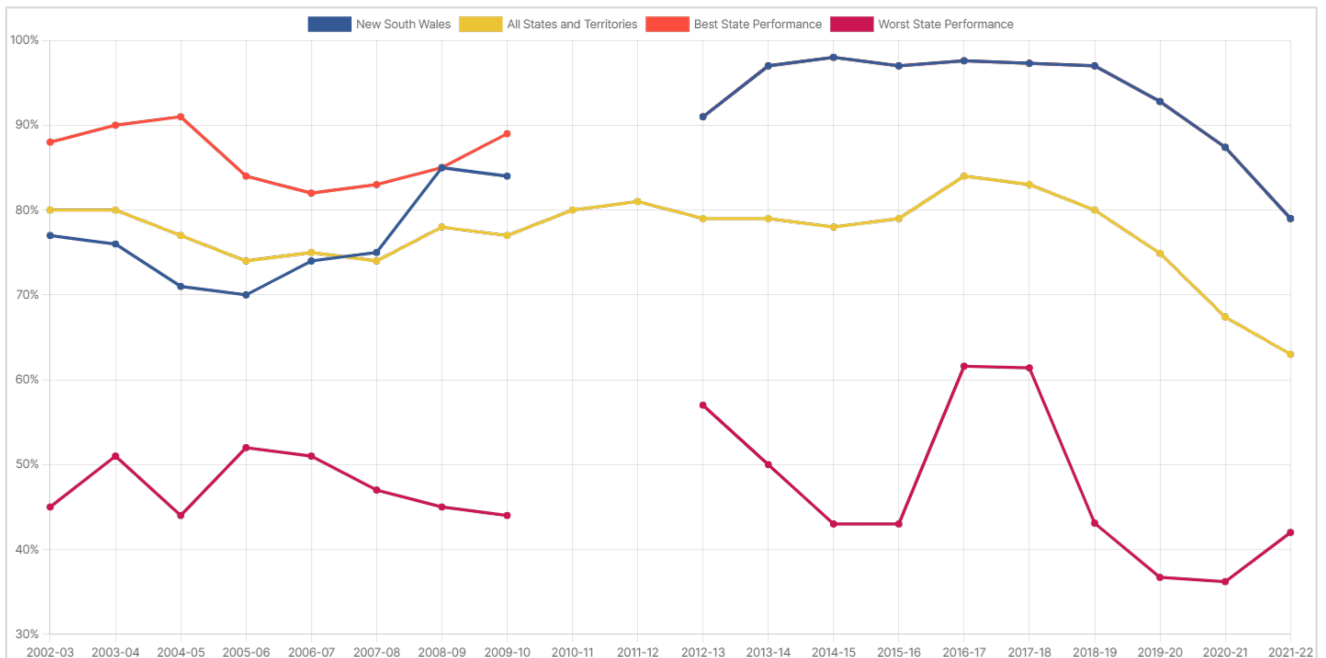

Source: Australian Institute of Health and Welfare (AIHW). Planned surgery data cubes (2001–02 to 2006–07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times (2007–08 to 2021–22): Australian hospital statistics

[49] AMA Public Hospital Report Card 2022
[50] NSW Bureau of Health Information 2023. Data portal – Healthcare Quarterly Results-Planned surgeries performed-Overall results https://www.bhi.nsw.gov.au/data-portal
[51] Australian Institute of Health and Welfare (2021). Australian Hospital Statistics: Planned surgery waiting times 2018–19 Table 4.11 https://www.aihw.gov.au/getmedia/5042f8a8-4711-455a-9c6d-60650f954fbe/Planned-surgery-waiting-times-2018-19.xlsx.aspx
[52] Australian Institute of Health and Welfare (2023). Australian Hospital Statistics: Planned surgery waiting times 2021–22 data tables Table 4.11 https://www.aihw.gov.au/getmedia/9d847d52-b1d3-4366-9900-1a0d4db1055d/Planned-surgery-waiting-times-2020-21.xlsx.aspx
[53] Ibid.

### Category 2 patients

### Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) New South Wales

In 2020–21 79 per cent of category 2 planned surgery patients were admitted within the recommended period in NSW. Although NSW is still the best performer on this indicator, 2021–22 marks a significant drop from 87.4 per cent in 2020–21.[54]



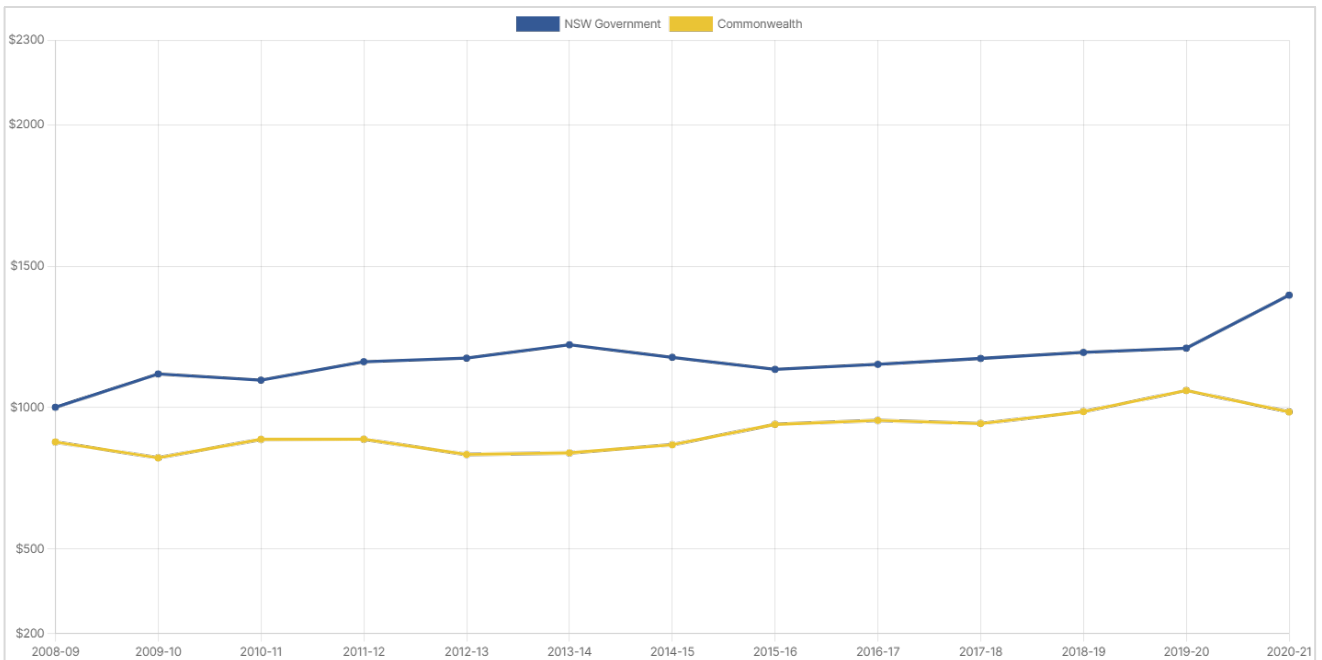

Source: The State of Our Public Hospitals (DoHA 2004 to 2010) FOI request reference 253-1001 lodged June 2011. 2011–12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by Australian Institute of Health and Welfare (AIHW) National emergency access and planned surgery targets 2012: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW) Planned surgery waiting times 2013–14 to 2021–22: Australian hospital statistics 2010–12 data not available

[54] Australian Institute of Health and Welfare (2023). Australian Hospital Statistics: Planned surgery waiting times 2021–22 data tables Table

## Public hospital funding

The most recent public hospital funding data is 2020–21, so it is affected by COVID 19 response.

**Commonwealth and New South Wales government per person funding for public hospitals (constant prices)**




Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 10 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **NSW Gov** | 4.1% | -1.0% | 8.1% | 2.82% |
| **Commonwealth** | -1.3% | 3.0% | -0.1% | 0.96% |

# VICTORIA

**Dr Roderick McRae**

President AMA Victoria

This year's Victorian public hospital report highlights the ongoing need to address substantial challenges in the delivery of emergency healthcare, its ability to meet elective, now urgent, demand, and basic hospital funding.

Patients are experiencing longer than ever emergency department wait times, and it is now significantly impacting their health outcomes. In the 2021–22 reporting period, only 58 percent of Triage Category 3 Victorian patients presenting to emergency departments were seen in the recommended 30 minutes. While this is the national average (albeit a poor one), this is 14 percent less than New South Wales. Patients who are discouraged from going to emergency departments then create additional burdens on our GPs, and yet our GPs are also desperately under-supplied and under-supported– creating a worsening vicious cycle.

AMA Victoria acknowledges Victorian hospitals have made significant strides in comparison to last year's report card in terms of reducing wait times for elective surgery. In fact, Victoria is the best-performing state in this parameter with a median wait time of 25 days – making it the only state nationally to have improved its pre-pandemic performance in this area.

However, although elective surgery wait times are reducing, about 10,000 fewer patients were added to the elective surgery list this year compared to last year. We must consider whether the true levels of demand are being met by our limited supply of surgeons or whether patients are simply waiting longer for outpatient clinic appointments to even reach the elective lists. Given that the national estimate for the average expected growth of the elective surgery waiting list is around 2.1 percent each year, we can be almost certain that a dangerous "hidden waiting list" lurks behind Victoria's figures. This means Victoria must address its supply of surgeons and public hospital outpatient clinic capacity now to prevent the hidden waiting list rearing its head in the future.

In 2020–21, 56 per cent of patients for Category 2 elective surgery were admitted within the recommended 90 days, marking a drop of 6 per cent compared to the year before, on top of the 14.5 per cent drop in 2020–21. Overall, Victoria has recorded a drop of 26 per cent in this category compared to the pre-pandemic 2018–19. Moreover, the remaining 38 per cent of patients who are overdue on the waiting list (a patient is considered overdue if the number of days they waited for elective surgery exceeded the clinically recommended time) on average waited additional 190 days in June 2022, on top of the 90 days that is clinically indicated for Category 2 elective surgery. By December 2022, that number has grown to 217 days. This means there could be patients in Victoria who wait for almost a year for a surgery that is indicated to be done within 90 days.

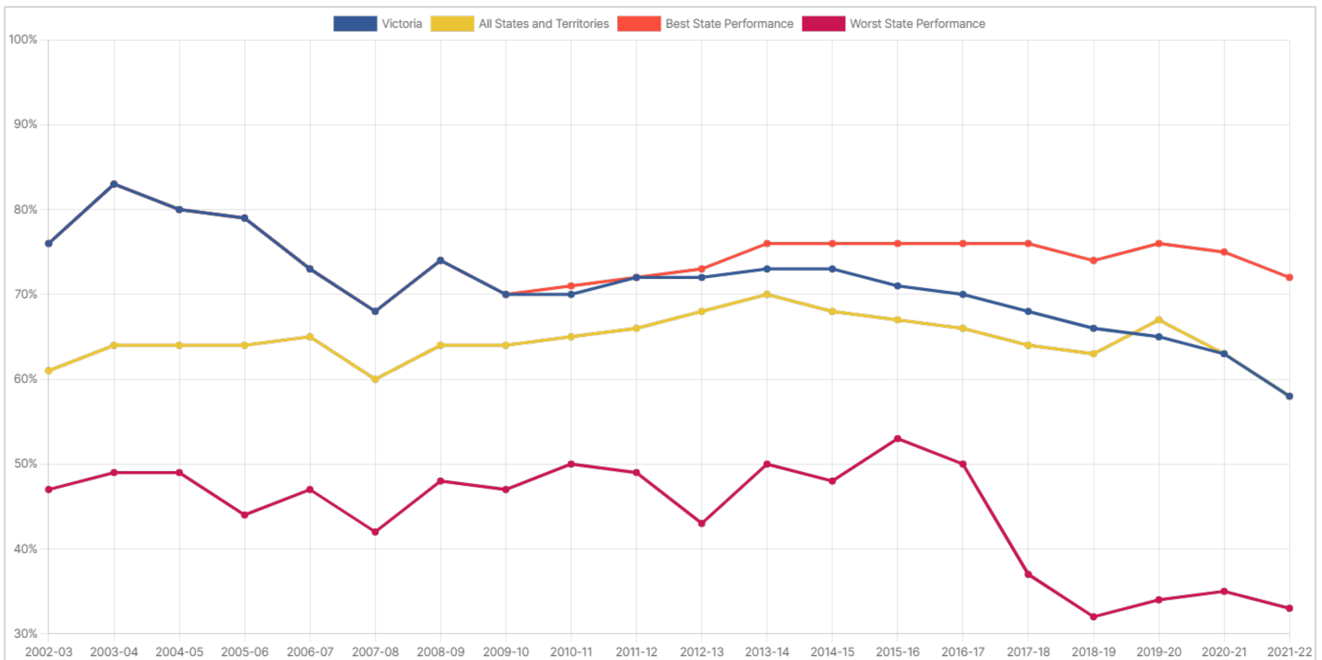
Our public hospitals need to have better workforce planning to ensure adequate numbers of doctors (both hospital doctors and GPs) and other healthcare staff are available, and more investment to increase bed numbers and outpatient clinic capacity (both physical and mental health). Victoria's health system needs far more responsibility-sharing and collaboration between the State and Federal Governments to ensure adequate levels of funding are available for our public hospitals.

## Emergency department

Victoria eased restrictions that were introduced to manage the spread of COVID-19 at the end of September 2021. By then there was already significant spread of the virus in the community.[55] The outcome was a significant pressure on Victoria's emergency departments in 2021–22 reporting period.

**Waiting times**

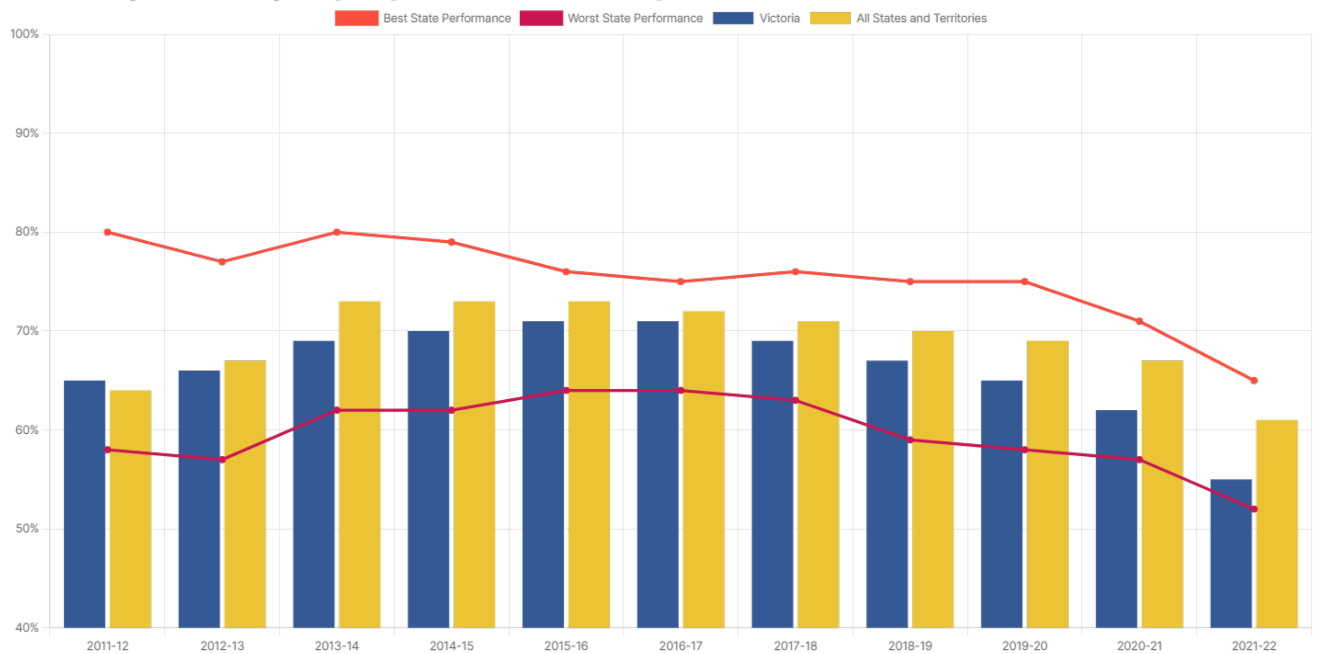
**Percentage of Triage Category 3 emergency department patients seen within recommended time (<30 minutes) — Victoria**




Source: The State of our Public Hospitals (DoHA 2004 to 2010). Australian Institute of Health and Welfare (AIHW). Emergency department care 2010–2021–22

[54] https://www.premier.vic.gov.au/slowing-spread-and-keeping-our-state-safe

**Percentage of emergency department visits completed in four hours or less — Victoria**




Source: Australian Institute of Health and Welfare (AIHW). Emergency department care (2011–12 to 2020–21): Australian hospital statistics.

Note: National emergency access targets were abolished with effect from 1 July 2015

## Planned surgery

Throughout 2021–22 the pandemic continued to affect the delivery of planned surgery in Victoria.[56] On 2 April 2022 the Victorian Premier announced a significant investment to catch up with the backlog of planned surgeries in Victoria "designed to exceed pre-pandemic levels by 25 per cent".[57]

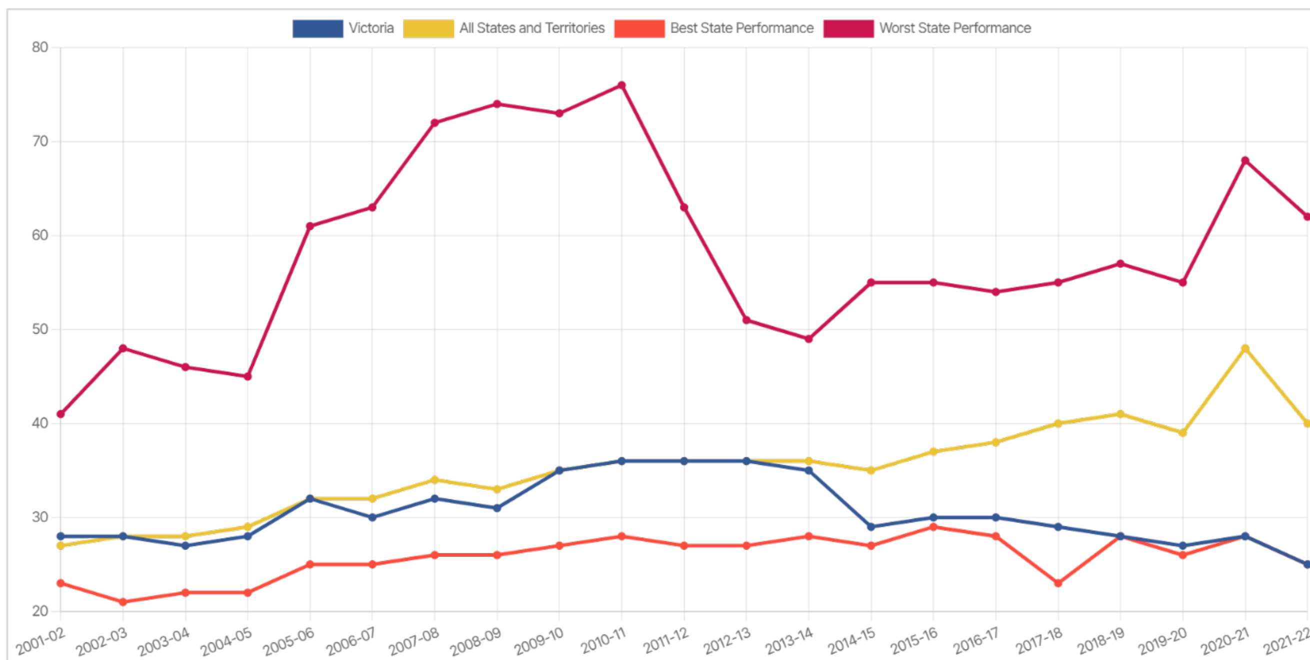
Under the plan, 40,000 extra surgeries would be performed over 2022–23, building up to record 240,000 surgeries every year in 2024. In addition, Frankston Private Hospital was to be transformed into a public surgery centre with the capacity to support up to 9,000 public patients per year once fully operational in 2023.[58]

[56] Andrews, D (Victorian Premier) 2020, COVID-19 capacity boost as planned surgery blitz starts, media release, Office of the Premier, Melbourne, 15 March 2020 https://www.premier.vic.gov.au/covid-19-capacity-boost-planned-surgery-blitz-start s
[57] https://www.premier.vic.gov.au/covid-catch-plan-deliver-patients
[58] Ibid.

### Waiting times

In 2020–21, with the number of Category 2 planned surgeries conducted dropped by 8.6 per cent compared to the year before in Victoria.[59,60] Still, 2021–22 On average, Victorians waited 25 days for planned surgery. Victoria is the best performing state on this parameter. However, similar to other states and territories, this data may be affected by the hidden waiting list — patients who are waiting to see a specialist as an outpatient in the public hospital system, who will eventually be added to the waiting list.

**Median waiting time for planned surgery (days) — Victoria**



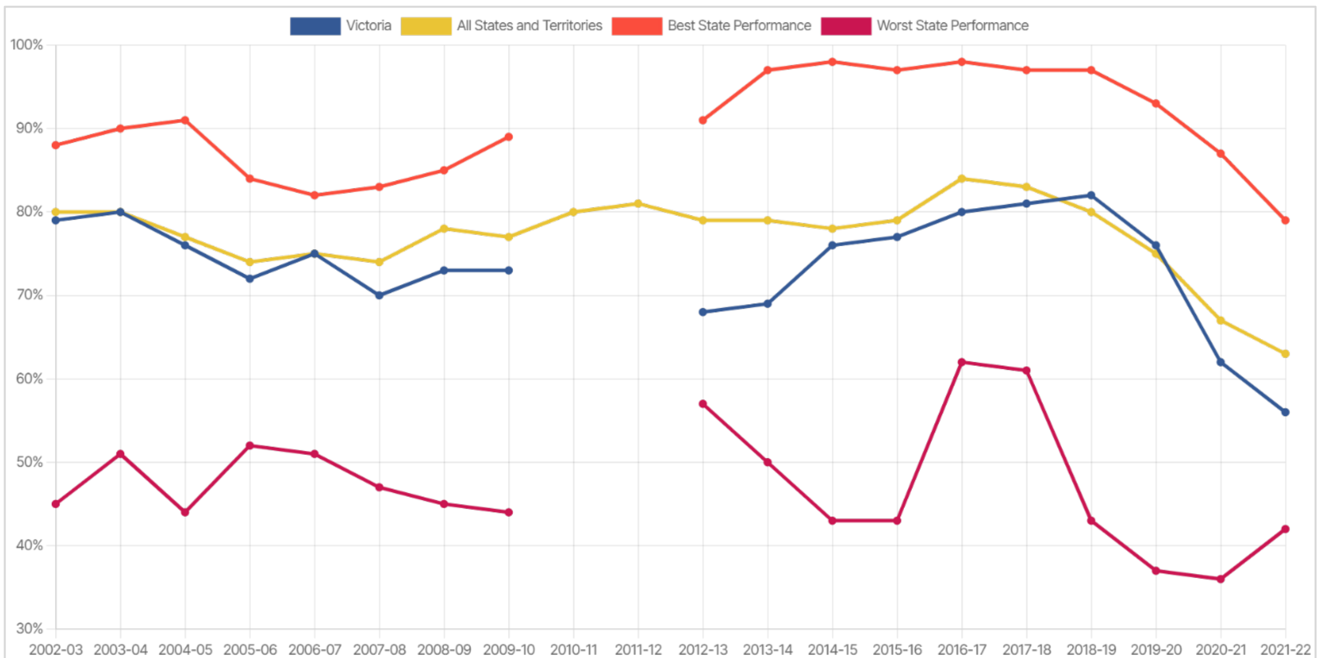

Source: Australian Institute of Health and Welfare (AIHW). Planned surgery data cubes (2001–02 to 2006–07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times (2007–08 to 2021–22): Australian hospital statistics

[59] Australian Institute of Health and Welfare (2021). Australian Hospital Statistics: Planned surgery waiting times 2019–20 Table 4.12 viewed 5 August 2021 https://www.aihw.gov.au/reports-data/myhospitals/sectors/planned-surgery
[60] Australian Institute of Health and Welfare (2022). Australian Hospital Statistics: Planned surgery waiting times 2020–21 Table 4.12 viewed 1 Feb 2022 https://www.aihw.gov.au/getmedia/9d847d52-b1d3-4366-9900-1a0d4db1055d/Planned-surgery-waiting-times-2020-21.xlsx.aspx

**Category 2 pati–1ts**

**Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) — Victoria**

In 2020–21, 62 per cent of patients for Category 2 planned surgery were admitted within the recommended 90 days, marking a drop of 14.5 per cent compared to the year before. 2021–22 marked another drop of 6 per cent, down to 56 per cent of patients in Category 2 who were admitted in recommended time.




Source: The State of Our Public Hospitals (DoHA 2004 to 2010) FOI request reference 253-1001 lodged June 2011. 2011–12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by Australian Institute of Health and Welfare (AIHW) National emergency access and planned surgery targets 2012: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW) Planned surgery waiting times 2013-14 to 2021–22: Australian hospital statistics

2010–12 data not available

[54] Australian Institute of Health and Welfare (2023). Australian Hospital Statistics: Planned surgery waiting times 2021–22 data tables Table

## Public hospital funding

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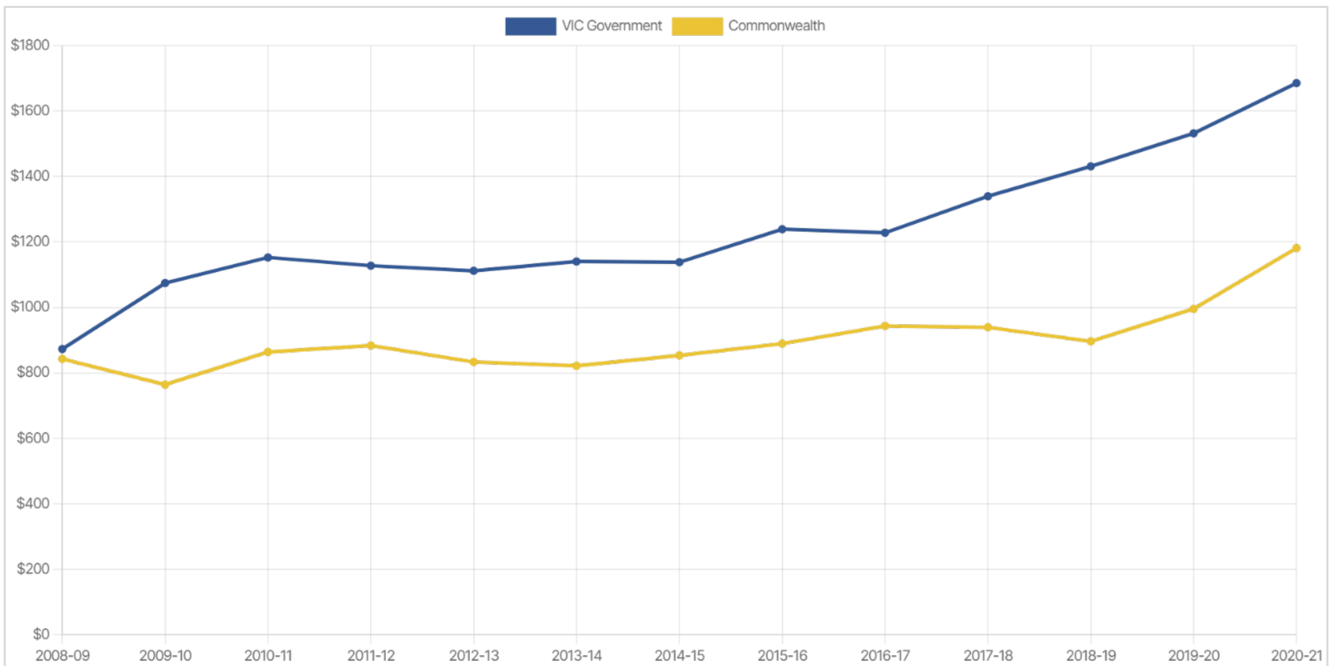
**Commonwealth and Victorian government per person funding for public hospitals (constant prices)**




Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 10 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **Victoria Gov** | 6.2% | 4.1% | 8.5% | 5.63% |
| **Commonwealth** | -0.3% | 3.4% | 14.8% | 2.85% |

# QUEENSLAND

**Dr Maria Boulton**

President AMA Queensland

From the outset, I want to congratulate and thank all our dedicated hospital doctors, nurses and healthcare workers who have carried such a burden during the pandemic. These tireless workers kept our hospitals going as we experienced our first major COVID-19 waves.

Queensland went from seven COVID deaths in the first year of the pandemic to more than 2,800 by March 2023. We have gone through stages of having close to 1,000 COVID patients in our overstretched hospitals and hundreds of doctors furloughed with infection or as close contacts. Even now, we still have more than 200 COVID patients in hospital.

The Queensland government listened to our Ramping Roundtable and pledged 2,500 new hospital beds in the 2022–23 budget. But the majority of these beds will not come online for years, and there is no workforce strategy to recruit the staff needed to run them. We needed these beds yesterday.

In this light, it is disappointing but understandable to see decreases in Category 3 Urgent patients being seen within the recommended time and in ED visits being completed within four hours.

We need the Queensland government to urge their federal Labor colleagues to agree to a fairer share of state-federal funding for public hospitals and increase the federal share to 50 per cent. Maybe then we will see our waiting lists start to ease.

Queensland is facing several real pressure points. We have a population the size of Denmark in an area 40 times the size. Recruiting and retaining staff in regional Queensland is becoming increasingly difficult in both hospitals and general practice.

It's a very long drive between hospitals in regional Queensland, particularly if you have a medical emergency.

We have multiple maternity units closed or on bypass across the state. Obstetricians are choosing to work as locums in New South Wales due to demand and poor conditions in Queensland, and then get labelled as 'greedy' by the state government.

At the same time, our state government is introducing proposals that only make regional practice less attractive. Allowing pharmacists in North Queensland – everywhere from the north and west of Mackay – to autonomously diagnose and prescribe for a range of conditions is a dangerous experiment with patient health that will only deter GPs from moving to regional towns, putting more stress on our hospitals.

Changing the interpretation of payroll tax for private practitioners will force general practices to close or pass the costs on to patients. Bulk billing is already a thing of the past, and the new urgent care clinics being established by the federal Labor government will have the perverse effect of putting existing after-hours practices out of business.

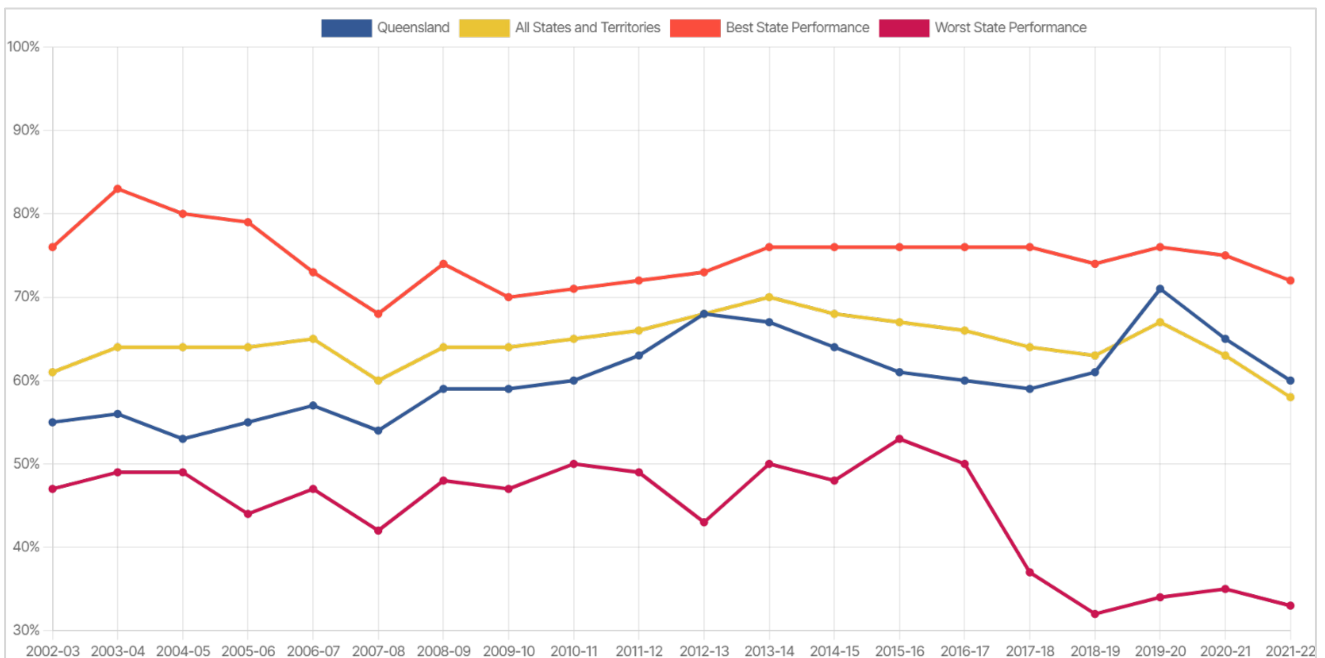
## Emergency department

Australian Institute of Health and Welfare data show that in 2021–22 year, the volume of emergency presentations at Queensland public hospitals increased by 17.5 per cent, averaging around 5,171 daily presentations in 2020–21, compared to 4,401 presentations per day in 2019–20.[61,62] In 2021–22 the daily number of ED presentations in Queensland was 5,117, a slight increase compared to the year before, meaning that the pressure on EDs in Queensland continues.[63]

**Waiting times**

**Percentage of Triage Category 3 emergency department patients seen within recommended time (<30 minutes) — Queensland**

In 2021–22, 60 per cent of patients visiting emergency department in Queensland and triaged as Category 3 were seen within the recommended 30 minutes. This is a drop of five percentage points compared to the year before.

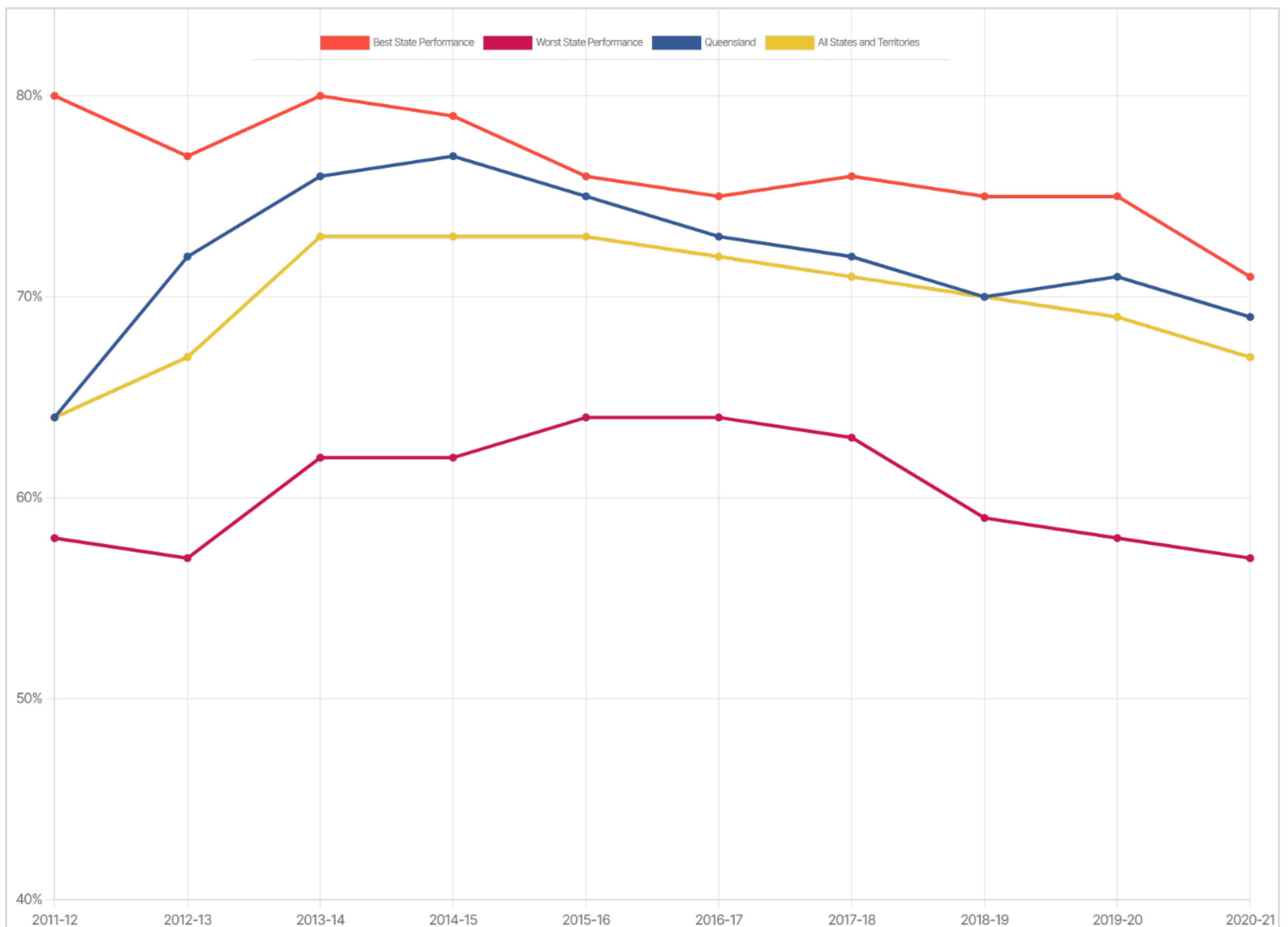



Source: The State of our Public Hospitals (DoHA 2004 to 2010). Australian Institute of Health and Welfare (AIHW). Emergency department care 2010 to 2021–22

[61] Australian Institute of Health and Welfare 2021. Australian Hospital Statistics: Emergency Department care 2019–20 viewed 2 August 2021 https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed
[62] Australian Institute of Health and Welfare 2022. Australian Hospital Statistics: Emergency Department care 2020–21 viewed 1 Feb 2021 Table 2.2 https://www.aihw.gov.au/getmedia/0d0d6cbf-e764-4a89-a71a-b03c5156235d/Emergency-Department-Care-2020-21.xlsx.aspx
[63] Australian Institute of Health and Welfare 2022. Australian Hospital Statistics: Emergency Department care 2020–21 viewed on 16 February 2023 Table 2.2.

**Percentage of emergency department visits completed in four hours or less — Queensland**

In the same reporting period, 61 per cent of emergency department visits were completed in four hours or less.




Source: Australian Institute of Health and Welfare (AIHW). Emergency department care (2011–12 to 2021–22): Australian hospital statistics.

Note: National emergency access targets were abolished with effect from 1 July 2015

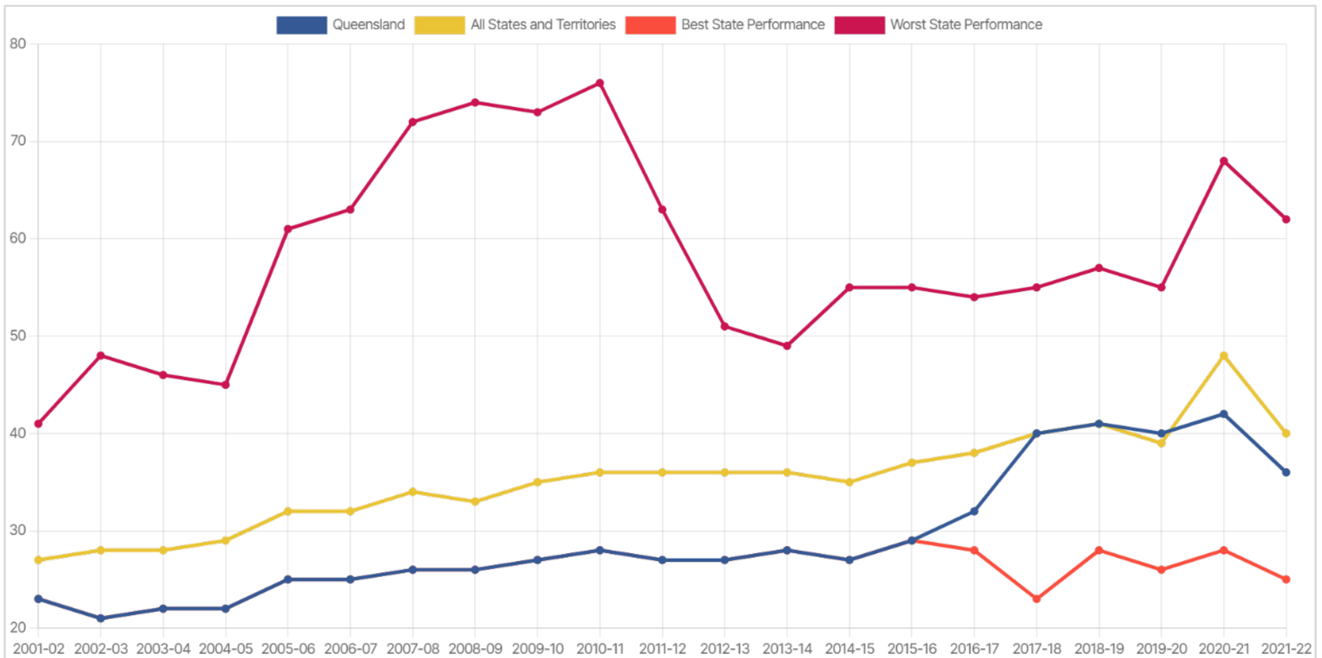
# Planned surgery

**Waiting times**

Similar to other jurisdictions, Queensland started to ease its COVID-19 restrictions in the last quarter of 2021. Following the announcement of "Quarter of a billion-dollar planned surgery blitz" by the Queensland Premier in 2020,[64] the median wait time in Queensland improved in 2021–22.

**Median waiting time for planned surgery (days) — Queensland**

Median wait time for planned surgery in Queensland in the 2020–21 reporting period was 36 days, improvement by 6 days compared to the year before, and 11 days longer than the best performing State, Victoria.



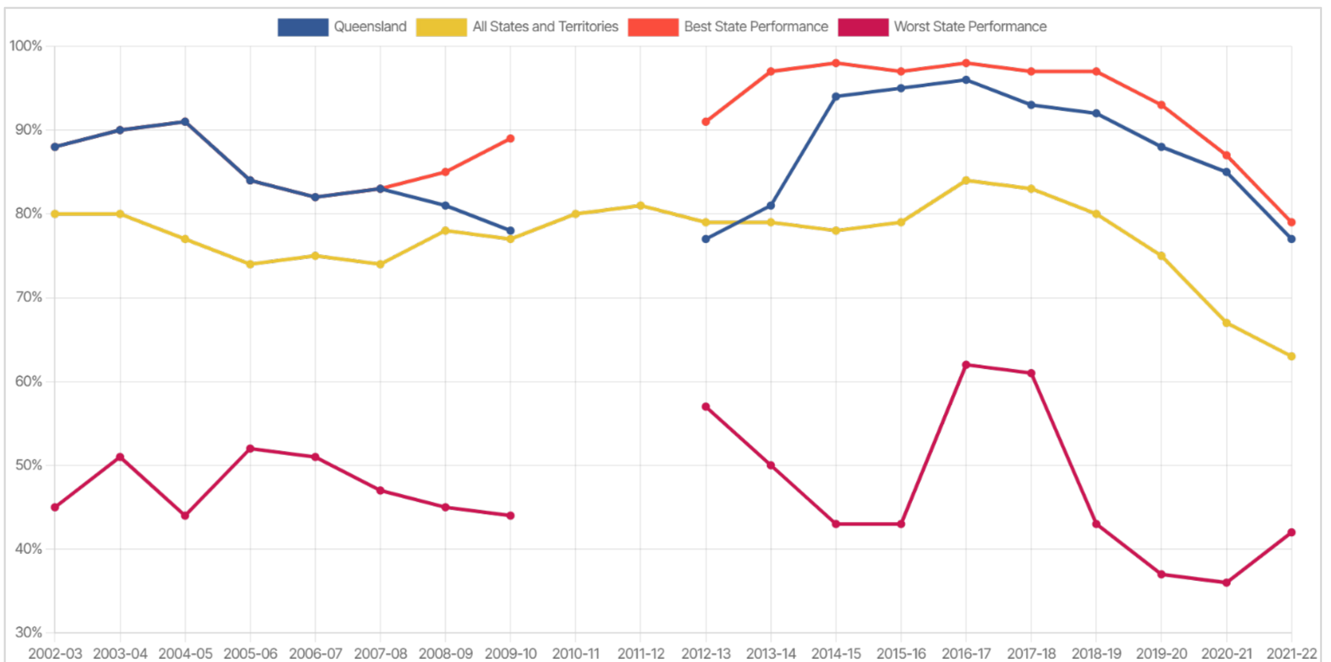

Source: Australian Institute of Health and Welfare (AIHW). Planned surgery data cubes (2001–02 to 2006–07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times (2007–08 to 2021–22): Australian hospital statistics

[64] https://statements.qld.gov.au/statements/90009

### Category 2 patients

### Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) — Queensland

77 per cent of patients on the Category 2 planned surgery waiting list were seen within the recommended 90 days in Queensland. This is an 8 per cent drop compared to previous year, and a drop of 15 percentage points compared to the pre-pandemic 2018–19.



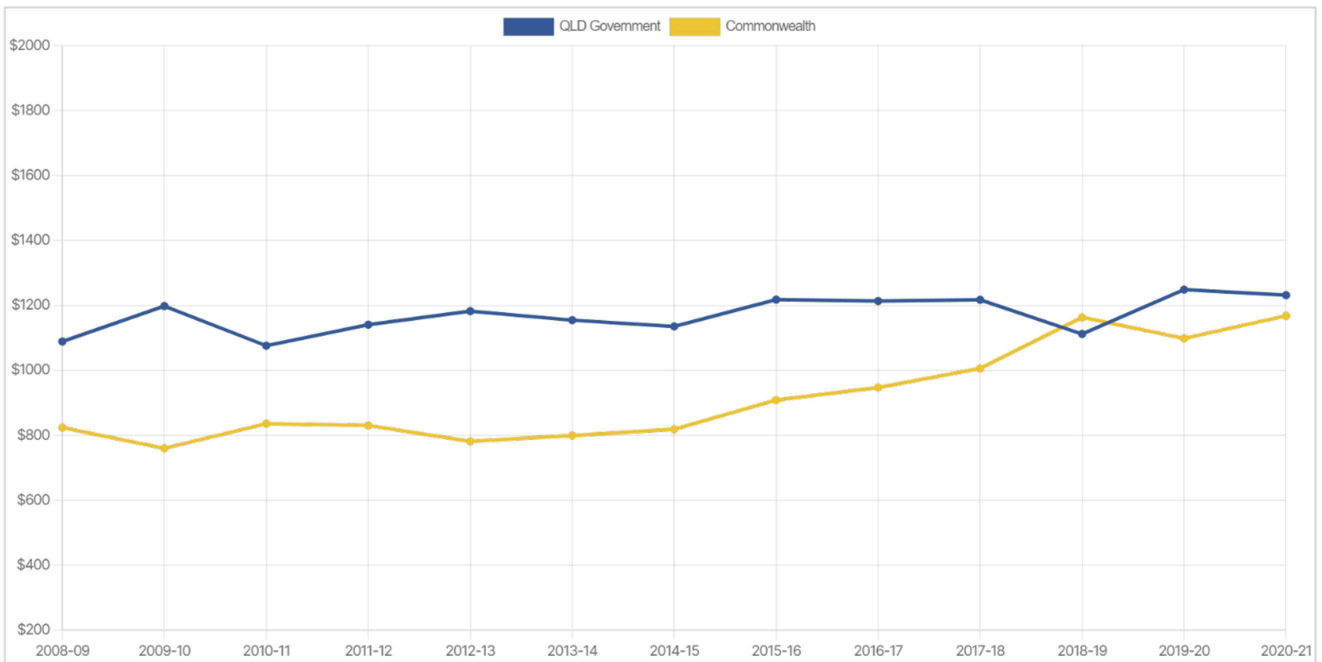

Source: The State of Our Public Hospitals (DoHA 2004 to 2010) FOI request reference 253-1001 lodged June 2011. 2011–12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by Australian Institute of Health and Welfare (AIHW) National emergency access and planned surgery targets 2012: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW) Planned surgery waiting times 2013–14 to 2021–22: Australian hospital statistics

2010–12 data not available

## Public hospital funding

The most recent public hospital funding data is 2020–21, so it is affected by COVID 19 response.

**Commonwealth and Queensland government per person funding for public hospitals (constant prices)**




Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 10 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **Queensland Gov** | 2.1% | 1.3% | 5.2% | 1.03% |
| **Commonwealth** | -1.3% | 5.9% | 0.2% | 2.95% |

# WESTERN AUSTRALIA

**Dr Marc Duncan-Smith**

President AMA WA

WA's 2023 report card has fulfilled my prediction a year ago that "the WA Government will go back to its old ways of starving WA Health of operational budget, and not have a focus on quality and safety of patient care again".

WA's performance overall is very poor, with only one glimmer of light. WA is top of the leader board for the four-hour rule, but this metric doesn't capture the time patients spent waiting in ambulances, to get into our ED departments.

Ambulance ramping in WA is continuously at crisis levels. Ambulance ramping - or the time in excess of 30 minutes, spent by patients in ambulances waiting to get through the front door of WA's EDs - increased by 103 per cent in the year 2020–21, compared to 2019–20.

Triage Category 3 (Urgent) Emergency department presentations (seen within the recommended 30-minute time period) in Western Australia are 25 per cent below the national average and 39 per cent behind Victoria, which is the best performing state on this indicator.

The current data comes from WA's COVID-free era when the other states and territories were crippled by COVID-19. We in comparison had business as usual and yet we did not top all the other states for performance.

WA may be the richest state, but our health system is the sickest.

Our hospitals routinely run at or near 100 per cent occupancy, well over the 90 per cent where international studies have established that bed block, ramping, cancellation of elective surgery, increased surgical and general hospital mortality all start and then increase predictably. Where our health system is now is and was predictable.

We have increases in the number of over-boundary elective surgery cases, ramping that has peaked at 6,972 hours in July 2022 and preventable deaths in our hospital system.

The McGowan Government increased non-COVID health operational budget in 2022 by 3 per cent, less than CPI.

Despite the McGowan Government claiming WA has the best state economy in Australia and possibly the world, it appears they have assessed that a sick WA Health system will not lose them votes, as they increasingly retreat to rhetoric that medical systems are sick everywhere, so why would it be different here.

## Emergency department

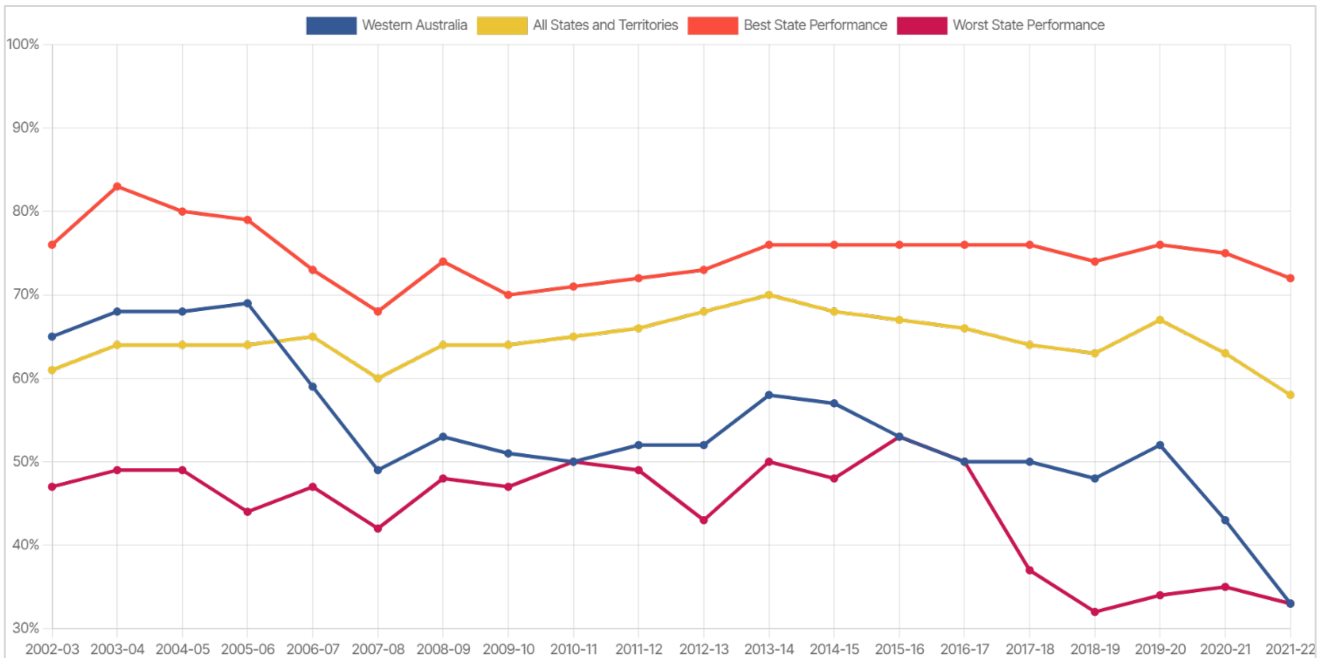
**Western Australia — COVID-19 impact on public hospital emergency department patient volumes**

Following the slowdown in emergency department presentations due to COVID-19 restrictions, in 2020–21 emergency presentations in Western Australia increased by 7.3 per cent compared to the year before, and significantly above the average yearly increase of 4.5 per cent since 2016–17.[65] The decline in emergency department performance in Western Australia continued in 2021–22.

**Waiting times**

**Percentage of Triage Category 3 emergency department patients seen within recommended time (<30 minutes) — Western Australia**

Only 33 per cent of Category 3 patients – one in three - in Western Australia emergency departments are seen within the recommended 30-minute time period. This is a drop of 10 per cent compared to the year before. Western Australia was the worst performing state on this indicator in 2021–22.

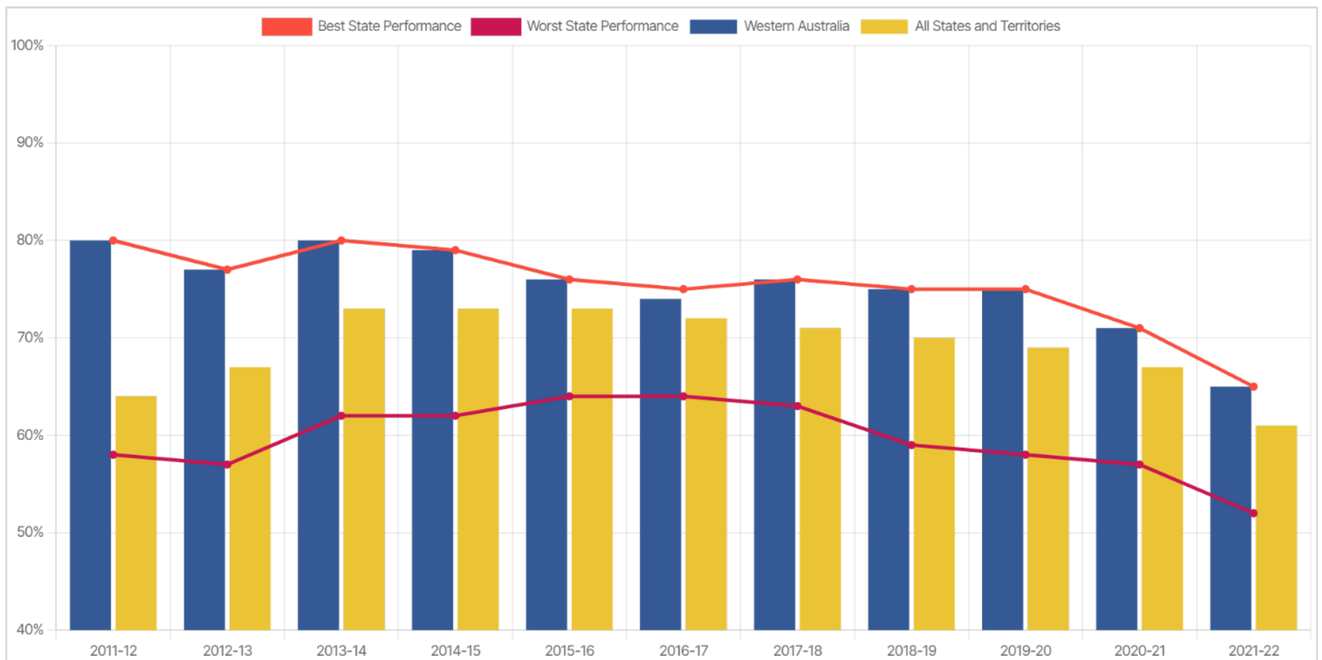



Source: The State of our Public Hospitals (DoHA 2004 to 2010). Australian Institute of Health and Welfare (AIHW). Emergency department care 2010 to 2021–22

[65] Australian Institute of Health and Welfare 2022. Australian Hospital Statistics: Emergency department care 2020–21 table 2.2 viewed 1 February 2022 https://www.aihw.gov.au/getmedia/0d0d6cbf-e764-4a89-a71a-b03c5156235d/Emergency-Department-Care-2020-21.xlsx.aspx

**Percentage of emergency department visits completed in four hours or less — Western Australia**

With 65 per cent of emergency department visits completed in four hours or less, Western Australia is the best performing state on this parameter. However, this is a 6 per cent drop in performance compared to the year before.




Source: Australian Institute of Health and Welfare (AIHW). Emergency department care (2011–12 to 2021 22): Australian hospital statistics.

Note: National emergency access targets were abolished with effect from 1 July 2015

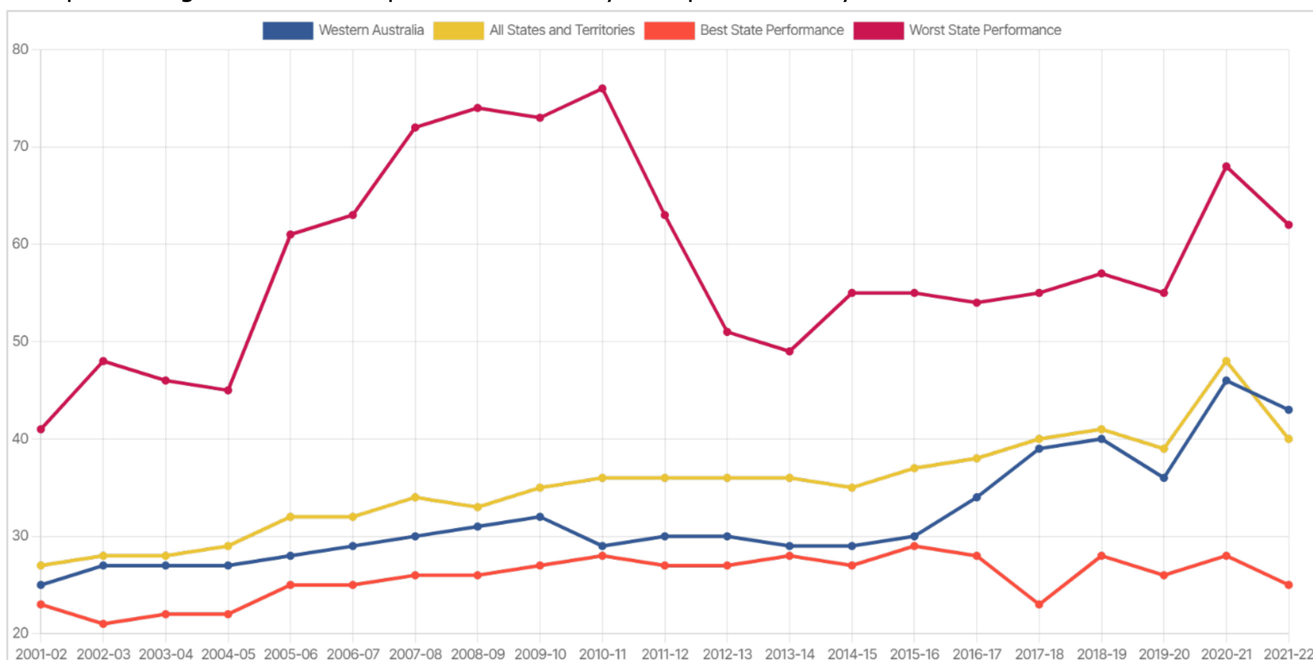
## Planned surgery

### Waiting times

Following the increase in 2020–21 in the number of performed Category 2 planned surgeries by 16 per cent, in 2021–22 WA recorded a 23 per cent drop in planned surgery admissions, with around 20,000 less people having access to surgeries they were assessed as needing.

### Median waiting time for planned surgery (days) — Western Australia

Median wait time for planned surgery in 2021–22 in Western Australia was 43 days, 18 days longer than the best performing state and an improvement of 3 days compared to the year before.

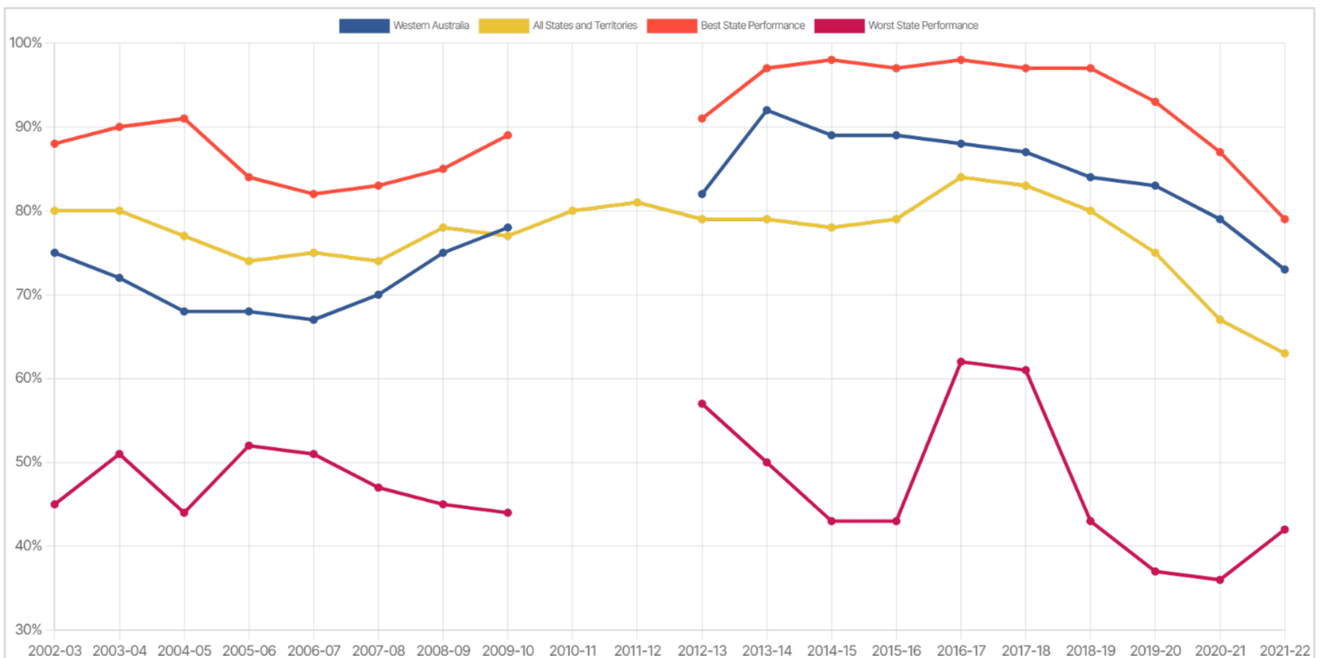



Source: Australian Institute of Health and Welfare (AIHW). Planned surgery data cubes (2001–02 to 2006–07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times (2007–08 to 2021–22): Australian hospital statistics

[64] https://statements.qld.gov.au/statements/90009

### Category 2 patients

**Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) — Western Australia**



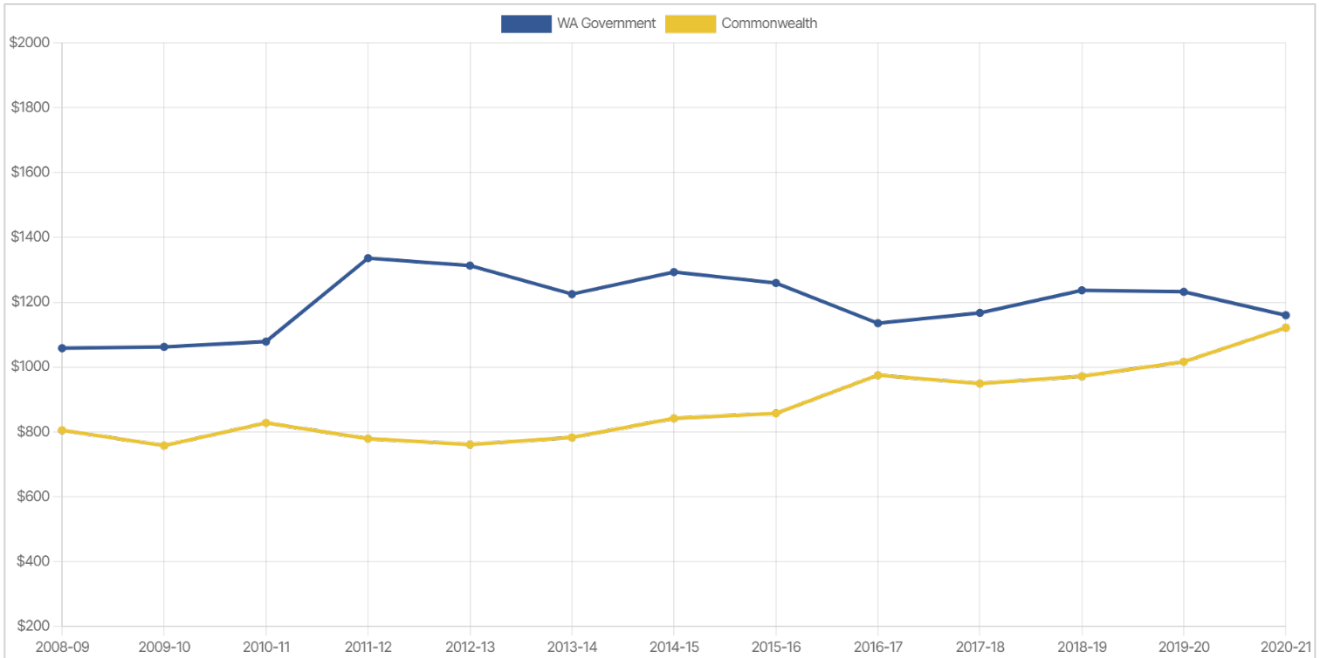

Source: The State of Our Public Hospitals (DoHA 2004 to 2010) FOI request reference 253-1001 lodged June 2011. 2011–12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by Australian Institute of Health and Welfare (AIHW) National emergency access and planned surgery targets 2012: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW) Planned surgery waiting times 2013–14 to 2021–22: Australian hospital statistics

2010–12 data not available

## Public hospital funding

The most recent public hospital funding data is 2020–21, so it is affected by COVID 19 response.

**Commonwealth and Western Australia government per person funding for public hospitals (constant prices)**[66]




Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 10 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **West Australian Gov** | 5.5% | -1.2% | -3.2% | 0.77% |
| **Commonwealth** | -1.4% | 4.9% | 7.4% | 2.80% |

[65] Note: The funding data in the AMA Public Hospital Report Card 2022 differs slightly compared to the Public Hospital Report Card 2021 for Western Australia. The data change is in line with the latest updates from AIHW and their ongoing work program to consolidate the data. For more information see Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2019–20 – Different Reports on Health Expenditure https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/comparison-and-alignment-of-health-expenditure-estimates/different-reports-on-health-expenditure

# SOUTH AUSTRALIA

**Dr Michelle Atchison**

President AMA SA

Our health system is a disaster, in South Australia and across the nation. With the limited political response and financial investment to fix what the AMA and other groups highlight as the pressing issues, it is difficult to understand if it will ever recover. I wonder what the next generations of Australians will accept as 'normal'.

In South Australia, COVID continues to preoccupy resources and attention. It continues to create staff shortages, through workforce illness and the capacity of SA Health to attract health practitioners. It continues to amplify already problematic issues of workplace stress, especially for junior doctors. And, of course, the virus itself is not going away.

Data collected for this Report Card demonstrates the impact of the health crisis on our public hospital system – which, in turn, reflects the awful scenario confronted by patients who present to our emergency departments seeking urgent care. Across the country, in 2021–22, the proportion of Triage category 3 (Urgent) Emergency Department patients seen within recommended 30 minutes dropped to 58 per cent nationally - the lowest number since the AMA started tracking ED performance in 2002–03. And in South Australia, the proportion is less than half.

South Australia is again one of the worst-performing states in completing ED presentations within four hours – and that's within a nation where the overall performance has again declined.

We urgently need governments at all levels to invest in public hospitals and primary care, aged care and disability services, and a Medicare system that ensures health care remains accessible and affordable to all.

Our hospital system needs a crash cart; meanwhile, it is failing patients who should be able to find and receive efficient, effective, world-class emergency health care when they need it.

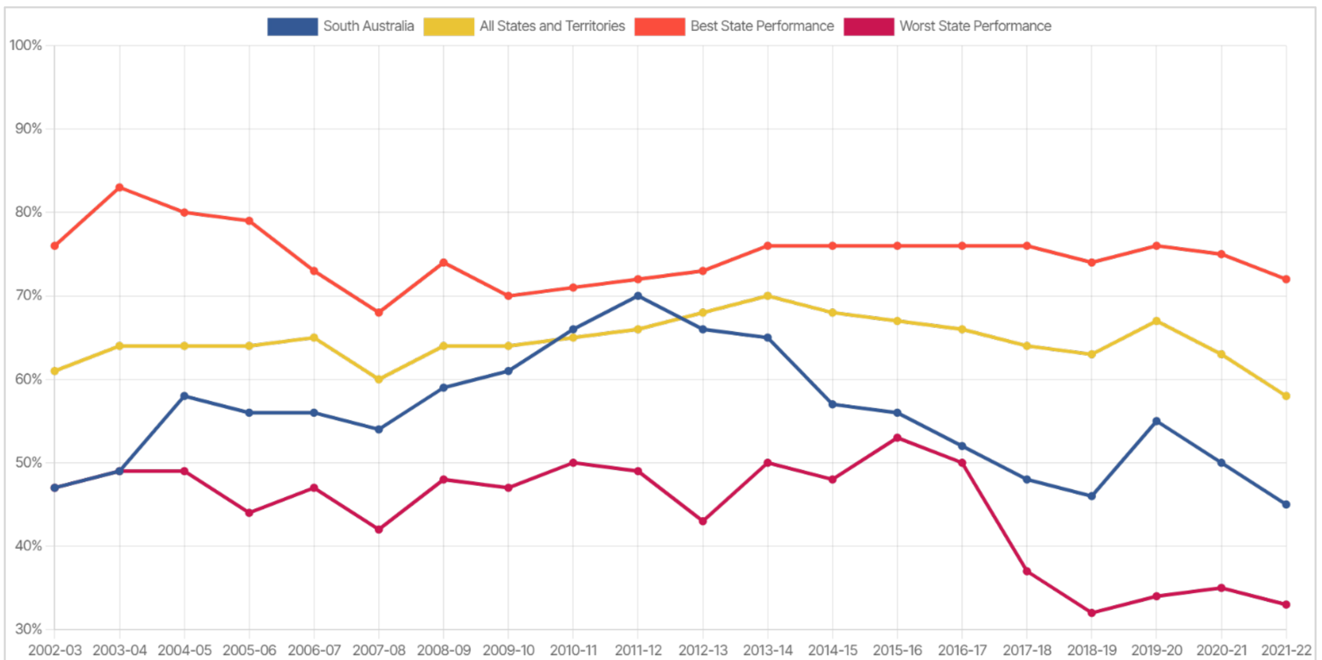
## Emergency department

Following the increase of 8.4 per cent in emergency presentations in 2020–21 compared to the year before,[67] in 2021–22 South Australia recorded a slight decrease of 1.3 per cent.[68]

**Waiting times**

**Percentage of triage Category 3 emergency department patients seen within recommended time (<30 minutes) — South Australia**

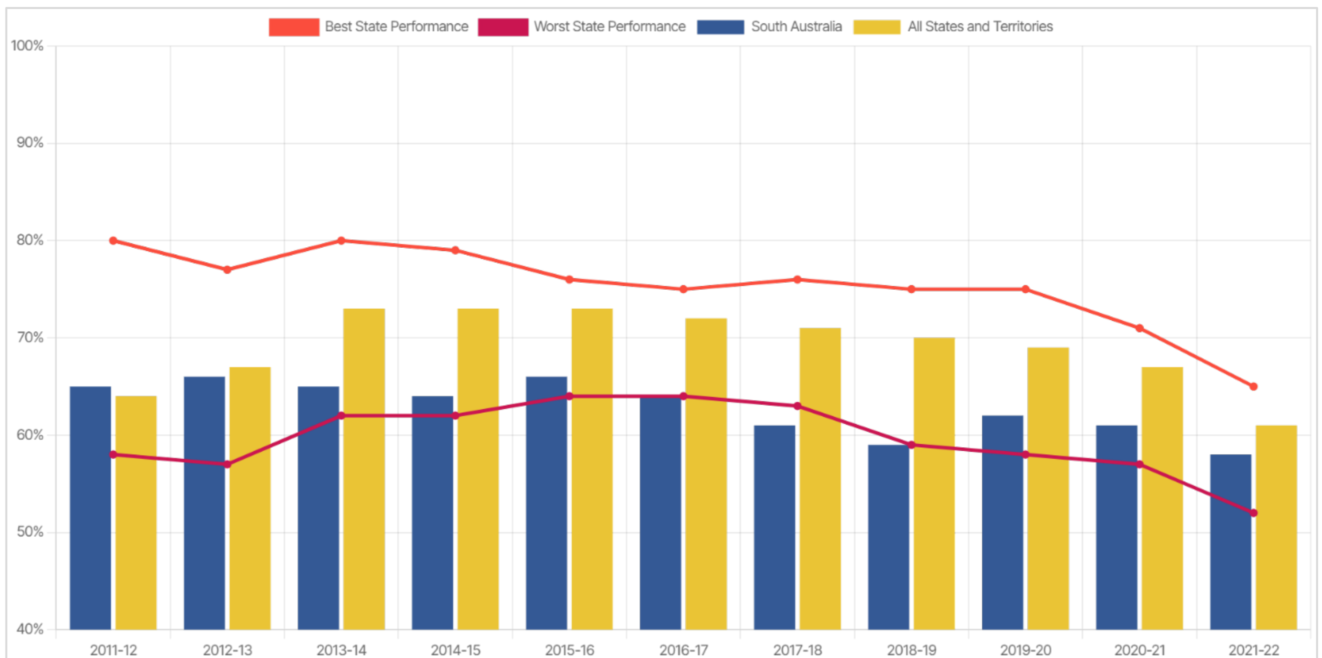
In 2021–22 the percentage of Category 3 emergency presentations seen on time in South Australia was 45 per cent, a 5.0 per cent drop compared to the year before and 27 per cent below the best performing state.




Source: The State of our Public Hospitals (DoHA 2004 to 2010). Australian Institute of Health and Welfare (AIHW). Emergency department care 2010 to 2021–22

[67] Australian Institute of Health and Welfare 2022. Australian Hospital Statistics: Emergency department care 2020–21 table 2.2 viewed 1 February 2022 https://www.aihw.gov.au/getmedia/0d0d6cbf-e764-4a89-a71a-b03c5156235d/Emergency-Department-Care–2020–21.xlsx.aspx
[68] Australian Institute of Health and Welfare 2023. Australian Hospital Statistics: Emergency department care 2021–22 table 2.2 viewed 17 February 2023

**Percentage of emergency department visits completed in four hours or less — South Australia**




Source: Australian Institute of Health and Welfare (AIHW). Emergency department care (2011–12 to 2021 22): Australian hospital statistics.

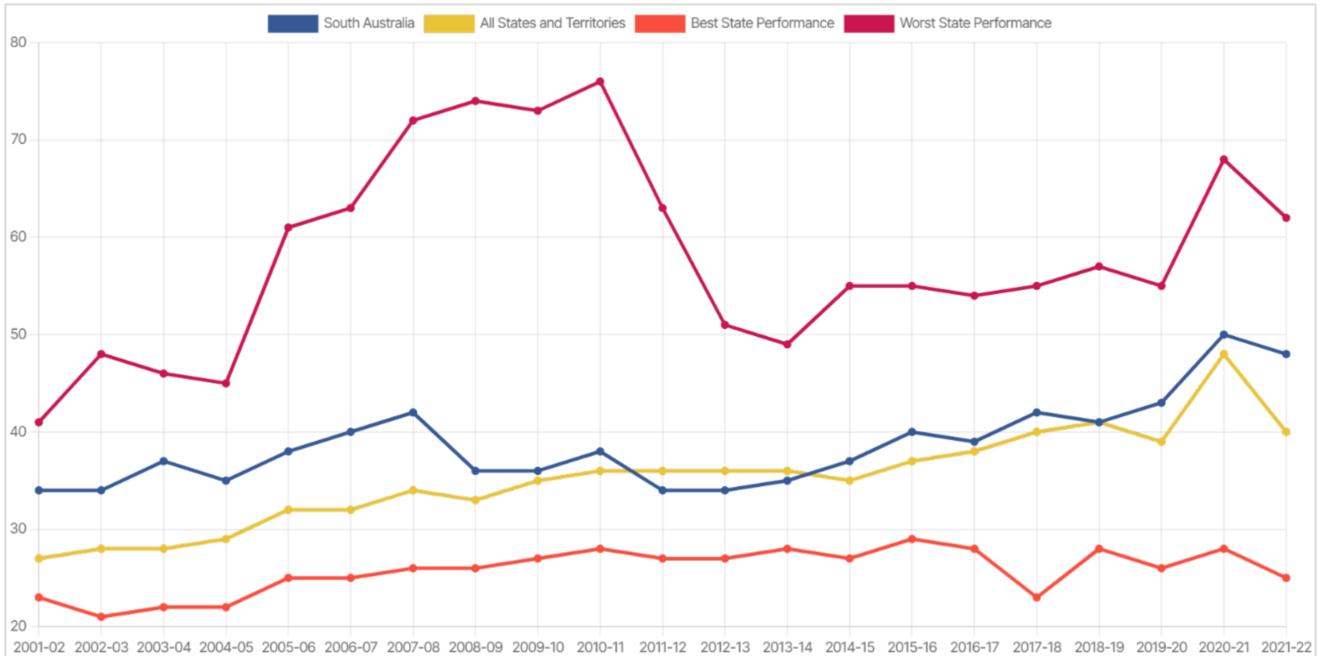
Note: National emergency access targets were abolished with effect from 1 July 2015

## Planned surgery

**Waiting times**

Following the increase in the volume of Category 2 planned surgeries in 2020–21 by 2.3 per cent,[69] in 2021–22, the number of planned surgery admissions in South Australia dropped by 8 per cent.[70]

**Median waiting time for planned surgery (days) — South Australia**



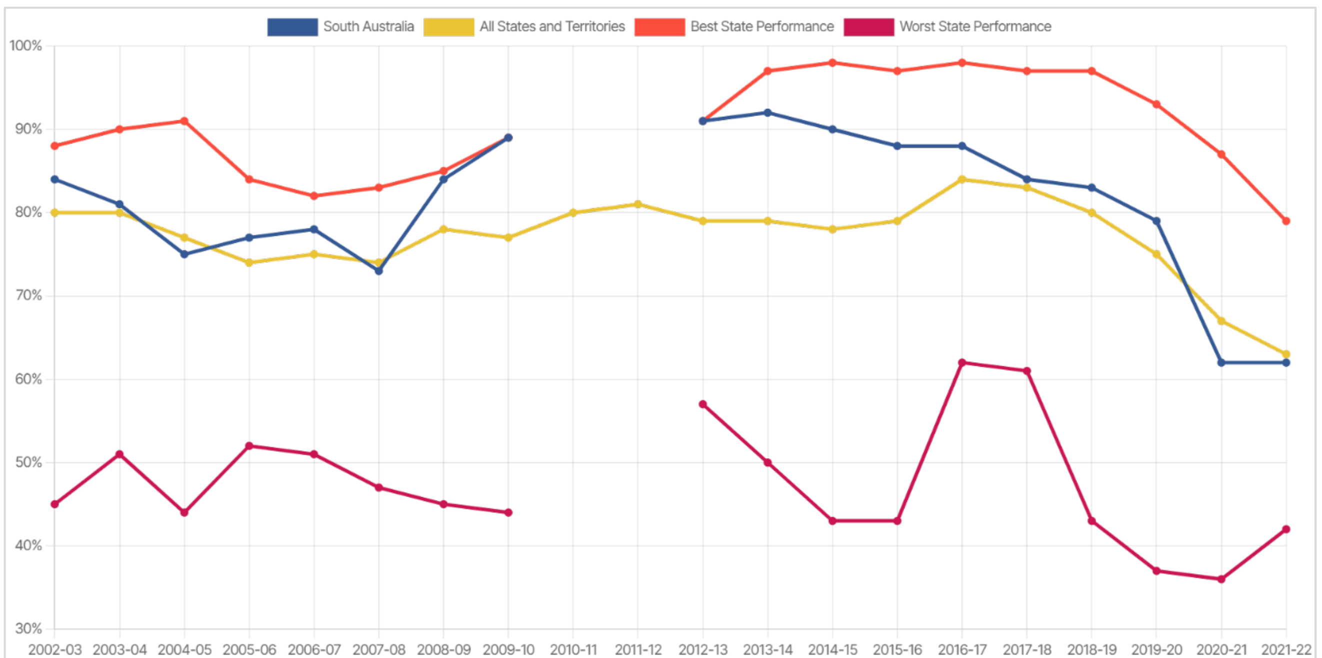

Source: Australian Institute of Health and Welfare (AIHW). Planned surgery data cubes (2001–02 to 2006–07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times (2007–08 to 2021–22): Australian hospital statistics

[69] Australian Institute of Health and Welfare (2022). Australian Hospital Statistics: Planned surgery waiting times 2020–21 Table 4.15 viewed 2 Feb 2022 https://www.aihw.gov.au/getmedia/9d847d52-b1d3-4366-9900-1a0d4db1055d/Planned-surgery-waiting-times-2020-21.xlsx.aspx
[70] Australian Institute of Health and Welfare (2023). Australian Hospital Statistics: Planned surgery waiting times 2021–22 Table 2.4 viewed 17 Feb 2023

### Category 2 patients

### Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) — South Australia

62 per cent of patients on the Category 2 planned surgery waiting list were seen within the recommended 90 days in South Australia in 2021–22, same as the year before.



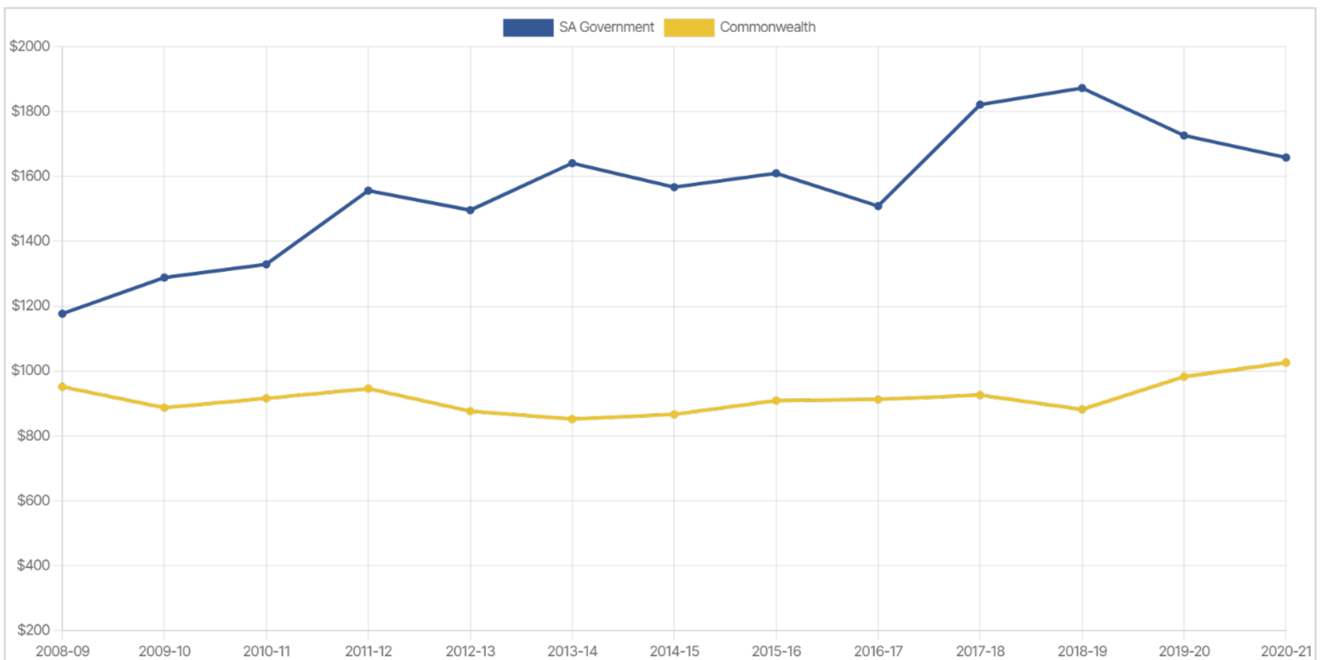

Source: The State of Our Public Hospitals (DoHA 2004 to 2010) FOI request reference 253-1001 lodged June 2011. 2011–12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by Australian Institute of Health and Welfare (AIHW) National emergency access and planned surgery targets 2012: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW) Planned surgery waiting times 2013–14 to 2021–22: Australian hospital statistics

2010–12 data not available

## Public hospital funding

The most recent public hospital funding data is 2020–21, so it is affected by COVID 19 response.

**Commonwealth and South Australian government per person funding for public hospitals (constant prices)**[66]




Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 10 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **South Australian Gov** | 6.2% | 2.6% | -5.9% | 2.90% |
| **Commonwealth** | -2.0% | 2.1% | 7.9% | 0.63% |

[65] Note: The funding data in the AMA Public Hospital Report Card 2022 differs slightly compared to the Public Hospital Report Card 2021 for Western Australia. The data change is in line with the latest updates from AIHW and their ongoing work program to consolidate the data. For more information see Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2019–20 – Different Reports on Health Expenditure https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/comparison-and-alignment-of-health-expenditure-estimates/different-reports-on-health-expenditure

# TASMANIA

**Dr John Saul**

President AMA Tasmania

Tasmania's population is expanding and ageing, and we still, albeit tenuously, retain the luxury of achieving a balance of highly skilled and dedicated staff who excel at personalised care more akin to community-sized hospitals; chances are the cardiologist on staff knows the patient's oncologist as well as their GP, and so on.

While all of us in health care know the enormous benefits of this for both staff and patients, once again, we find ourselves at a crucial crossroads, and this time the wrong turn could have grave consequences.

We must ensure Tasmania's three main public hospitals are sufficiently resourced to navigate the nuanced balance of gold-standard patient care while at the same time providing opportunity for our doctors.

COVID shone a light on our healthcare system like no other time during my career in medicine; every level of government appealed to us all to stay at home and stay safe and help our hospitals arm themselves for the tsunami of patients anticipated, and by doing this, we were assured that we would all, hospital systems especially, come out better for it on the other side.

This is quite different from the reality we are now facing in our public hospitals, with a largely burnt-out workforce, access, and bed block at all-time highs, blown out wait times whether it's for elective surgery or specialist appointments and morale and recruitment and retention at the lowest I've ever witnessed.

If the predicted COVID-protected hospital environment had worked, the figures we see in this year's AMA public hospital report would be measurably different.

Only 43 per cent of patients in Triage Category 3 in Tasmania were seen within the recommended time in the 2021–22 reporting period, a drop of six per cent compared to the previous year.

We saw a further drop in our emergency department presentations completed within four hours by seven per cent compared to the pre-pandemic 2018–19.

As for elective surgery, Category 2 elective surgery wait times during 2021–22 median wait in Tasmania was 62 days, the longest wait time in Australia and 37 days longer (over an extra month longer) than the best-performing state, granted this is a slight improvement compared to the year before; however, as it's only by three days, it's just not enough to celebrate.

In the Category 2 elective surgery, where patients are admitted within the recommended time (90 days), we saw only 42 per cent of patients on the Category 2 elective surgery waiting list seen within the recommended timeframe. At the same time, pleasingly, this is a six per cent improvement compared to the year before; for clarity, Tasmania has been the worst-performing state in this area yearly since 2013–14, with these minor improvements being achieved by short-term funding injections rather than the long term planned investment with strategic surge capacity allowances built-ins that are needed.

In Tasmania, in 2022, over 57,000 patients were waiting to see a specialist in the public health system for their medical conditions. That includes patients with urgent referrals waiting over 880 days (nearly three years) to see a specialist, such as a neurosurgeon.

In 2020–21 there was an increase in public hospital expenditure per person in terms of both state and federal funding, with the Tasmanian government investing $1,678.00, a significant increase compared to the year before ($1,375.05) and the federal government investing $1,230.00 and while we have no recent data available on this, it shows we are somewhat heading in the right direction.

With emergency department wait times and bed block unrelenting, it is no surprise that our doctors are at the end of their tether when little seems to have changed or the ad hoc measures put in place are quickly overtaken by demand growth. The government needs to implement sustainability.

For Tasmania's public hospitals, workforce issues must remain our primary focus, recruiting medical staff, from interns to consultants. The time is right now for Tasmania while we are still small enough that we can afford to experiment with new patient care models by developing innovative policies and hospital systems that are sufficiently resourced and flexible enough to grow with the population.

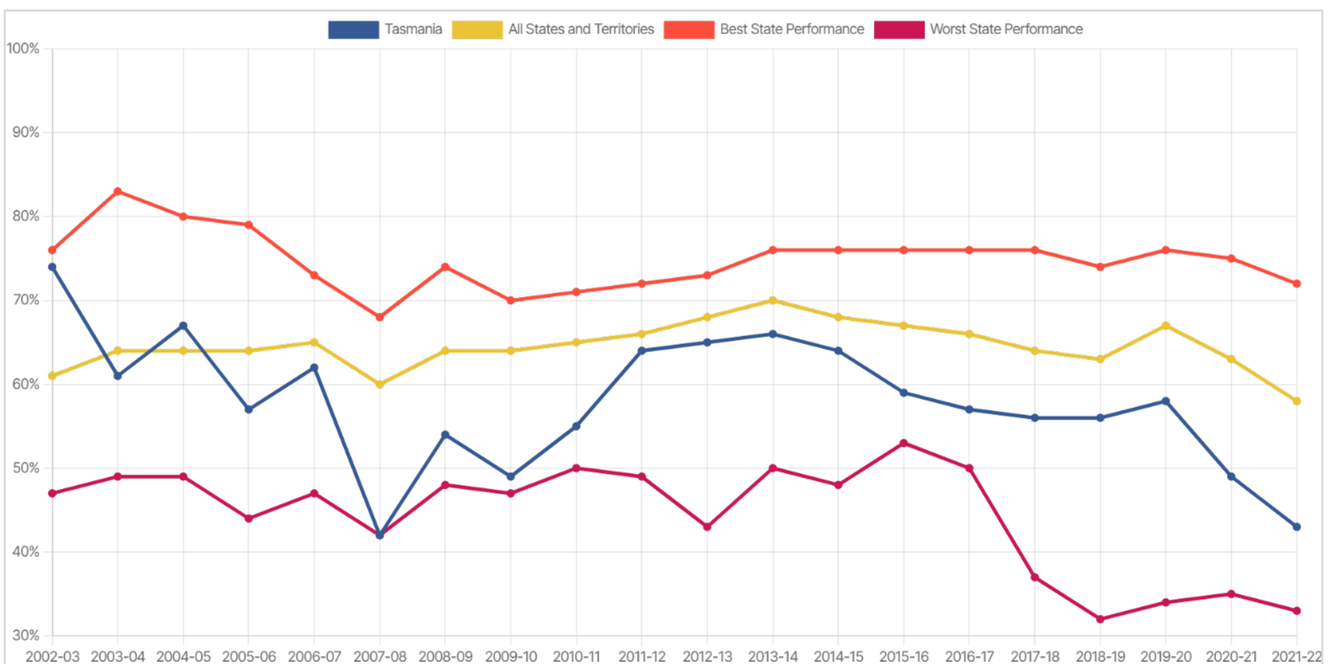
## Emergency department

The growth in emergency department presentations in Tasmania continued in 2021–22. After the 10.8 per cent increase in 2020–21,[71] an increase of 1.8 per cent was recorded.

**Waiting times**

**Percentage of Triage Category 3 emergency department patients seen within recommended time (<30 minutes) — Tasmania**

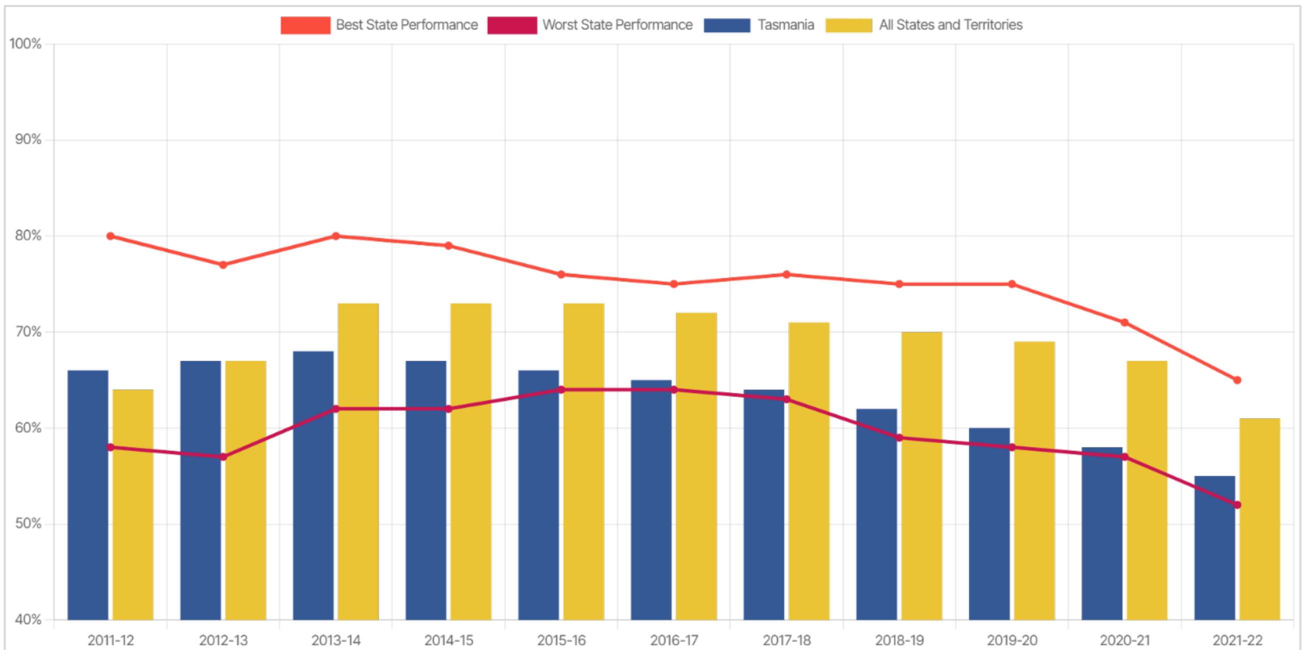
Only 43 per cent of patients in Triage Category 3 in Tasmania were seen within the recommended time in 2021–22 reporting period.




Source: The State of our Public Hospitals (DoHA 2004 to 2010). Australian Institute of Health and Welfare (AIHW). Emergency department care 2010 to 2021–22

[71] Australian Institute of Health and Welfare 2022. Australian Hospital Statistics: Emergency department care 2020–21 Table 2.2 viewed 2 February 2022 https://www.aihw.gov.au/getmedia/0d0d6cbf-e764-4a89-a71a-b03c5156235d/Emergency-Department-Care-2020-21.xlsx.aspx

**Percentage of emergency department visits completed in four hours or less — Tasmania**




Source: Australian Institute of Health and Welfare (AIHW). Emergency department care (2011–12 to 2021 22): Australian hospital statistics.

Note: National emergency access targets were abolished with effect from 1 July 2015

## Planned surgery

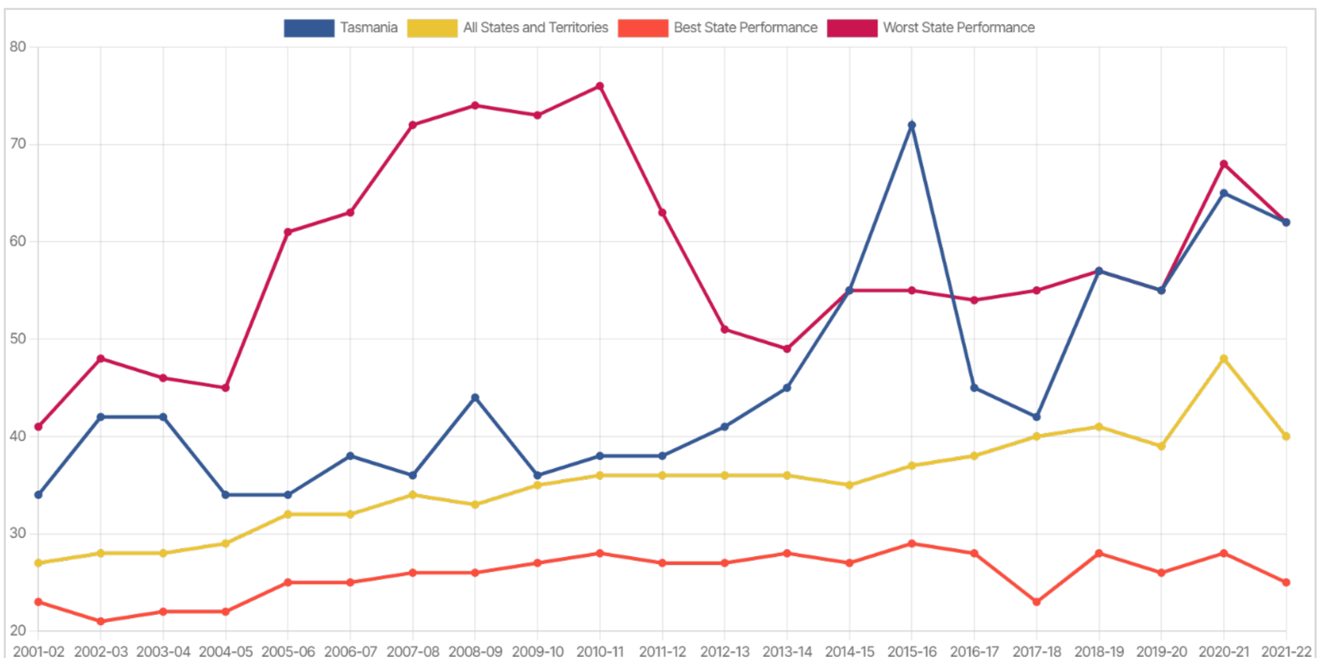
**Waiting times**

The suspension of planned surgeries due to COVID in 2020 resulted in an increase in wait times and the number of patients on the wait list in 2020–21.[72]

Even with the extra investment by the Commonwealth Government to clear the surgical backlog ($15 million in Community Health and Hospitals Program funding),[73] in 2021–22 Tasmania had the longest median wait time for planned surgery in the country. On average, Tasmanians waited 62 days for planned surgery, a slight improvement compared to the year before when they waited 65 days.

**Median waiting time for planned surgery (days) — Tasmania**

**In 2021–22, median wait in Tasmania was 37 days longer than best performing State.**



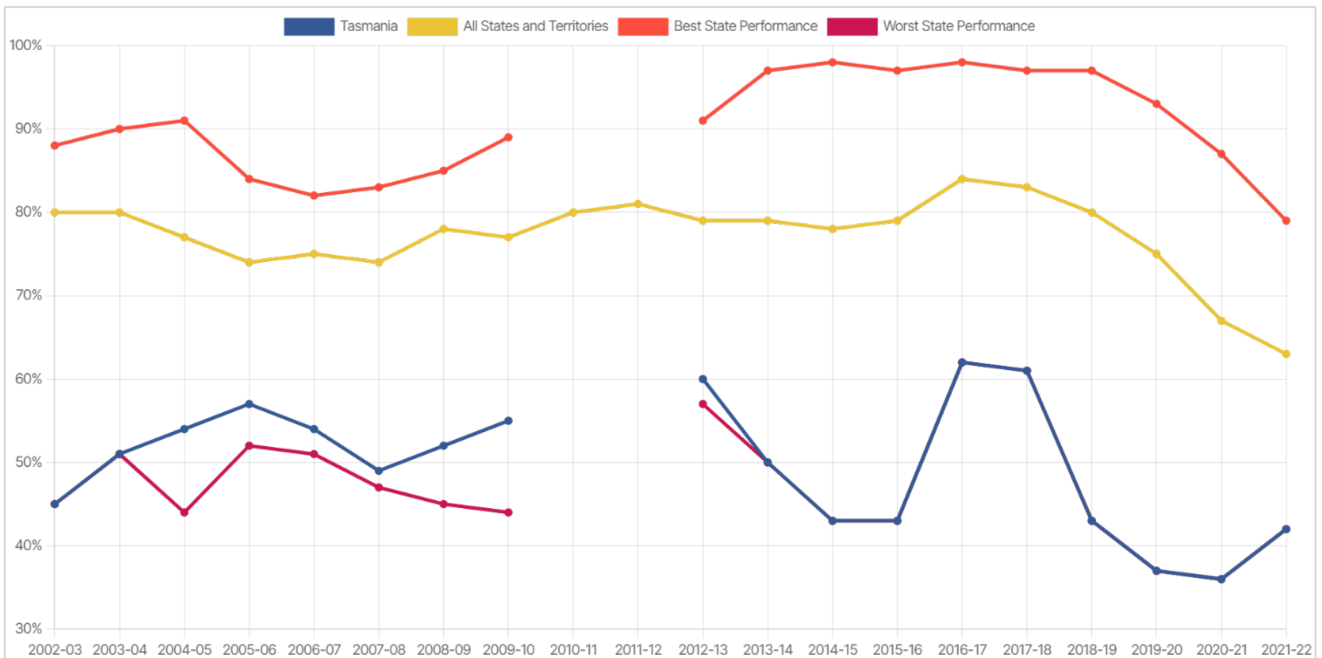

Source: Australian Institute of Health and Welfare (AIHW). Planned surgery data cubes (2001–02 to 2006–07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times (2007–08 to 2021–22): Australian hospital statistics

[72] Tasmanian Government Department of Health 2021. Statewide Planned Surgery Four-Year Plan https://doh.health.tas.gov.au/__data/assets/pdf_file/0005/438845/Planned_Surgery_Plan_2021-22_to_2024-25.pdf
[73] Ibid

### Category 2 patients

### Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) — Tasmania

42 per cent of patients of category 2 patients were seen within the recommended time in Tasmania in 2021–22. Even with slight improvement compared to the year before (from 36 per cent) Tasmania has been the worst performing state on this parameter every year since 2013–14.



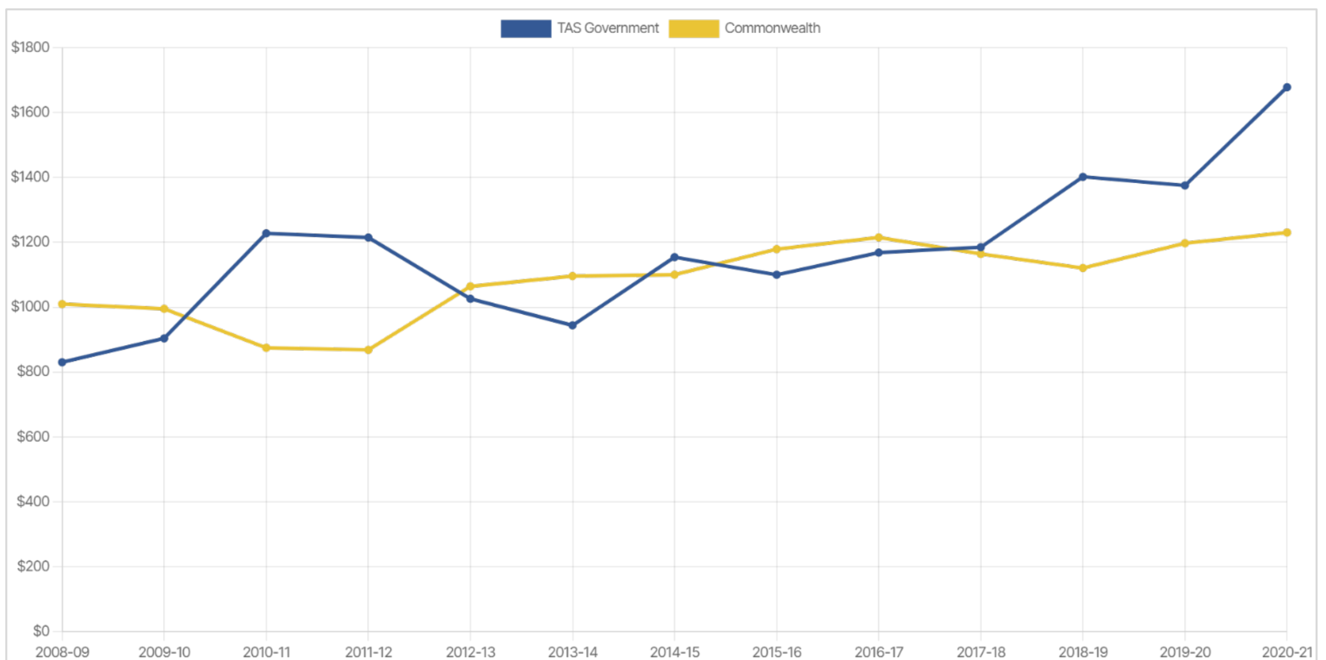

Source: The State of Our Public Hospitals (DoHA 2004 to 2010) FOI request reference 253-1001 lodged June 2011. 2011–12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by Australian Institute of Health and Welfare (AIHW) National emergency access and planned surgery targets 2012: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW) Planned surgery waiting times 2013–14 to 2021–22: Australian hospital statistics

2010–12 data not available

## Public hospital funding

The most recent public hospital funding data is 2020–21, so it is affected by COVID 19 response.

**Commonwealth and Tasmania government per person funding for public hospitals (constant prices)**




Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 10 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **Tasmanian Gov** | 5.4% | 5.8% | 9.4% | 6.04% |
| **Commonwealth** | 1.3% | 1.5% | 4.8% | 1.66% |

# AUSTRALIAN CAPITAL TERRITORY

**Prof Walter Abhayaratna OAM**

President AMA ACT

There is a reasonable expectation that our Nation's capital should represent the best version of Australia, including its performance in the health sector.

This year, as in recent years, the ACT public hospital performance sits disappointingly below the expected standard on measures that are considered to be important to consumers and the quality of healthcare – how long it takes to be seen when you present to the emergency department with a condition considered by healthcare providers as urgent; how long it takes for the emergency department care, regardless of whether the decision is to discharge from the emergency department, admit to hospital or appropriately transfer to another hospital for further care. Access to non-urgent (yet essential) surgery, whilst not the worst in the country, considerably lags the performance in other jurisdictions.

Another annual reminder of the suboptimal public hospital performance is not only disappointing to consumers in the Australian Capital Territory, it defies the efforts of healthcare providers in the ACT public hospitals who work tirelessly and often against a healthcare ecosystem that is geared to generate these less-than-ideal results year-on-year. Yes, we can do better; but it will require changes that address systemic challenges including a primary healthcare system that is under-resourced and a fragmented healthcare system that requires urgent reform through collaboration between our Territory government and the Federal government. If we are unable to achieve this collaboration in the Nation's capital, then where can we….?

Concerningly, the Australian Capital Territory may be the canary in the mine for the Australian healthcare system given the dynamics of the vicious downward cycle occurring in the primary healthcare sector across the country. It is time to stop shifting blame to a single stakeholder in the healthcare system…..and it is time to ensure the 'short-term fixes' are not put forward and implemented when they have an adverse effect on the fundamental reforms required to address the 'whole-of-system' challenges and promote integrated and high-value care.

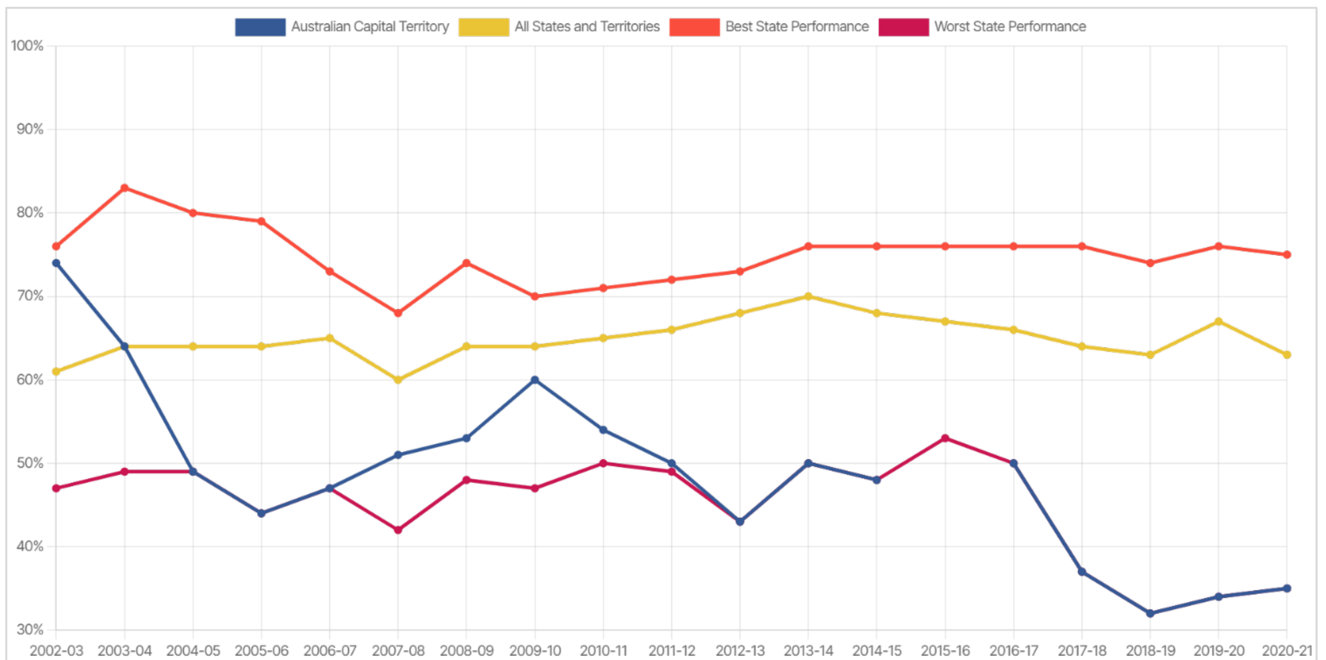
## Emergency department

Although the total number of emergency department presentations in 2020–21 in the ACT rose by 9 per cent compared to the year before,[74] in 2021–22, that number dropped by 6.5 per cent (about 10,000 less presentations).[75]

**Waiting times**

**Percentage of Triage Category 3 emergency department patients seen within recommended time (<30 minutes) — Australian Capital Territory**

Only 36 per cent of Category 3 presentations in the Australian Capital Territory were seen on time in 2021–22 reporting period. This is a one per cent increase on the year before.

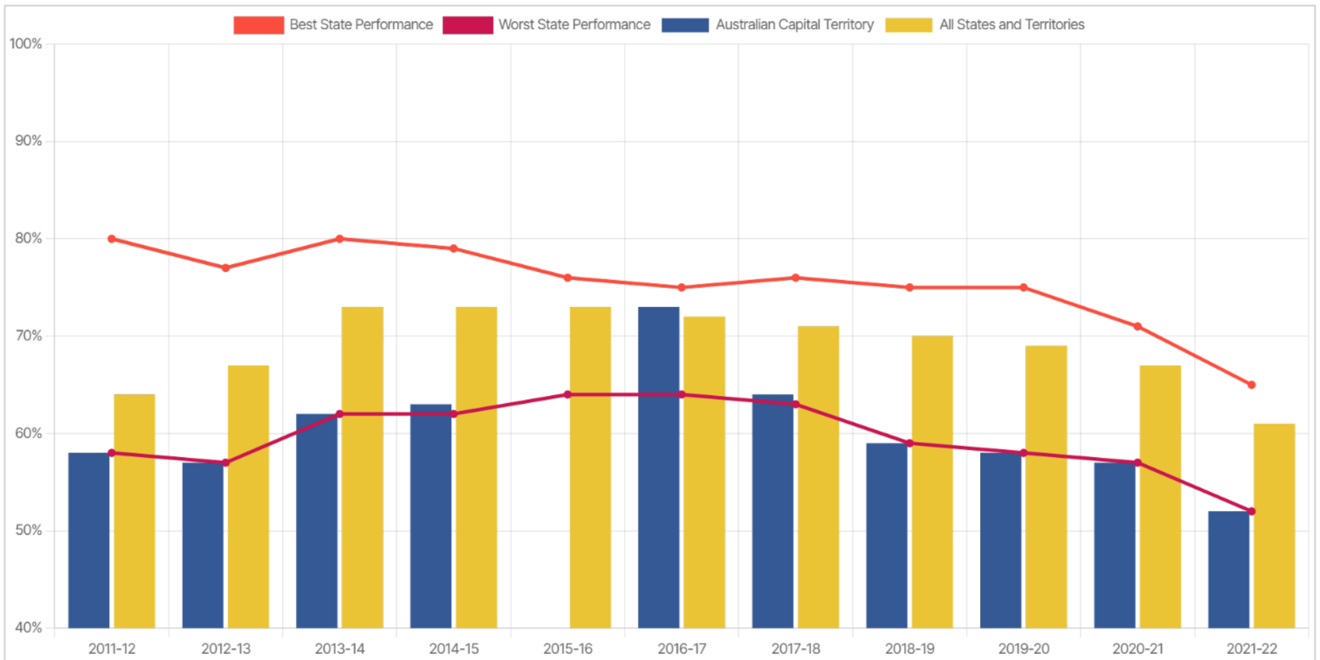



Source: The State of our Public Hospitals (DoHA 2004 to 2010). Australian Institute of Health and Welfare (AIHW). Emergency department care 2010 to 2021–22

[74] Australian Institute of Health and Welfare 2022. Australian Hospital Statistics: Emergency department care 2020–21 Table 2.2 viewed 2 February 2022 https://www.aihw.gov.au/getmedia/0d0d6cbf-e764-4a89-a71a-b03c5156235d/Emergency-Department-Care-2020-21.xlsx.aspx
[75] Australian Institute of Health and Welfare 2023. Australian Hospital Statistics: Emergency department care 2021–22 Table 2.2 viewed 17 February 2023

**Percentage of emergency department visits completed in four hours or less — Australian Capital Territory**

Almost one in two patients (48 per cent) spent longer than 4 hours in the ACT emergency departments in 2021–22. ACT is the worst performer on this indicator.




Source: Australian Institute of Health and Welfare (AIHW). Emergency department care (2011–12 to 2021 22): Australian hospital statistics.

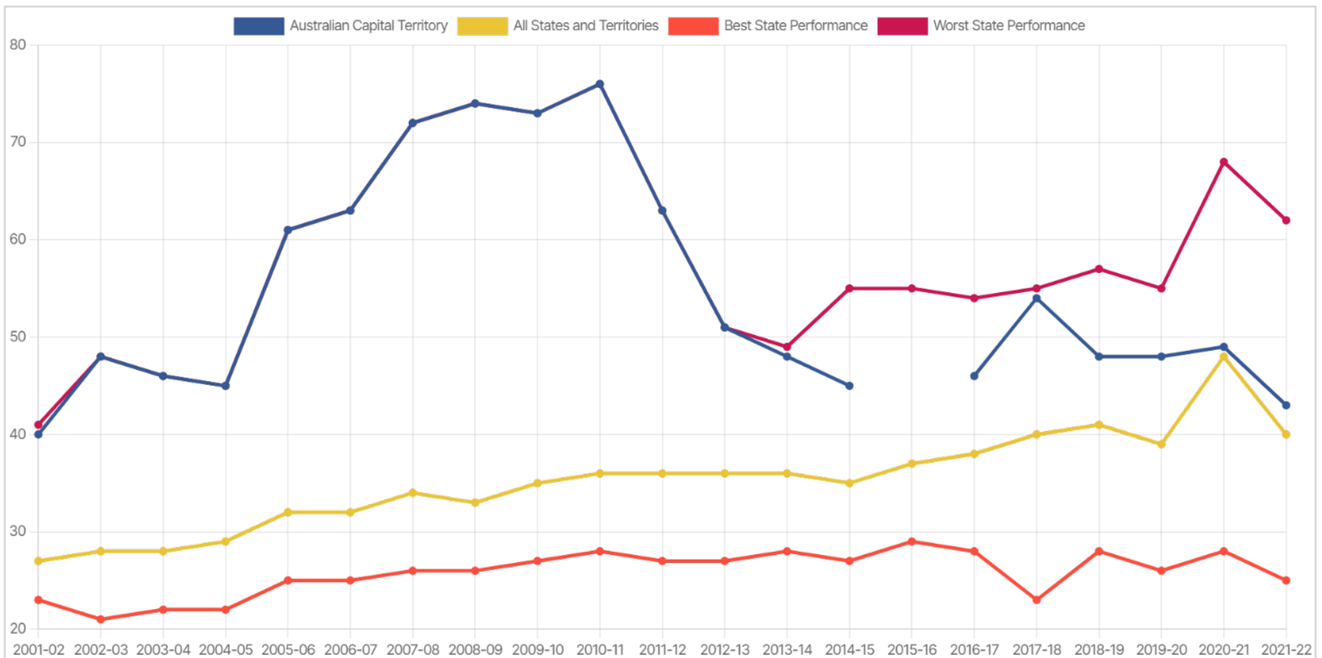
Note: National emergency access targets were abolished with effect from 1 July 2015

## Planned surgery

### Waiting times

The wait times for planned surgery in the ACT improved slightly in 2021–22 compared to the year before, from 49 days in 2020–21 to 43 days, ACT was still below the national average and the median wait time in the Australian Capital Territory was 18 days longer than the best performing state.

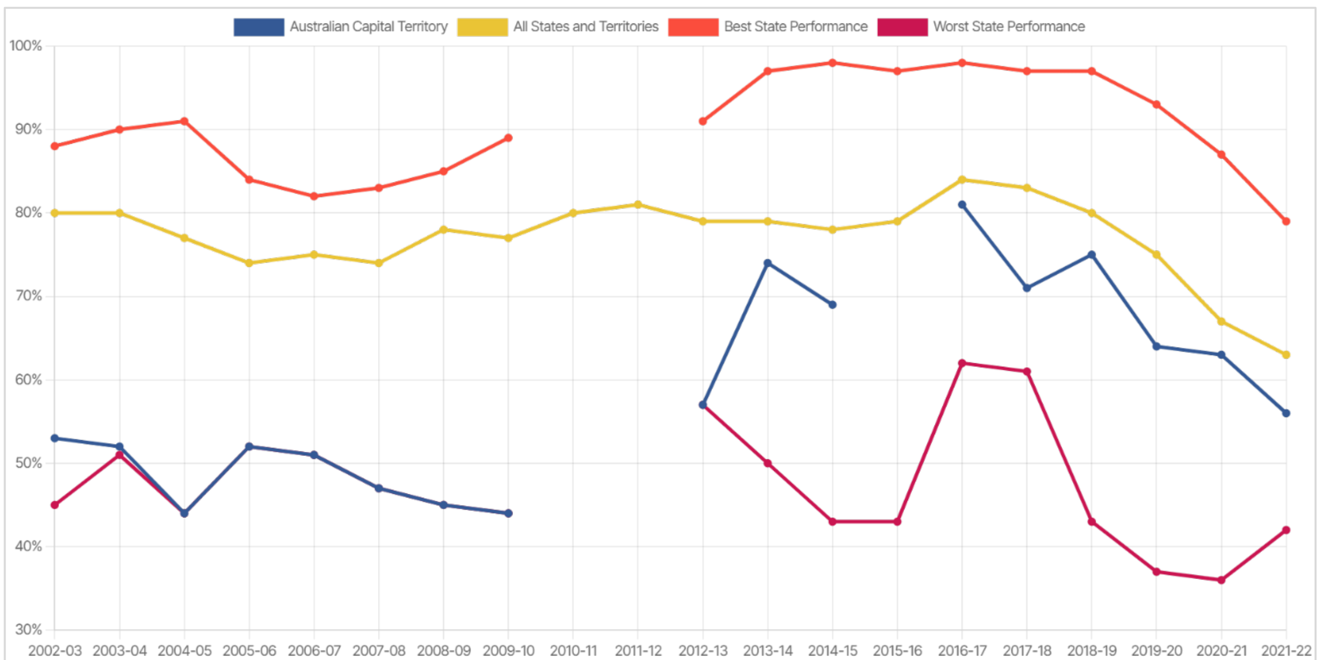
**Median waiting time for planned surgery (days) — Australian Capital Territory**




Source: Australian Institute of Health and Welfare (AIHW). Planned surgery data cubes (2001–02 to 2006–07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times (2007–08 to 2021–22): Australian hospital statistics

**Category 2 patients**

**Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) — Australian Capital Territory**



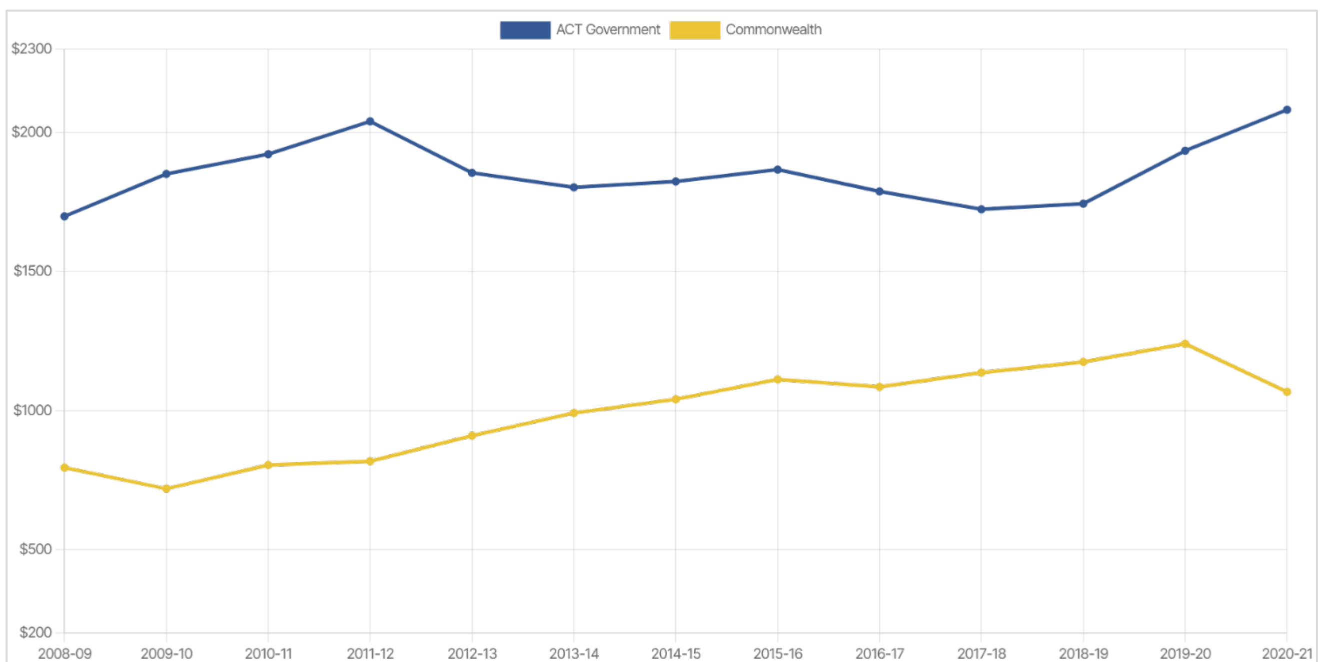

Source: The State of Our Public Hospitals (DoHA 2004 to 2010) FOI request reference 253-1001 lodged June 2011. 2011–12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by Australian Institute of Health and Welfare (AIHW) National emergency access and planned surgery targets 2012: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW) Planned surgery waiting times 2013–14 to 2021–22: Australian hospital statistics

2010–12 data not available

## Public hospital funding

The most recent public hospital funding data is 2020–21, so it is affected by COVID 19 response.

**Commonwealth and Australian Capital Territory government per person funding for public hospitals (constant prices)**[76]




Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 10 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **ACT Gov** | 2.2% | -1.1% | 9.3% | 1.71% |
| **Commonwealth** | 3.4% | 3.5% | -4.7% | 2.48% |

[76] Note: The funding data in the AMA Public Hospital Report Card 2022 differs slightly compared to the Public Hospital Report Card 2021 for the Australian Capital Territory. The data change is in line with the latest updates from AIHW and their ongoing work program to consolidate the data. For more information see Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2019–20 – Different Reports on Health Expenditure https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/comparison-and-alignment-of-health-expenditure-estimates/different-reports-on-health-expenditure

# AUSTRALIAN CAPITAL TERRITORY

**Associate Professor Robert Parker**

President AMA NT

This year’s data reflects the continuing pressures on NT Hospitals during the review period with recurrent Code Yellows and a Code Brown following a fire at a Health Department warehouse ( that destroyed $30 Million of health supplies) impacting on Hospital performance. Despite the issues above, the reduction in surgical waiting times below the National average is a welcome finding. integrated and high-value care.

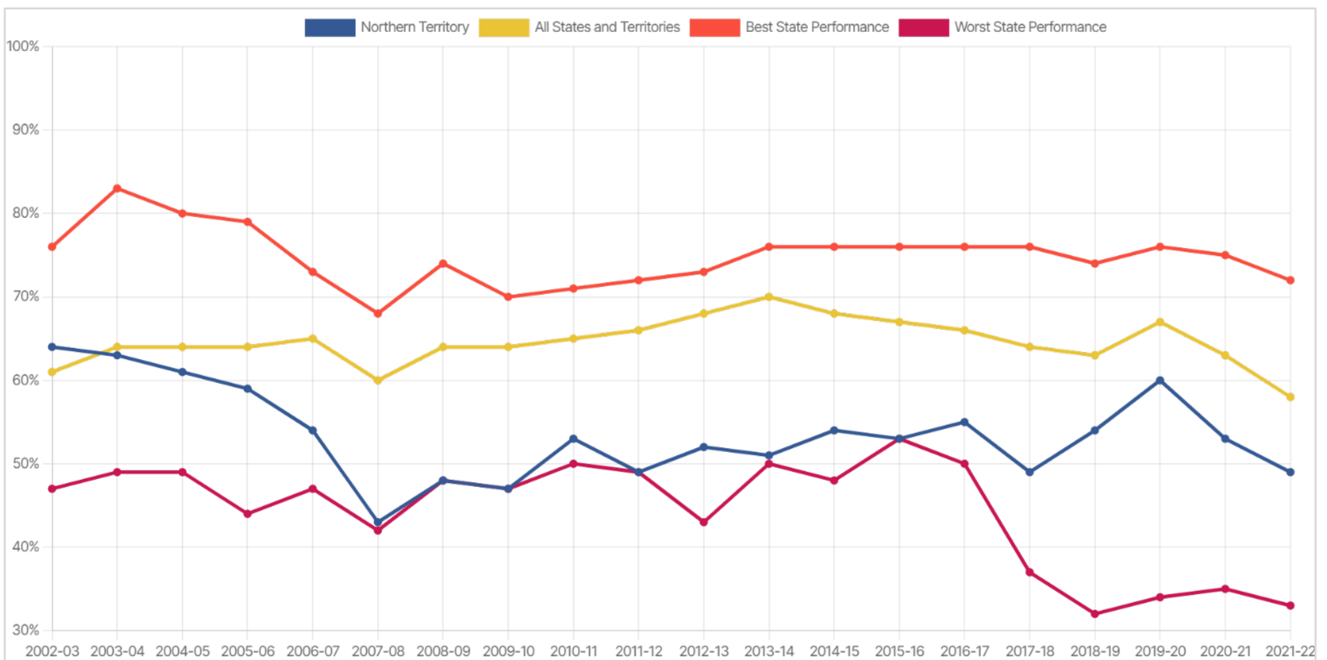
## Emergency department

Following a spike in the Northern Territory emergency presentations by 7.9 per cent in 2020–21 financial year,[77] in 2021–22, a reduction in presentations of 3.6 per cent was recorded.[78]

**Waiting times**

**Percentage of Triage Category 3 emergency department patients seen within recommended time (<30 minutes) — Northern Territory**

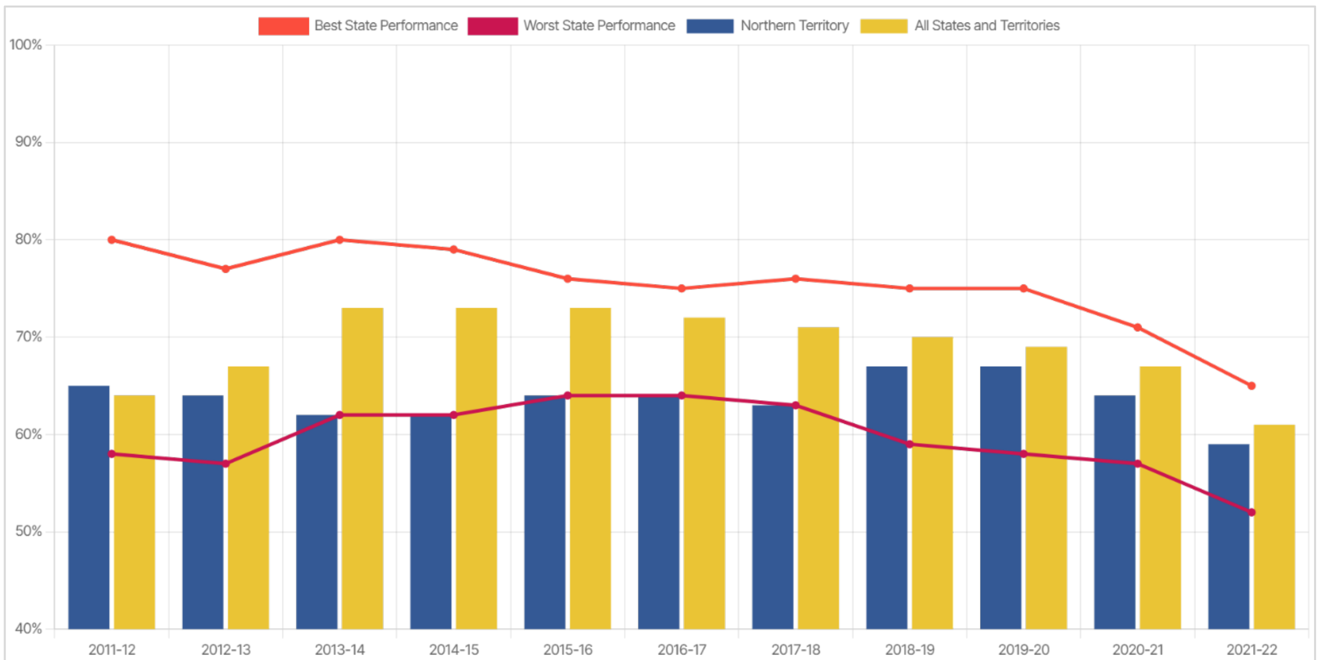
In 2021–22, 49 per cent of patients triaged as Category 3 were seen on time, a drop of 4 per cent compared to the year before. The Northern Territory is 23 per cent below the best performing state in this category.




Source: The State of our Public Hospitals (DoHA 2004 to 2010). Australian Institute of Health and Welfare (AIHW). Emergency department care 2010 to 2021–22

[77] Australian Institute of Health and Welfare 2022. Australian Hospital Statistics: Emergency department care 2020–21 Table 2.2 viewed 2 February 2022 https://www.aihw.gov.au/getmedia/0d0d6cbf-e764-4a89-a71a-b03c5156235d/Emergency-Department-Care-2020-21.xlsx.aspx
[78] Australian Institute of Health and Welfare 2023. Australian Hospital Statistics: Emergency department care 2021–22 Table 2.2 viewed 17 February 2023

**Percentage of emergency department visits completed in four hours or less — Northern Territory**




Source: Australian Institute of Health and Welfare (AIHW). Emergency department care (2011–12 to 2021 22): Australian hospital statistics.

Note: National emergency access targets were abolished with effect from 1 July 2015

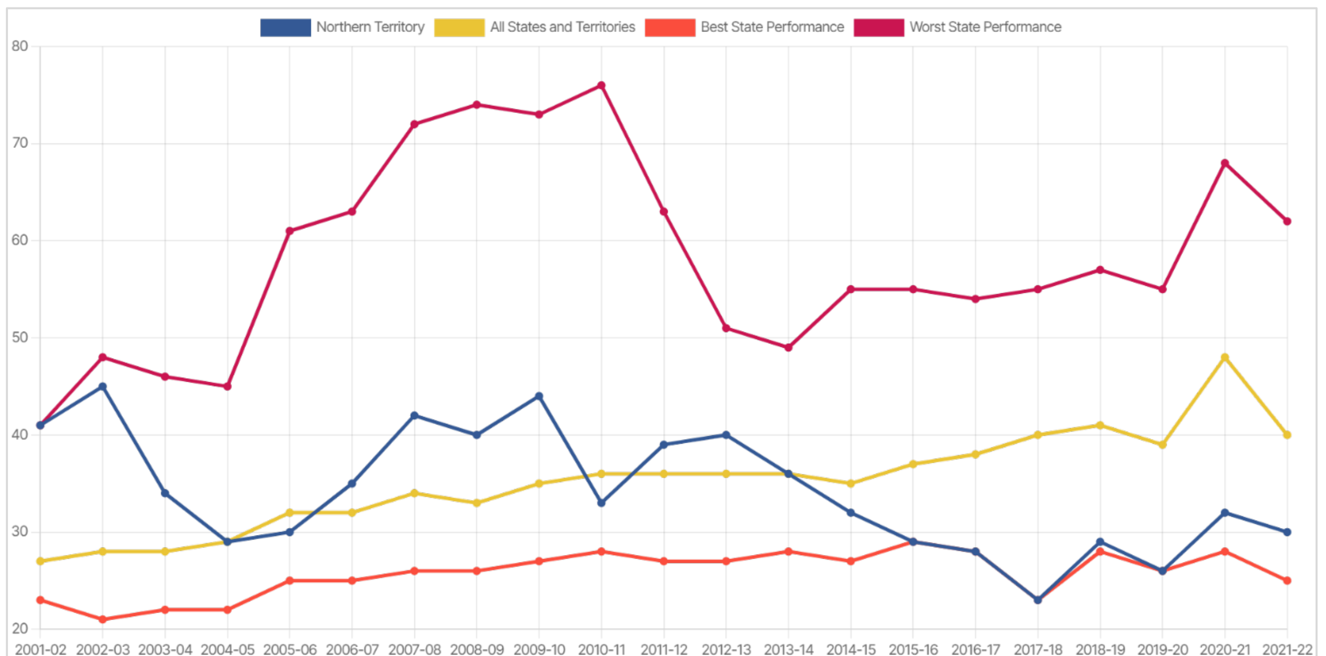
## Planned surgery

**Waiting times**

In 2021–22 in the Northern Territory, planned surgery number of admissions dropped by 13 per cent compared to the year before.[79]

**Median waiting time for planned surgery (days) — Northern Territory**

In 2021–22, median wait in the Northern Territory was 5 days longer than the best performing State in this category.



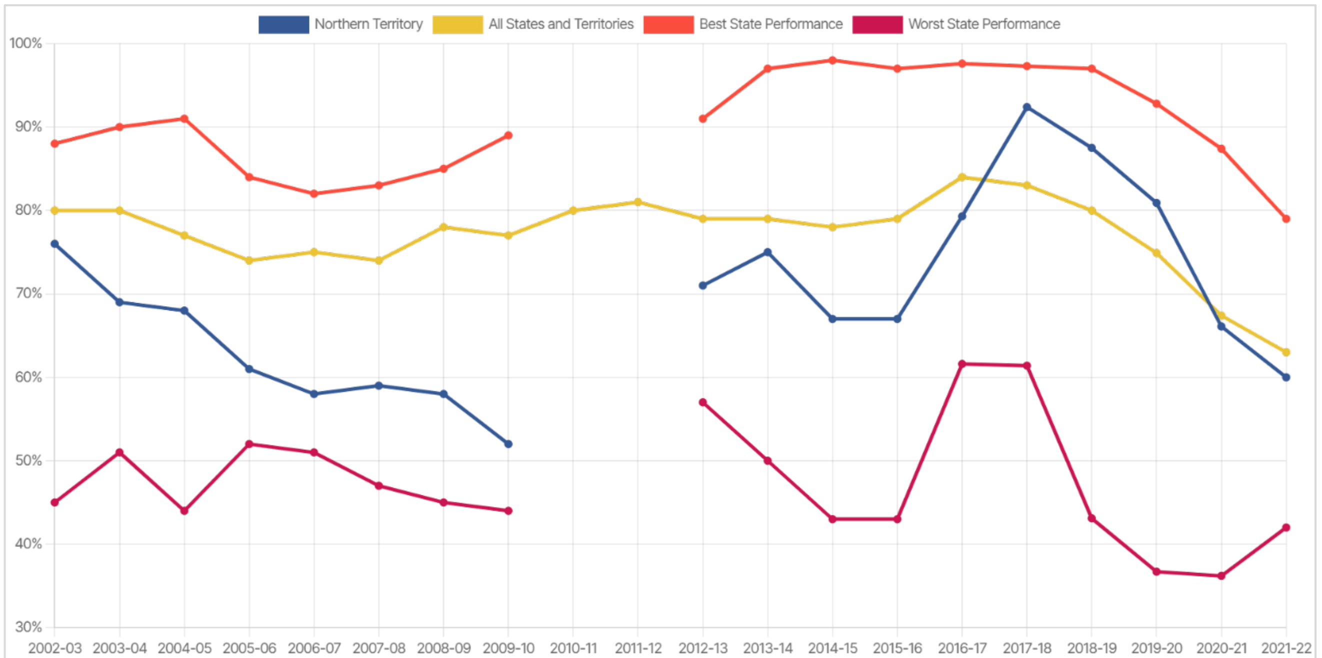

Source: Australian Institute of Health and Welfare (AIHW). Planned surgery data cubes (2001–02 to 2006–07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Planned surgery waiting times (2007–08 to 2021–22): Australian hospital statistics

[79] Australian Institute of Health and Welfare (2023). Australian Hospital Statistics: Planned surgery waiting times 2021–22 Table 2.4 viewed 2 February 2022 https://www.aihw.gov.au/getmedia/9d847d52-b1d3-4366-9900-1a0d4db1055d/Planned-surgery-waiting-times-2020-21.xlsx.aspx

### Category 2 patients

**Percentage of Category 2 planned surgery patients admitted within the recommended time (90 days) — Northern Territory**

Only 60 per cent of Category 2 planned surgery were performed within the recommended time in 2021–22 in the Northern Territory, a drop of 6 per cent compared to the year before and a staggering 28 per cent compared to 2018–19, the pre-pandemic year.



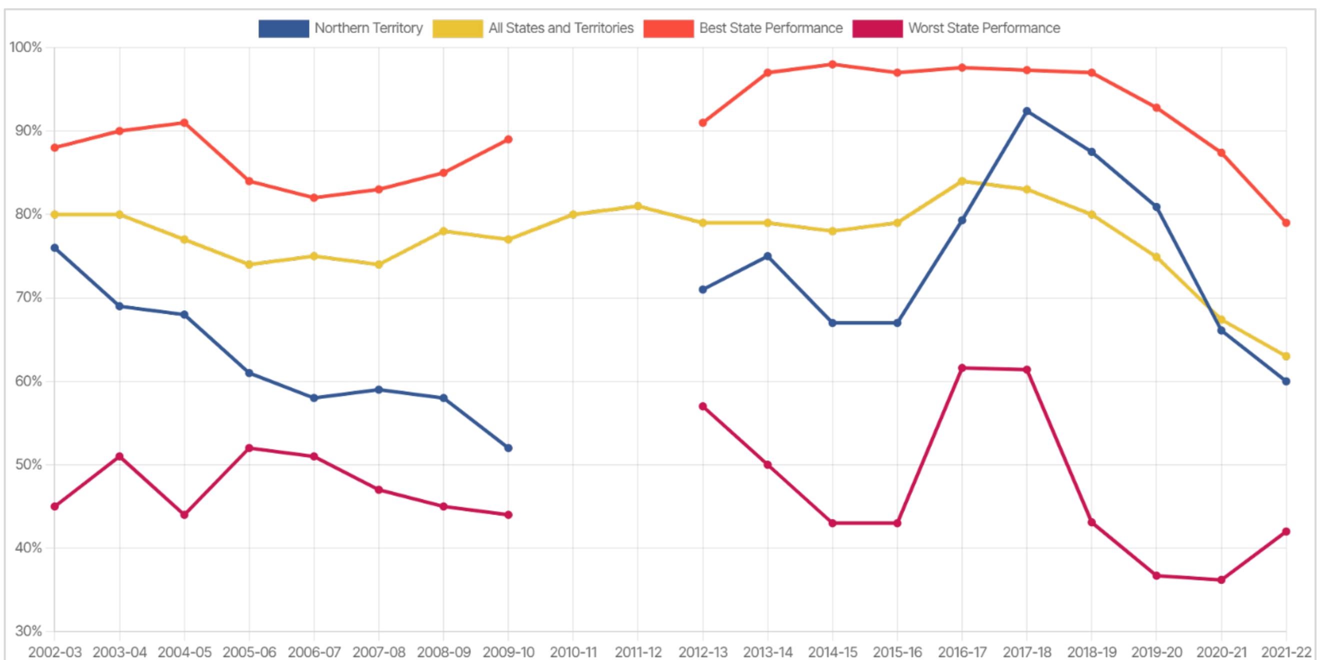

Source: The State of Our Public Hospitals (DoHA 2004 to 2010) FOI request reference 253-1001 lodged June 2011. 2011–12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by Australian Institute of Health and Welfare (AIHW) National emergency access and planned surgery targets 2012: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW) Planned surgery waiting times 2013–14 to 2021–22: Australian hospital statistics

2010–12 data not available

## Public hospital funding

The most recent public hospital funding data is 2020–21, so it is affected by COVID-19 response.

**Commonwealth and Northern Territory government per person funding for public hospitals (constant prices)**




Source: Australian Institute of Health and Welfare (AIHW) 2022, Health Expenditure Australia: 2008–09 to 2019–20 viewed 10 February 2022 https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/main-visualisations/overview

| | 2008–09 to 2012–13 | 2013–14 to 2017–18 | 2018–19 to 2020–21 | 2008–09 to 2020–21 |
|---|---|---|---|---|
| **NT Gov** | 10.1% | -5.1% | 2.9% | 2.91% |
| **Commonwealth** | -3.4% | 12.8% | 5.7% | 3.28% |

2023
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