Public Hospital Report Card 2026

AMA

Contents

Acronyms

ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
IHACPA	Independent Health and Aged Care Pricing Authority
LHN	Local Hospital Network
NEP	National Efficient Price
NHRA	National Health Reform Agreement
NWAU	National Weighted Activity Unit
OECD	Organisation for Economic Co-operation and Development

President's introduction

Australia's public hospitals are the backbone of our health system. They are where Australians turn in moments of crisis and vulnerability. But year after year, the Australian Medical Association (AMA) Public Hospital Report Card shows a system under mounting strain — a strain that is now impossible to ignore.

While all the data contained in this report reflects the situation before the National Health Reform Agreement (NHRA) was signed, the trends in performance, access and capacity confirmed just how important it was for the parties to come to this agreement.

Overall performance in 2024–25 was markedly worse than it was five and ten years ago, and the pressures facing public hospitals continued to intensify as Australia's population grew and aged. Nowhere was this more evident than in our emergency departments. The proportion of patients completing their emergency department visit within four hours has fallen again to the lowest level on record. Just over half of Australians presenting to an emergency department are now seen, treated, admitted, or discharged within the nationally agreed benchmark. Underlying all of this is a fundamental capacity problem, one that won't be fixed without specific attention. The number of public hospital beds per person has effectively stagnated.

On 30 January 2026, National Cabinet announced the new NHRA for 2026–2031. The AMA welcomed this announcement as a significant and long overdue shift in the right direction for Australia's public hospitals, and a clear win for the AMA's Clear the Hospital Logjam campaign.

Let's look at the positives:

- The additional $25 billion in federal funding lifts the artificial growth cap and increases the federal government's share of hospital funding — two structural constraints the AMA has consistently identified as driving declining performance, overcrowded emergency departments, ambulance ramping and growing surgical backlogs.
- It also provides the states and territories with funding certainty over the next five years.
- Finally, the NHRA will allow hospitals to better meet rising and increasingly complex demand and creates the conditions for improved access and performance.

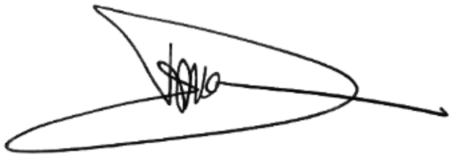
But the AMA warns having come to an agreement is not a cure-all.

- The NHRA should shift the focus from announcing funding or aspirational targets to demonstrating measurable increases in activity within the life of this agreement.
- States and territories will need to ensure they maintain and increase their own funding effort.
- And with the federal funding now in place, the states and territories need to translate this into a plan of action to increase their capacity and activity — all the funding in the world will not help if it is not used to increase activity.

While important details remain unresolved and further work is needed to ensure the agreement delivers on its promise, the NHRA reflects years of sustained advocacy by the AMA to name the problem, build public understanding and keep hospital funding reform firmly on the national agenda.

What this report card does stress, however, is that the system is not, and was never, failing because of a lack of effort by doctors, nurses, and other health professionals. It is failing because demand has outstripped capacity for too long.

Australians deserve timely access to emergency care and planned surgery. Our hospital workforce deserves a system that allows them to provide safe, high-quality care without burning out. This year’s report card is a warning — however following the announcement of the NHRA, it is also an opportunity. With the right investment and reform, we can still turn this around.



Dr Danielle McMullen

President

Australian Medical Association

Australia's public hospital system explained

Australia's public hospital system is complex and confusing, even for many doctors. This section is intended to provide an overview of how the system functions for the benefit of all readers. By better understanding how our system works, readers can also better appreciate the basis behind the AMA's proposed solutions.

As the peak body representing Australia's doctors, these solutions are informed by extensive consultation with our members, combined with qualitative research and economic modelling.

Who manages Australia's public hospitals?

Each state and territory government manages their own public hospital system, with funding arrangements shared between the state or territory and the federal government. For this reason, our report card looks at both national performance and state-by-state performance, with introductions by each state or territory president highlighting key policy issues within their own jurisdiction.

Although the federal government plays a central role in managing funding, monitoring performance, and supporting specific programs, healthcare is not explicitly mentioned within the Australian constitution. Instead, healthcare responsibilities are divided between governments through various agreements and legislative frameworks, leaving the bulk of public hospital policy to state and territory governments.

Each state and territory government approaches public hospital policy in their own way, with consistent rules laid out under the National Health Reform Agreement (NHRA). One central part of the NHRA is the establishment of Local Hospital Networks (LHNs). LHNs are organisations that manage local public hospital services in accordance with the rules laid out in the NHRA.

Every public hospital in Australia is part of an LHN, despite the fact some states and territories use their own local terminology — such as local health districts, health organisations, and hospital and health services — to describe these networks. For example, Victoria has 81 individual public health services within the state, while New South Wales, a state with a greater population than Victoria, operates only 15 local health districts, divided between six metropolitan and nine rural districts.

LHNs are valuable parts of our health system, allowing for more local approaches to be applied to public hospital care. The AMA has proposed potential revisions to funding models that allow LHNs to drive increased co-ordination between public hospitals and primary healthcare, incentivising increased co-ordination of care.

In summary, public hospitals are managed by their LHN, with state and territory governments setting the overall policy agendas, pay rates and performance targets for public hospitals, and the federal government co-ordinating funding.

How are public hospitals funded?

Australia's public hospitals are funded through a combination of federal, state and territory government contributions defined by the NHRA. Although state governments manage and define their own budgets, the federal government provides some funding to states through Activity Based Funding (ABF), which is paid to hospitals according to the amount of their activity, and the distribution of block grants.

Prior to 2011, all funding from the federal government to the states was provided through block grants, but the introduction of the first NHRA in 2011 introduced an activity-based model with the aim of improving efficiency and transparency. Block funding is still used to support services deemed not suitable for ABF, such as teaching, training, research, and certain public health programs. It also funds smaller rural and regional hospitals where ABF may not be practical due to lower patient volumes.

The Independent Health and Aged Care Pricing Authority (IHACPA) is an independent statutory authority that sets the guidelines for how ABF is distributed to states and territories. IHACPA is responsible for determining the National Efficient Price (NEP) and National Weighted Activity Unit (NWAU), two essential components of ABF.

- The NEP represents the average cost of providing a standard unit of hospital service.
- The NWAU is a measure of health service activity that accounts for variations in clinical complexity.

The states and territories fund the bulk of public hospital services in Australia, with the federal government providing part-funding under the NHRA.

The National Cabinet reached a new five-year NHRA on 30 January 2026, unlocking an additional $25 billion in federal funding for public hospitals after a year-long standoff with states and territories. Advocacy by the AMA was central in driving the federal government to commit to the funding agreed to under the new NHRA. States and territories must now address their capacity shortfall and lift their own funding to ensure their populations can access the care they need in a timely manner.

How are performance metrics decided?

Performance metrics for public hospital performance have been developed to be consistent across each jurisdiction in Australia and are designed to measure how well hospitals provide care to patients. These metrics, which are reported by the Australian Institute of Health and Welfare (AIHW) and used within this report card, are defined by the Australian Health Performance Framework.

The Australian Health Performance Framework is developed in conjunction between the AIHW and the Australian Commission on Safety and Quality in Health Care. The indicators within the framework, particularly those relating to accessibility to the health system, help monitor the performance of Australia's hospitals.

While some parts of health system reporting, such as ambulance ramping times, remain inconsistent between the states and territories, the Australian Health Performance Framework provides a nationally consistent framework to help government, the public, and organisations like the AMA monitor performance of the public hospital system. While all these data are reported publicly on an annual basis, they can be buried in dense statistical publications, which is why the AMA has picked four indicators to highlight in this report card and brings the data together into one snapshot to interrogate long-term trends in performance.

What are the greatest challenges facing public hospitals?

Australia's publicly funded hospital system has long been considered one of the best in the world. However, as highlighted by consecutive AMA Public Hospital Report Cards and research reports, our performance has been waning. Key indicators, such as capacity and planned surgery waiting times, paint a worrying picture.

Australia's ageing population

Australia, like many Organisation for Economic Co-operation and Development (OECD) nations, is facing an ageing population as life expectancy increases and birth rates remain below the replacement rate (according to the OECD, the replacement rate is around 2.1 children per female[i]). While it is good news Australians are living longer than before, the reality of an ageing population will place an ever-growing burden on Australia's public hospital system, and by extension, health budgets.

As this report card shows, Australians aged 65 and over represented 17.3 per cent of Australia's total population in 2024 (compared with 15.9 per cent in 2019), yet this portion of our population represented 49.8 per cent of the total patient days occupying beds within public hospitals in 2023–24.[ii] Without increased investment in capacity, Australia will fail to address the inevitable increase in older patients who use the public hospital system, placing greater strain on our staff and patients.

Workforce shortages

Australia, like many countries, is grappling with health workforce shortages and maldistribution. The effectiveness and efficiency of healthcare services are intrinsically linked to the availability of a workforce that can meet the evolving needs of communities. Despite our world-class medical workforce, many regions continue to face challenges in accessing appropriate healthcare professionals because of their maldistribution.

It is imperative Australia builds a medical workforce aligned with future needs, ensuring a balanced distribution across geographical areas and an appropriate mix of medical specialties. Without this workforce, Australia's public hospitals will be left without the first prerequisite to drive high-quality patient care — our irreplicable health workforce. The AMA is calling for an independent agency that can measure, model, plan, and build the future of Australia's health workforce in a coordinated way (see below).

What are the AMA's proposed solutions for these challenges?

Fund public hospitals to improve their performance and increase capacity

The AMA welcomed the NHRA announcement and its additional $25 billion in hospital funding as "long overdue", but warned the agreement alone would not be enough to halt worsening hospital performance, citing persistent issues such as long emergency waits, surgical delays, and ambulance ramping. The funding still falls short of AMA modelling for the bare minimum federal contribution required for a healthy hospital system, which was estimated at $34.8 billion over the five years of the agreement. This figure does not include additional funding from the states and territories, which is also necessary.

Establish and fund an independent national health workforce planning agency

The primary role of an independent national health workforce planning agency is to ensure the healthcare workforce meets the current and future healthcare needs of the population, through planning, co-ordination, and policy advice. The agency would consider factors such as population demographics, healthcare trends, technological advancements, and the changing nature of diseases, to make informed decisions about workforce requirements.

The AMA is calling for the establishment and funding of an independent national health workforce planning agency to collate, analyse, and use health workforce data to inform evidence-based policies and strategies, enabling us to proactively and efficiently adapt to changing healthcare demands and ensure all Australians have access to high-quality healthcare. It should also use this data to produce evidence-based national supply and demand projections for various health professions based on a range of alternative planning scenarios. This will ensure Australia has a health workforce — with the right skills and in the right locations — to meet community needs and demand. Given the focus on the medical workforce with the National Medical Workforce Strategy 2021–2031, priority should be given to medical workforce planning in the first instance.

Performance indicators and terminology used in this report card

Definitions

Emergency surgery is surgery to treat trauma or acute illness subsequent to an emergency presentation. Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective surgery procedure (for example, in cases of acute deterioration of an existing condition).

Elective surgery is 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. This report card uses the term "**planned surgery**" instead of "elective surgery" to highlight the medical necessity of the surgery required to improve the patient's health and wellbeing. This surgery is planned in accordance with the triage scale and the health system's capacity, as opposed to it being the patient's choice.

Indicators

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

Public hospital capacity is 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

The proportion of patients seen within the clinically recommended timeframes set by the Australian Triage Scale — 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 is the proportion of presentations where the length of the emergency department stay (from entering the hospital to physically leaving the hospital) is four hours or less.

Planned surgery waiting times

Planned surgery waiting and treatment times is the median waiting time for planned surgery, number of days within which half of patients (50 per cent) were admitted for their planned surgical procedure.

- Urgent (Category 1): Requires prompt attention but not immediate lifesaving, e.g., removing a malignant skin lesion or breast lump — within 30 days.
- Semi-urgent (Category 2): Addresses issues that could worsen but allow some time, e.g., heart valve replacement, non-healing fractures — within 90 days.
- Non-urgent (Category 3): Less time-sensitive, e.g., most joint replacements, tonsillectomies, endometriosis removal, carpal tunnel release — within 365 days.

Funding for public hospitals

Public hospital expenditure per person (constant prices).

National public hospital performance

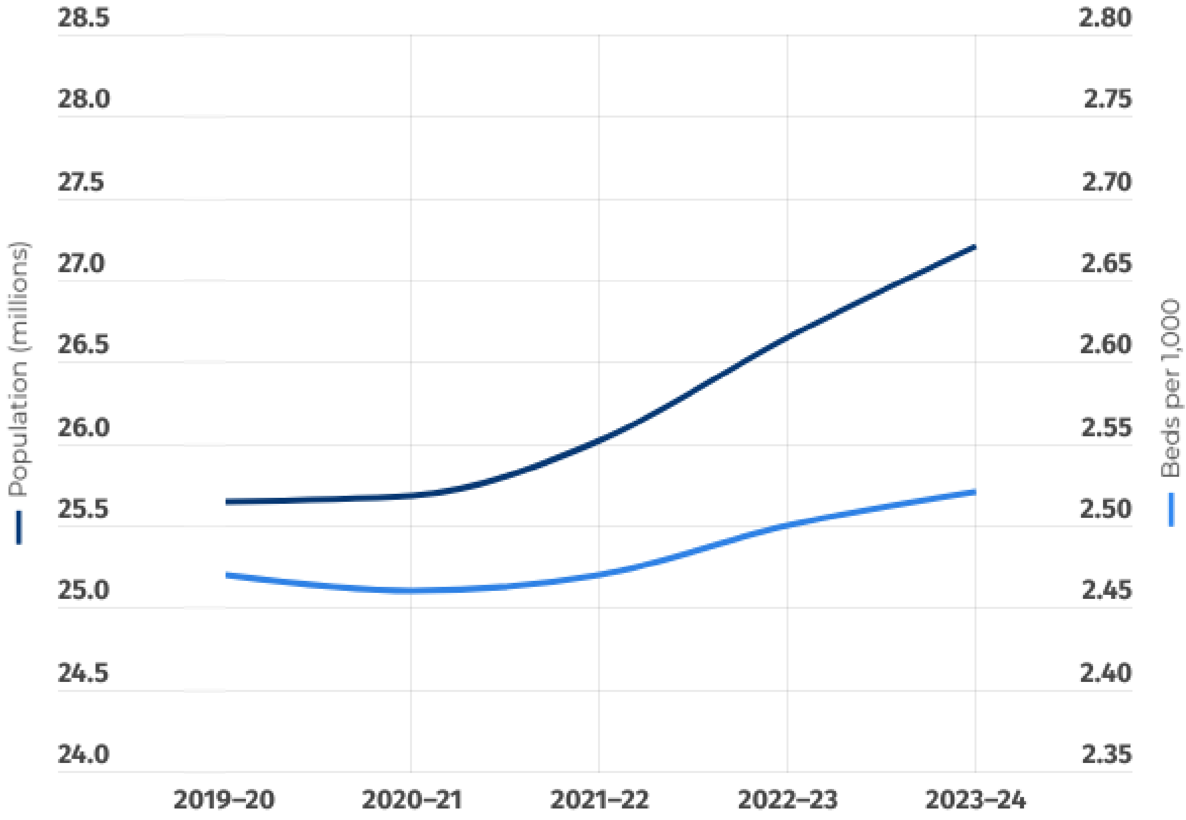
Public hospital capacity

The most important prerequisite to receiving care in a public hospital is an available bed. Without enough beds and physical resources, hospitals frequently experience "access block", where unwell patients must wait for others to be discharged before they can receive admitted care. Despite the world-class doctors and nurses staffing our public hospitals, their ability to deliver the care sick Australians deserve relies on hospitals having sufficient capacity.

The AMA is glad to see an increase in the number of public hospital beds in 2023–24, the latest period for which the data are available. Australia saw an additional 2,223 public hospital beds (other than psychiatric beds) become available in this period.[iii] However, the benefits of these increased numbers have been partially offset by Australia's growing population, which grew by more than 500,000 between 2022–23 and 2023–24.[iv]

Despite 5,048 new beds being made available between 2019–20 to 2023–24, the number of beds per 1,000 Australians has grown only from 2.47 to 2.52 over this time (Figure 1). In other words, while the number of total beds has grown by 8.3 per cent, the number of beds per person has grown by only 2 per cent.

Figure 1: Overall Australian population compared with rate of public hospital beds for every 10,000 Australians, 2019–20 to 2023–24

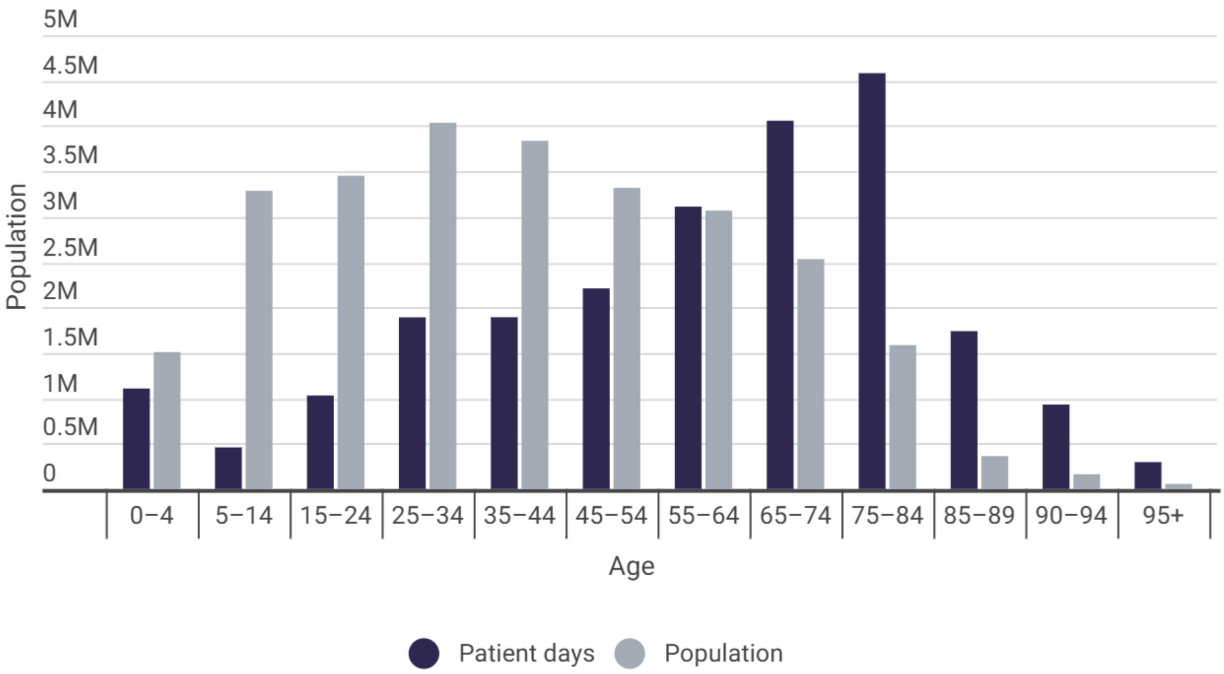


Note: 2023–24 is the most recent data on hospital beds available.

Source: AIHW and Australian Bureau of Statistics (ABS).

Following the trend of most OECD countries, Australia's population is ageing, as people are living longer and reproduction rates fall. As demonstrated in Figure 2, older Australians disproportionally use the public hospital system more often and for longer than younger Australians.[v]

Figure 2: Public hospital patient days compared with population, by age group, 2023–24



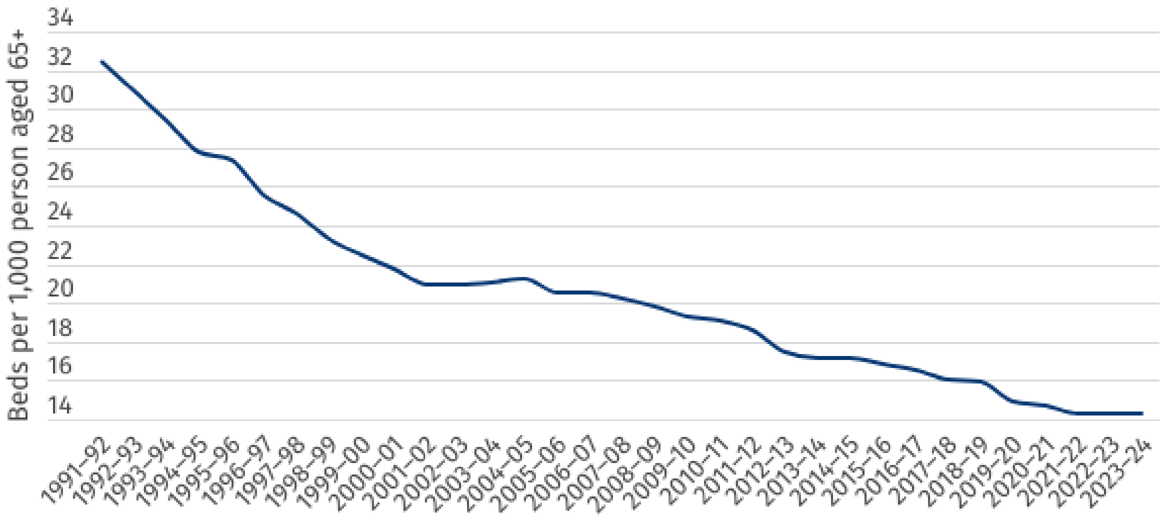
Note: 2023–24 is the most recent data on patient days available.

Source: AIHW and ABS.

ABS data shows Australians aged 65 and over accounted for 17.3 per cent of the nation's population in June 2024, up from 15.9 per cent in 2019 (with the total number of Australians aged over 65 growing from to 4.04 million 4.70 million over this time).[vi] Despite representing only a minor portion of the total population, this demographic comprised 49.8 per cent of all patient days in public hospitals in 2023–24 (most recent data). These figures underscore that, as the population of older Australians continues to grow, the corresponding increase in demand on Australia's public hospital system will also increase.

Despite the large increase in bed numbers across Australia, with all states increasing their total available public hospital beds, the number of public hospital beds per 1,000 aged over 65 has remained stagnant. In 2023–24, Australia had 14.3 available beds for every 1,000 people aged over 65 (Figure 3), a metric which has not changed for three years running despite the total number of public hospital beds (including psychiatric) increasing by more than 3,800 in this time.

Figure 3: Australian public hospital beds per 1,000 population, aged 65 and over, 1991–92 to 2023–24[vii viii]



Note: 2023–24 is the most recent data on hospital beds available.

Source: AIHW and ABS.

Without sustained investment into the capacity of the public hospital system, this long-term decline will continue, risking the ability of hospitals to deliver care and surgeries other than in emergencies.

Emergency department waiting times

The public hospital system's ability to treat emergency department presentations in a timely manner is a key indicator of its health. Australians who require emergency treatment should expect to be seen within the clinically recommended timeframe. Under the Australian Health Performance Framework, two of the key public hospital emergency department performance measures are:

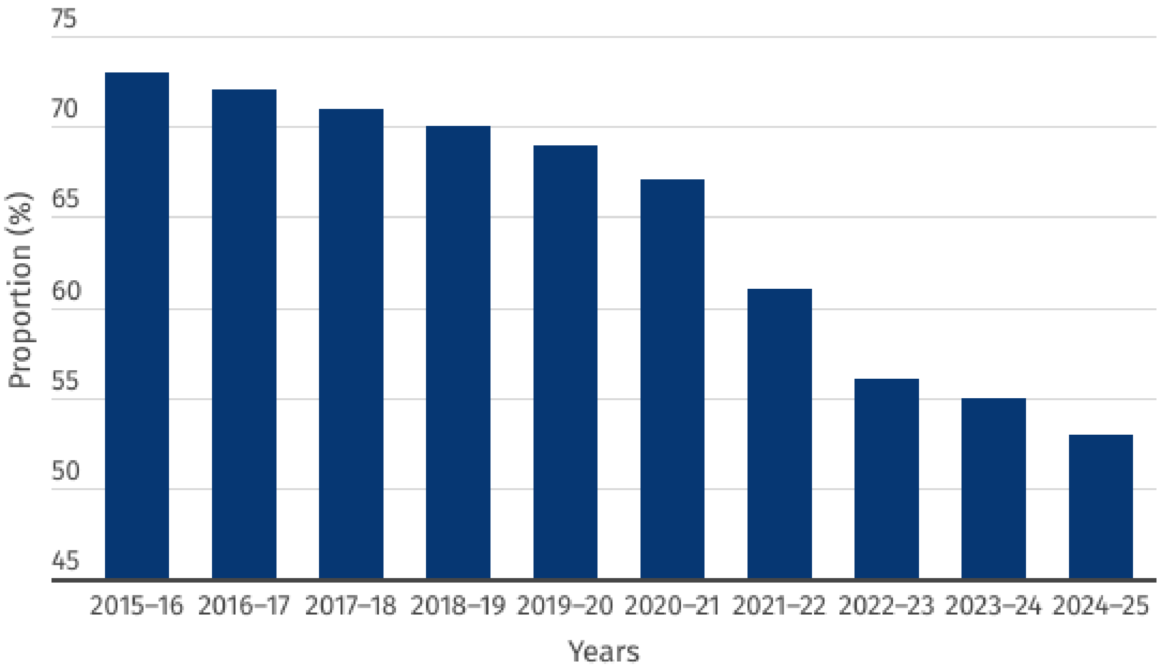
- the length of stay for emergency department care (proportion of patients either being discharged or admitted to hospital within four hours or less)
- the proportion of patients seen within the clinically recommended timeframes.

Australian emergency departments remain under intense strain across the country. Figure 4 shows the proportion of people in all triage categories who completed their emergency presentation in four hours or less has fallen yet again to a record low of 53 per cent, down 20 percentage points since 2015–16, and 16 percentage points since 2019–20.[ix]

An emergency department presentation is counted as 'completed' within four hours if a patient is discharged or admitted — thus departing the emergency department within four hours of arrival. The decline in performance for this metric is worryingly consistent across Australia.

Concerningly, no jurisdiction completed more than 61 per cent of their emergency department presentations within four hours. Four years prior, in 2020–21, all but two jurisdictions completed more than 61 per cent of presentations within four hours.

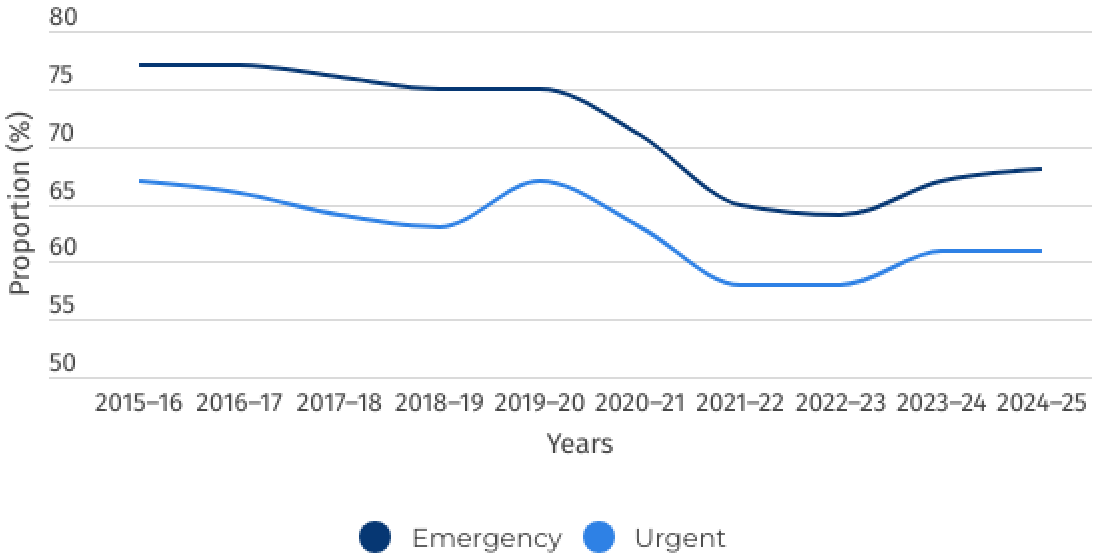
Figure 4: Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25



Source: AIHW.

Figure 5 highlights nation-wide emergency department performance for people who are triaged as emergency (treatment required within 10 minutes) and urgent (treatment required within 30 minutes), accounting for 1,592,671 and 3,615,178 presentations respectively[x] in 2024–25. While the AMA is pleased to see a slight improvement in the national average of emergency patients seen on time — from 67 to 68 per cent in 2024–25 compared with the previous year — both measures are well below their 10-year average.

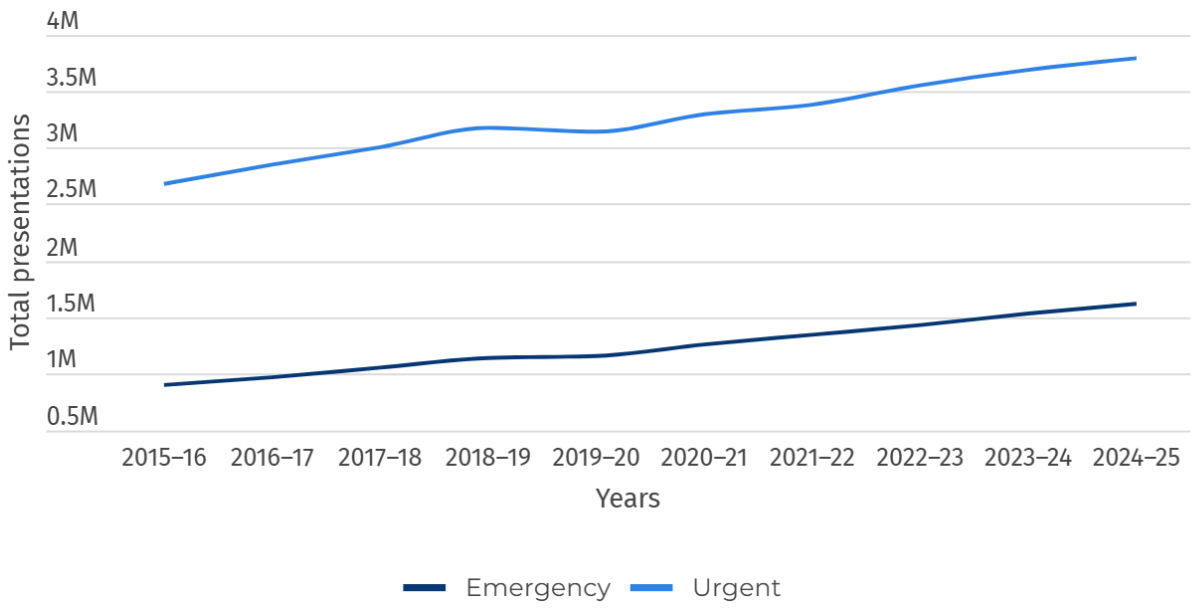
Figure 5: Proportion of emergency department presentations seen on time according to the clinically recommended timeframe, categories 2 and 3, 2015–16 to 2024–25



Source: AIHW.

Over the long term, the data are clear — performance has been falling since well before COVID-19, with an ever-increasing workload being placed on the medical and healthcare professionals in our emergency departments — the increasing activity is illustrated in Figure 6.[xi]

Figure 6: Total number of emergency department presentations in Australia, 2015–16 to 2024–25



Source: AIHW.

Without increased capacity and funding, the performance outcomes, patient experiences and workforce morale within our public hospitals will continue to fall.

Planned surgery waiting times

The Australian Health Performance Framework includes two performance indicators measuring the provision of timely planned surgery:

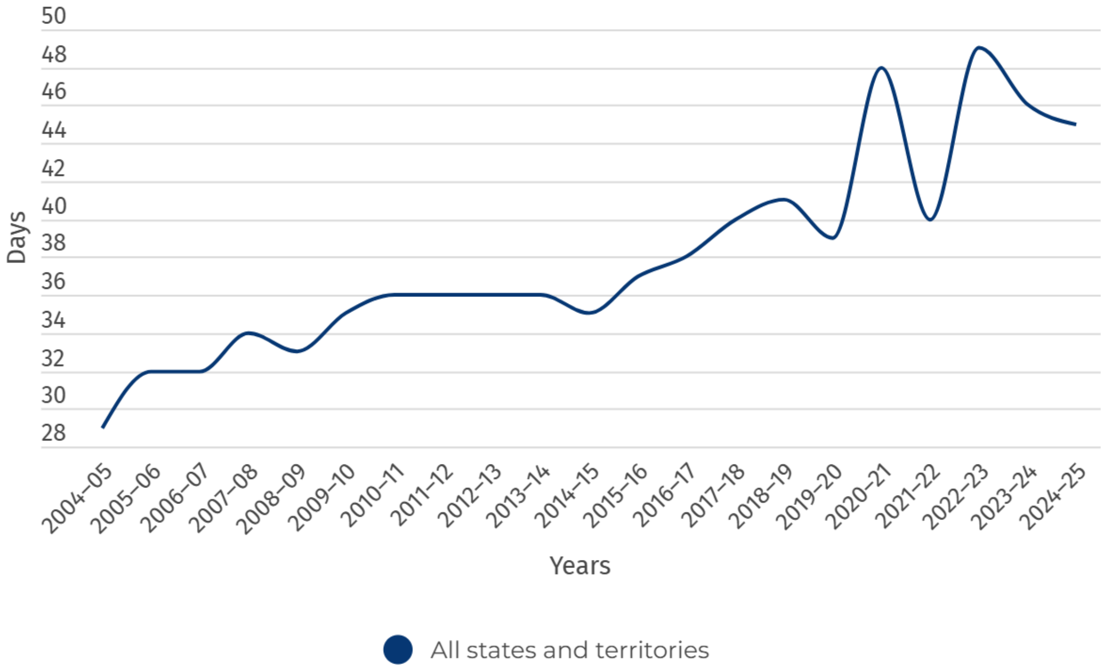
- the median waiting time for planned surgery
- the percentage of patients treated within the clinically recommended times.

Median wait time for planned surgery

The median wait time for planned surgery indicates the number of days within which half of patients were admitted for their planned procedure. This means half of the patients had a shorter wait time, and half had a longer waiting time. As shown in Figure 7, after large fluctuations in planned surgery waiting time across Australia during COVID-19, the median waiting time for planned surgery fell for the second year in a row, from 46 days in 2023–24 to 45 days in 2024–25.[xii] Despite this, Australians are waiting 55 per cent longer for planned surgery than they were 20 years ago (increasing from 29 days to 45 days), and 29 per cent longer than 10 years ago (increasing from 35 to 45 days).

Note: these data do not include the 'hidden' wait list of patients waiting to get onto the waiting list; having been referred by their GP but still waiting for an outpatient clinic appointment before they can be waitlisted for their procedure.

Figure 7: Median wait time for planned surgery, days, 2004–05 to 2024–25



Source: AIHW.

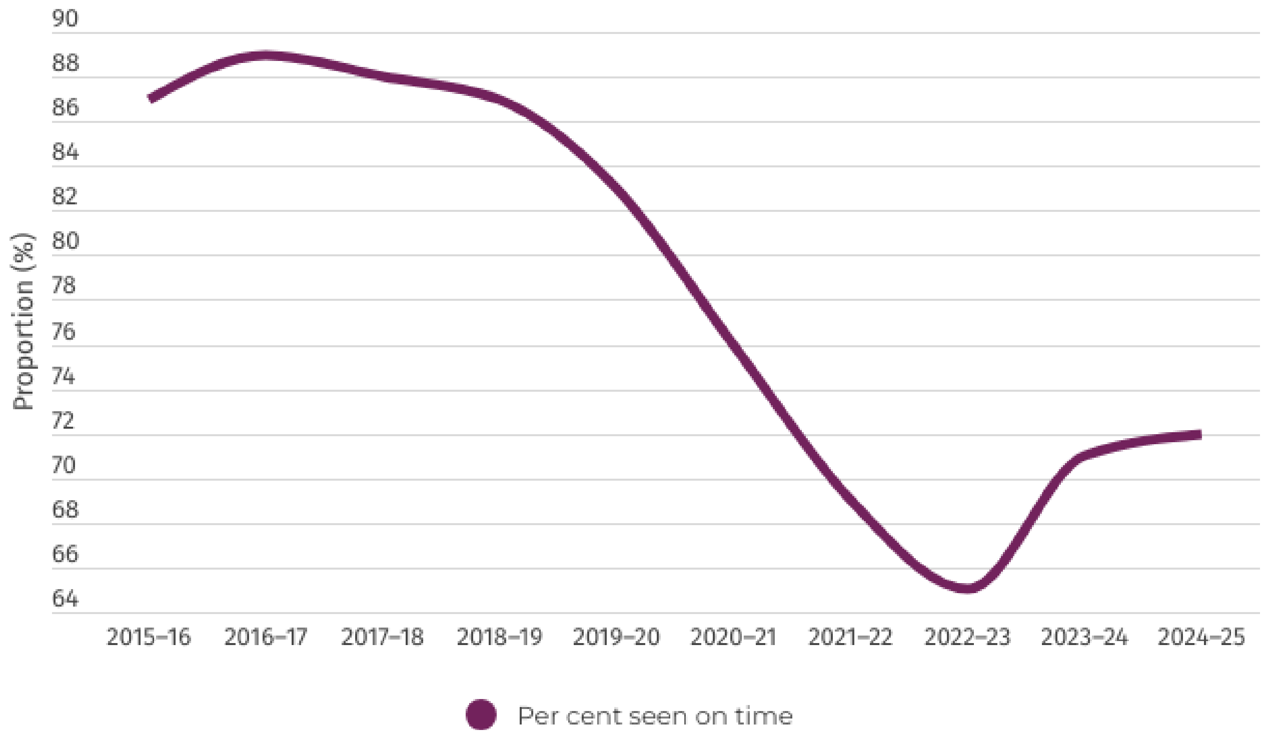
Proportion of patients treated on time

In 2024–25, there was a second consecutive improvement in the proportion of Category 2 patients admitted within the recommended 90-day timeframe (Figure 8). Despite this year-on-year improvement, the proportion of individuals receiving Category 2 planned surgery on time has seen a worrying long-term decline over the past decade, falling from 87 per cent in 2015–16 to 72 per cent in 2024–25.[xiii]

Figure 8 shows the proportion of Category 2 patients seen on time. Wait times for patients not admitted on time seem to have fallen almost universally across the board, which means waiting times are improving. Although they are still not back up to the proportions seen on time in 2016–17, when nearly nine in ten patients were seen on time, it is good to see an improvement, and this may be a sign that some parts of the extreme “backlog” are being cleared.

However, for those patients who do not receive their surgery within the recommended period (28 per cent of the total population), many are facing extremely long and potentially dangerous wait times.

Figure 8: Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Source: AIHW.

Public hospital expenditure

Important note on the data

While this report card is reporting on the most recent data available for public hospital expenditure, it is important to acknowledge these data are from 2023–24, thus during the previous NHRA.

In January 2026, the federal government and the states and territories signed a new NHRA, with an additional $25 billion in federal funding committed to the states, and thus funding will flow differently going forward. **None of this additional funding is reflected in this chapter.**

With defined federal funding in place, state and territory governments must now lift their funding commitments as well. They must also develop credible forward plans and begin delivering measurable improvements within the life of the agreement, rather than deferring reform beyond it.

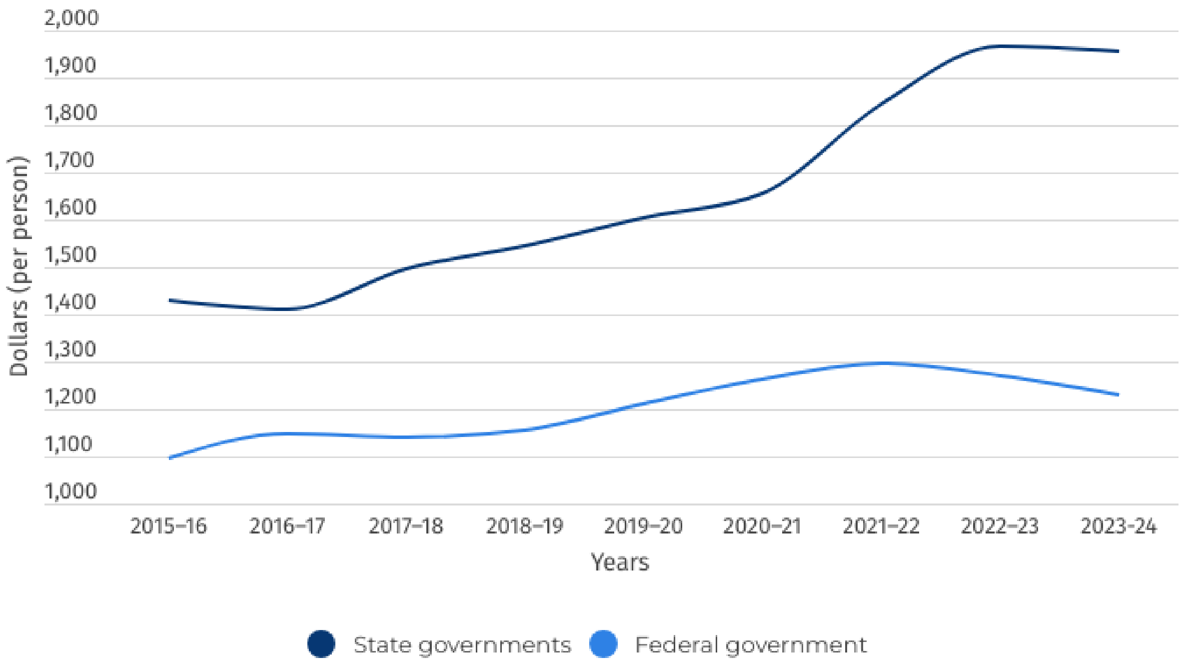
Over the next five years, expenditure must be aligned with workforce and capital planning, including the staffing and bed capacity needed to sustainably increase throughput and improve access. While the scale of improvement may be constrained by the level of additional funding secured, the public is entitled to expect tangible progress from what is currently a low base.

Funding certainty gives governments the space — and the responsibility — to plan for efficiencies and deliver them, with performance improvements closely monitored by the AMA as a test of the agreement's real-world impact.

Findings in the 2023–24 data

In 2023–24 (latest data), per person funding for public hospital resources across Australia fell when measured both by state and territory and federal government spending.[xiv] While funding for public hospitals was gradually increasing over time under the previous agreement, performance continued to decline, and a disproportionate funding burden fell on state and territory governments.

Figure 9: Public hospital funding, per person, by government source (constant prices), 2015–16 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Under the new NHRA, there has been a commitment to greater contribution to activity-based funding by the federal government. However, this does not equate to a lump sum injection of funds: full access to these funds will require an increase in activity, and to meet the added activity, there will need to be an increase in capacity (public hospital beds able to take patients). Capacity through the investment into capital within the public hospital system is driven by state and territory government budgets.

Both state and territory governments and the federal government have been increasing their public hospital funding on average over the past decade, with federal funding increasing by an average of 3.3 per cent annually and state and territory funding increasing by 2.6 per cent annually (Table 1).

Table 1: Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods[xv]

	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
States and territories	3.27%	1.75%	4.82%
Federal	2.62%	4.02%	1.24%

Note: 2023–24 is the most recent data available.

Source: AIHW.

State and territory public hospital performance

National overview

This section of the report card includes performance information for each state and territory. A summary of state and territory performance as per the four key metrics analysed at a national level is shown in Table 2. It represents data from 2024–25 compared with the previous year.

Performance for most states and territories declined in the past reporting period — red indicates a fall of more than one percentage point, while green indicates an improvement of more than one percentage point. Where the performance measure changed less than a percentage point, it has been left white.

Table 2: State and territory performance compared with the previous year, 2024–25

	Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery wait
NSW	Worse	Worse	Worse	Worse
VIC	Better	Equal	Better	Better
QLD	Better	Worse	Worse	Better
WA	Worse	Worse	Better	Equal
SA	Better	Worse	Worse	Worse
TAS	Worse	Worse	Worse	Worse
ACT	Equal	Better	Worse	Better
NT	Worse	Worse	Worse	Worse

Source: AMA analysis of AIHW data.

Some key takeaways:

- New South Wales, despite being the overall best performing state, was one of three jurisdictions (alongside Tasmania and Northern Territory) to have a performance decline across all four performance metrics.
- Only one jurisdiction (Victoria) saw an improvement in more than two out of the four categories monitored by the AMA.
- 23 out of 32 performance measures saw a decline in the past reporting period.

The following chapters will provide state-specific analysis of the available data.

New South Wales

AMA NSW President's introduction

New South Wales (NSW) remains home to some of the most skilled and dedicated doctors and healthcare workers in the country, and their professionalism continues to sustain our public hospital system under immense pressure. However, this year's Public Hospital Report Card paints a sobering picture of a system under growing strain.

While NSW still performs above the national average on key emergency department measures and continues to lead the nation in timely treatment for Category 2 planned surgery patients, performance has declined across all four indicators reported on by the AMA.

Most concerning is the state's persistently long median waiting time for planned surgery, which remains the worst in the country and is now almost double what it was two decades ago.

These trends reflect a health system struggling to keep pace with population growth, rising complexity of care, and ongoing workforce challenges. Although recent investments are welcome, they have not yet translated into measurable improvements in performance. Without a sustainably funded and properly supported medical workforce, new infrastructure and additional beds will not deliver the outcomes NSW patients deserve.

NSW is Australia's most populous state and one of the most expensive places to live. Our communities should be able to rely on a public health system that is adequately resourced, fairly staffed, and capable of meeting demand. The NSW Government must work in genuine partnership with doctors to address workforce conditions, reduce surgery backlogs, and restore confidence in our public hospitals.

Our patients deserve better and so do the doctors and healthcare workers who care for them every day.

Dr Katryn Austin
President
AMA New South Wales

Key takeaways

In 2024–25, NSW added 31 beds to their public hospital system.

In terms of the indicators monitored by the AMA, NSW's results have declined across all four categories in comparison to last year's results (Table 1).

Table 1 (NSW): Performance compared with the previous year, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Worse	Worse	Worse	Worse

Source: AMA comparison, AIHW.

Yet, when comparing these indicators to the national average, NSW performed above average for three of the four indicators (Table 2) in 2024–25. NSW continues to hold the highest national rates for:

- Category 3 emergency department patients seen on time
- Category 2 planned surgery patients treated promptly.

Despite some progress, NSW still has the longest median wait time for surgery, highlighting the pressing need to address its planned surgery backlog.

Table 2 (NSW): Performance compared with national average, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Better	Better	Worse **(worst)**	Better **(best)**

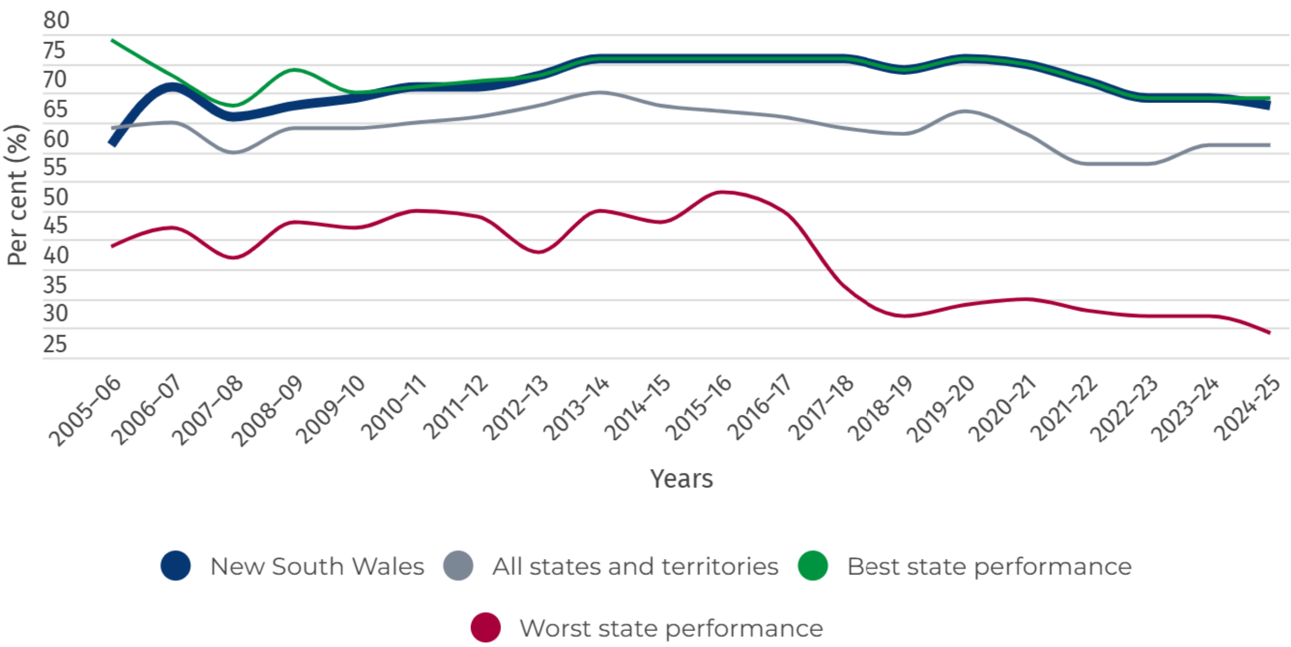
Source: AIHW.

Emergency department performance[xvi]

Despite NSW's emergency departments continuing to perform above the national average, both key indicators monitored by the AMA have declined over the past five years. The NSW public hospital system is struggling to keep up with demand, with longstanding (although now abolished) public service salary caps having detrimental impact on retention of the state's essential medical workforce.

In 2024–25, nearly seven in ten (68 per cent) people presenting to emergency departments and triaged as urgent were seen on time, down from 75 per cent in 2020–21 (Figure 1).

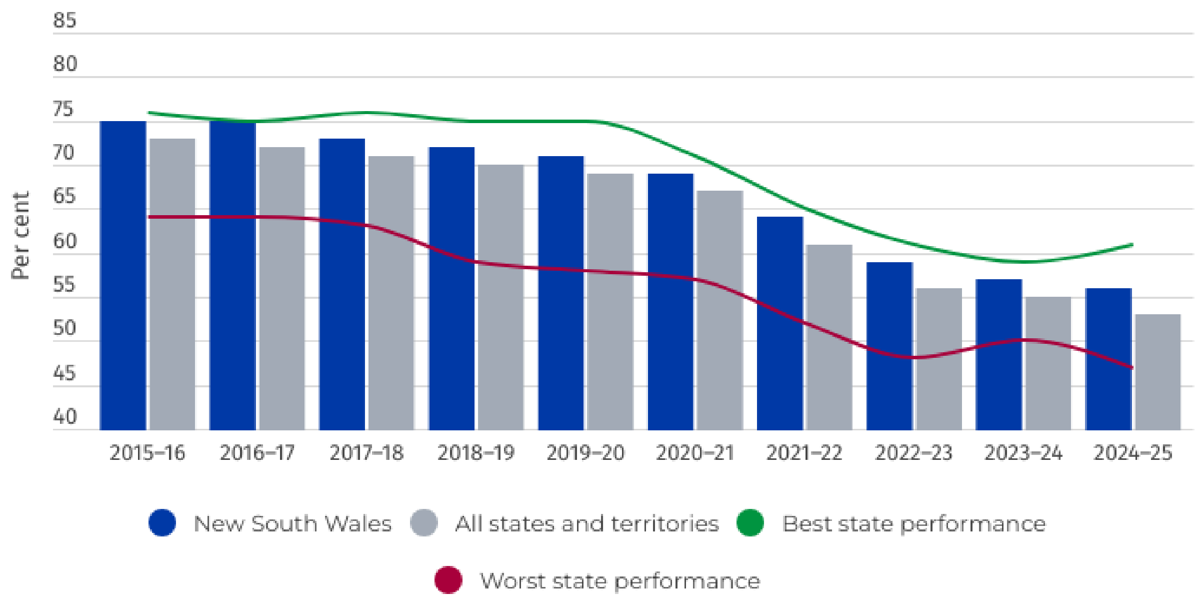
Figure 1 (NSW): Proportion of Category 3 (urgent) emergency department presentations seen within the recommended time (under 30 minutes), 2005–06 to 2024–25



Source: AIHW.

For all persons presenting to NSW emergency departments, slightly more than half (56 per cent) of visits were completed in four hours of less, one percentage point down from the previous year, and 16 percentage points down from pre-COVID-19 levels.

Figure 2 (NSW): Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25

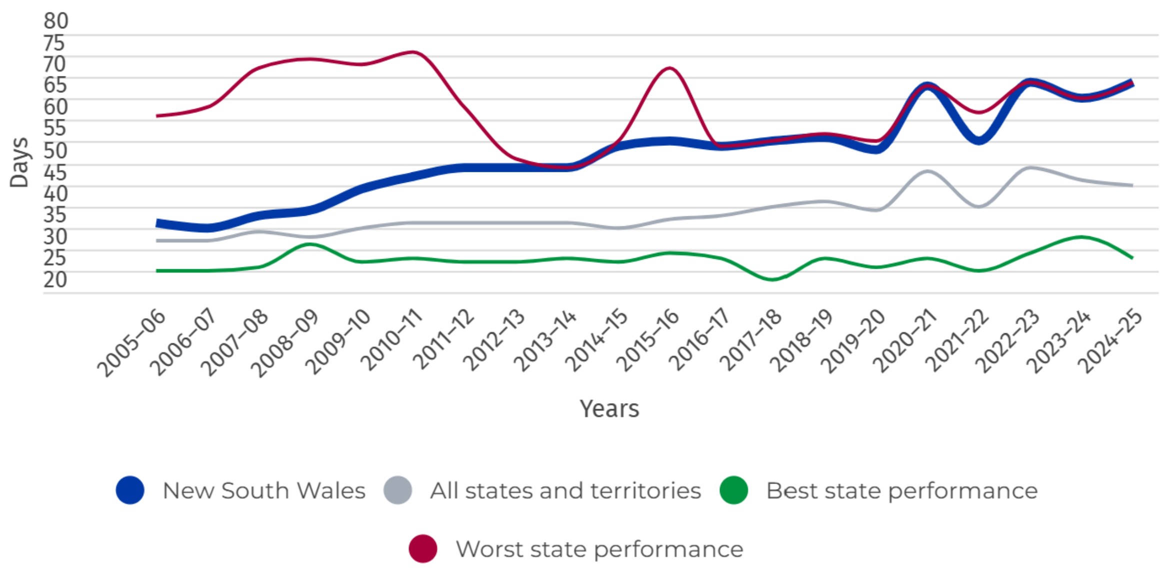


Source: AIHW.

Planned surgery performance[xvii]

The greatest weakness of NSW's public hospital performance remains the state's lengthy median waiting time for planned surgery, which has doubled over the past 20 years. At an equal worst on record 69 days for the state, NSW remains the worst performing state for this measure in 2024–25 (Figure 3).

Figure 3 (NSW): Median wait time for planned surgery, days, 2005–06 to 2024–25

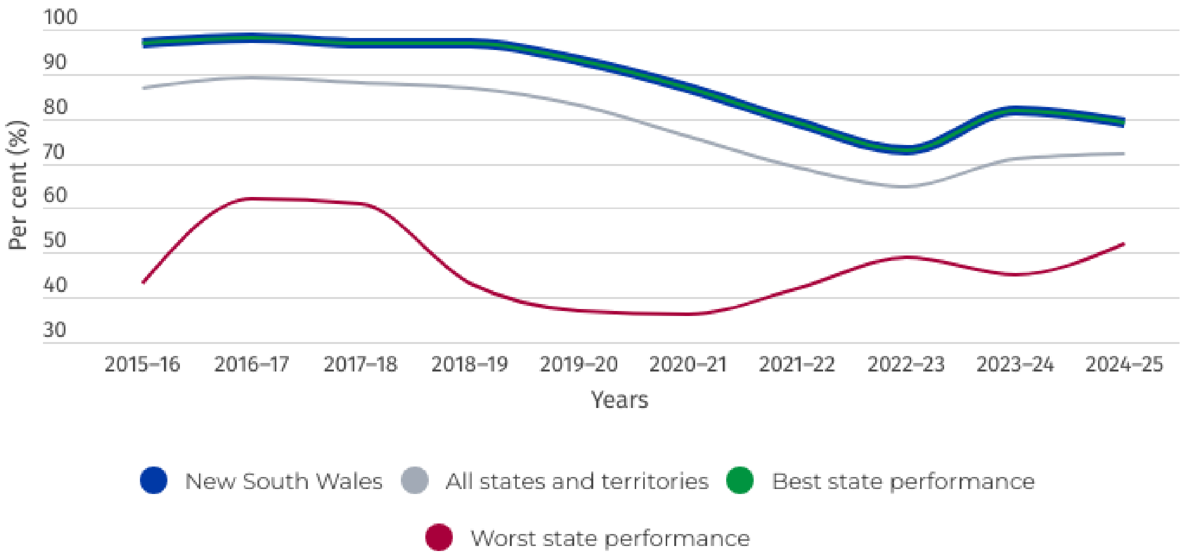


Source: AIHW.

NSW leads the nation in the proportion of Category 2 planned surgery patients admitted within the recommended timeframe of 90 days, despite a fall in this measure between 2023–24 and 2024–25.

More than one in five (20.8 per cent) of Category 2 patients are overdue for surgery. These patients wait 148.5 days on average.

Figure 4 (NSW): Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Source: AIHW.

Public hospital expenditure[xviii]

The most recent public hospital funding data are from 2023–24 and does therefore not reflect the new NHRA that was agreed to in January 2026. See note on the expected impact of the NHRA at the end of this chapter.

In NSW, most public hospital funding (59.6 per cent) is provided by the state government. This is largely in line with the national average of 61.4 per cent, as most state and territory governments continue to take on most of the funding burden for our public hospital system.

While the average increase in funding by the NSW and federal governments is similar over the decade on a yearly average basis, when broken down into the two five-year agreements, it is clear the NSW government's funding increase was front-loaded under the initial NHRA (3.7 per cent annual average), whereas federal government increases were concentrated under the second NHRA (4.2 per annual average) (Table 3).

Table 3 (NSW): Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods

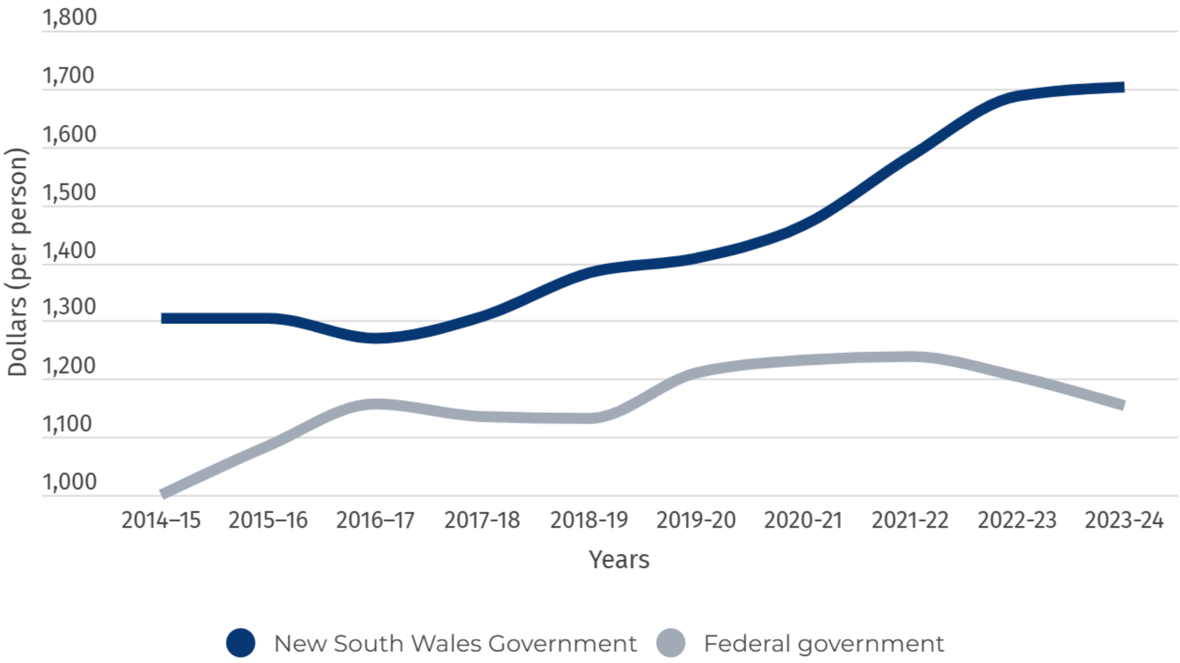
	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
Federal government	2.12%	0.08%	4.22%
NSW Government	2.01%	3.67%	0.38%

Note: 2023–24 is the most recent data available.

Source: AIHW.

Despite this, the per-person average funding from the federal government remains well below the per-person funding from the NSW government (Figure 5), and the difference has in fact been widening towards the end of the latest agreement.

Figure 5 (NSW): Public hospital funding, per person, by government source (constant prices), 2014–15 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Expected impact of the NHRA

The new NHRA marks an important shift for NSW, where the state government continues to carry most of the public hospital funding burden. As shown in this chapter, nearly 60 per cent of public hospital funding in NSW has historically been provided by the state, broadly in line with the national average, with federal funding growth uneven over time. While the expenditure data presented here reflects the period prior to the new agreement and therefore does not yet capture the additional federal funding now committed, the NHRA provides NSW with greater funding certainty over the next five years and the opportunity to recalibrate its approach to capacity and performance.

For a system as large and complex as NSW's, this certainty changes the test of public hospital expenditure. Short-term funding injections and marginal activity boosts have not been sufficient to resolve entrenched access and performance challenges, including long emergency department and planned surgery waits documented in this report card.

Now the federal government has lifted its funding effort, the states will need to continue to do so as well. NSW faces a clear task: to translate this agreement into a credible forward plan that aligns workforce, bed capacity and capital investment over the life of the NHRA. While the level of additional funding may limit the scale of improvement achievable, the public can reasonably expect progress, and the AMA will closely monitor whether the new agreement delivers meaningful, system-wide gains rather than another cycle of temporary relief.

Victoria

AMA Victoria President's introduction

Victoria's public hospital system continues to operate under sustained pressure, even as this year's Public Hospital Report Card records improvement in several key measures. Urgent emergency department patients in Victoria are more likely to be seen on time, and the median wait for planned surgery has again fallen to the lowest level nationally.

These gains are real. They reflect the commitment of a workforce delivering care in demanding conditions. But the data also shows the limits of that progress. Patients who are not treated within recommended timeframes continue to wait far too long. Category 2 patients wait on average more than 280 days. Category 3 patients wait 704 days, approaching two years for surgery that should occur within 12 months. Emergency department performance against the four-hour benchmark has stalled at the national average.

Evidence across Victoria shows unsafe fatigue and high stress levels remain common among hospital doctors, particularly doctors in training. When fatigue risk is routine, patient safety risk follows. Working conditions are patient care conditions.

That is why the current Victorian enterprise bargaining negotiations for public hospital doctors matter beyond the workforce itself. Safer rostering, enforceable fatigue limits, protected breaks and secure employment are practical safeguards for timely care, clinical quality and system stability. Fair and competitive remuneration is equally essential to retaining experienced doctors, attracting new clinicians to Victoria, and ensuring the public system remains a viable long-term place to practise medicine.

Recent Victorian occupational health and safety reforms reinforce this responsibility. Public health services are now required to identify and control psychosocial hazards such as excessive workload, fatigue, bullying and poor organisational systems. These duties must translate into real change on hospital floors.

Funding remains decisive. Victoria continues to carry a larger share of public hospital funding than the national average. National agreements and funding settings determine whether investment becomes staffed beds, theatre capacity and a sustainable workforce. Without that conversion, performance gains will not hold.

Victoria's doctors want a public hospital system that is safe, properly resourced, and able to deliver timely care. The report card shows progress can occur. Sustaining that progress now depends on protecting the public medical workforce and strengthening the system that supports it.

Dr Simon Judkins
President
AMA Victoria

Key takeaways

In 2024–25, Victoria added 476 beds to their public hospital system.

Despite ongoing challenges, Victoria has demonstrated improvements in three out of four key metrics monitored by the AMA compared with the previous year (Table 1). The fourth indicator remained unchanged.

Table 1 (Vic): Performance compared with the previous year, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Better	Equal	Better	Better

Source: AMA comparison, AIHW.

In 2024–25, Victoria performed better or equal to three of the four indicators compared with the national average (Table 2). Although the state reports the nation's lowest median wait time for elective surgery, it also records one of the longest average overdue wait times for Category 2 planned procedures, at 281.9 days.

Table 2 (Vic): Performance compared with national average, 2024–25

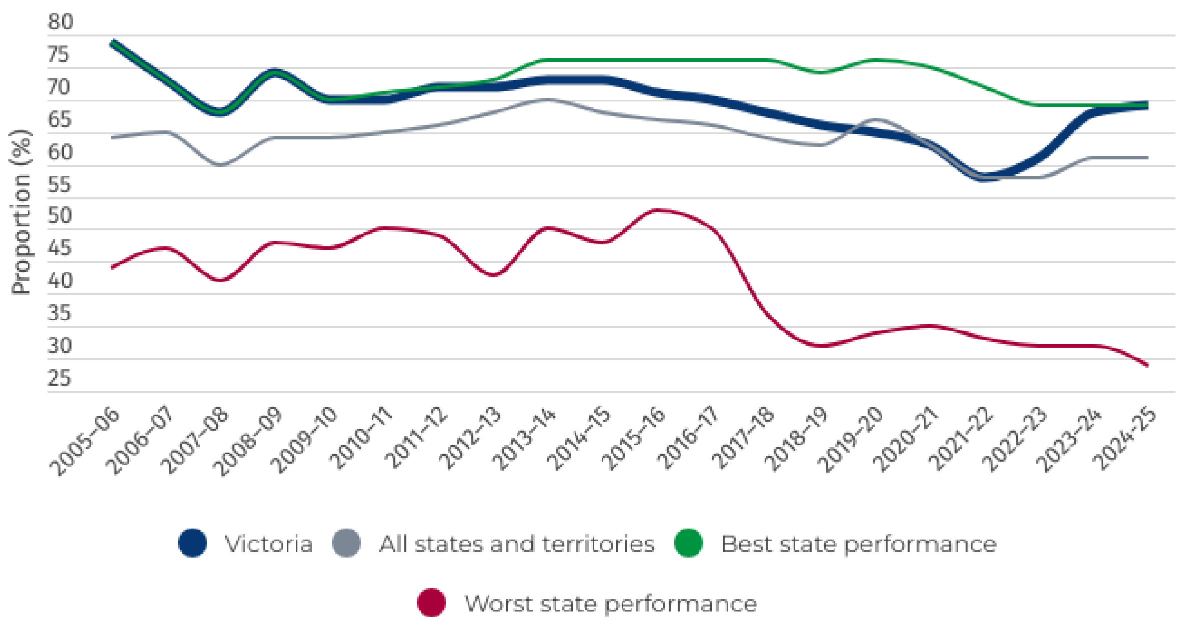
Category 3 on time	4-hour Rule	Median surgery wait	Category 2 surgery on time
Better **(best)**	Equal	Better **(best)**	Worse

Source: AIHW.

Emergency department performance[xix]

Following two consecutive years of improvement, Victoria now leads the nation in the percentage of urgent emergency department patients seen on time. Over the past two years, this figure has risen from 61 to 69 per cent (Figure 1).

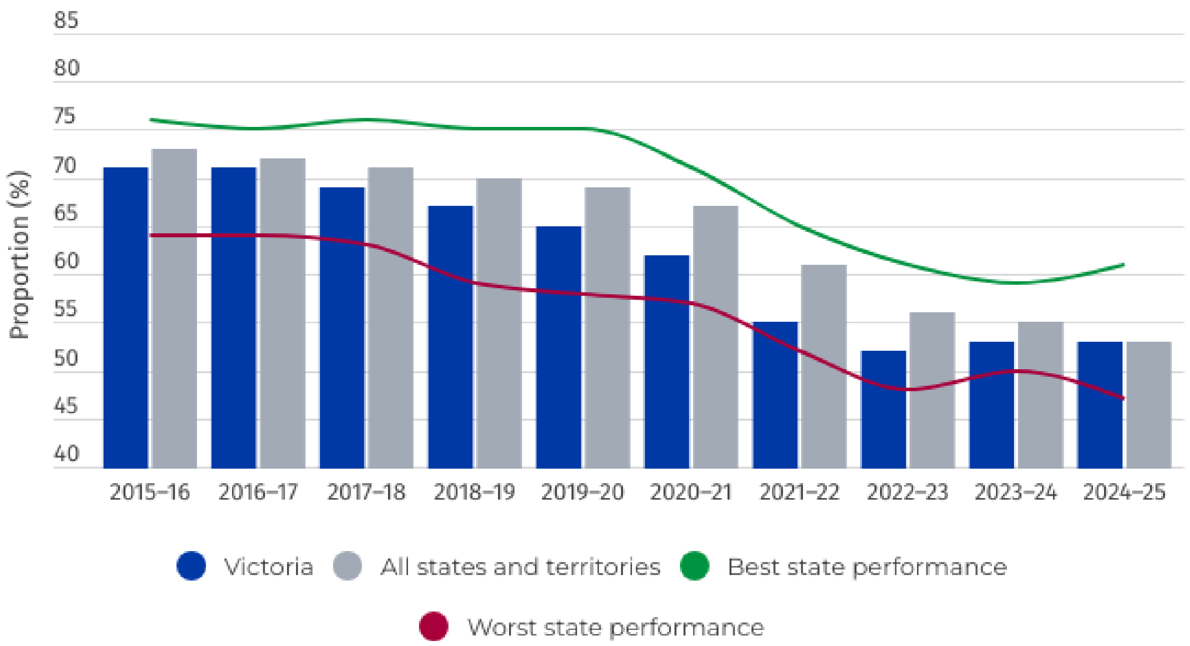
Figure 1 (Vic): Proportion of Category 3 (urgent) emergency department presentations seen within the recommended time (under 30 minutes), 2005–06 to 2024–25



Source: AIHW.

While the proportion of emergency department visits completed within four hours increased from 52 to 53 per cent in the previous reporting period, it showed no further improvement in 2024–25 and is currently aligned with the national average.

Figure 2 (Vic): Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25

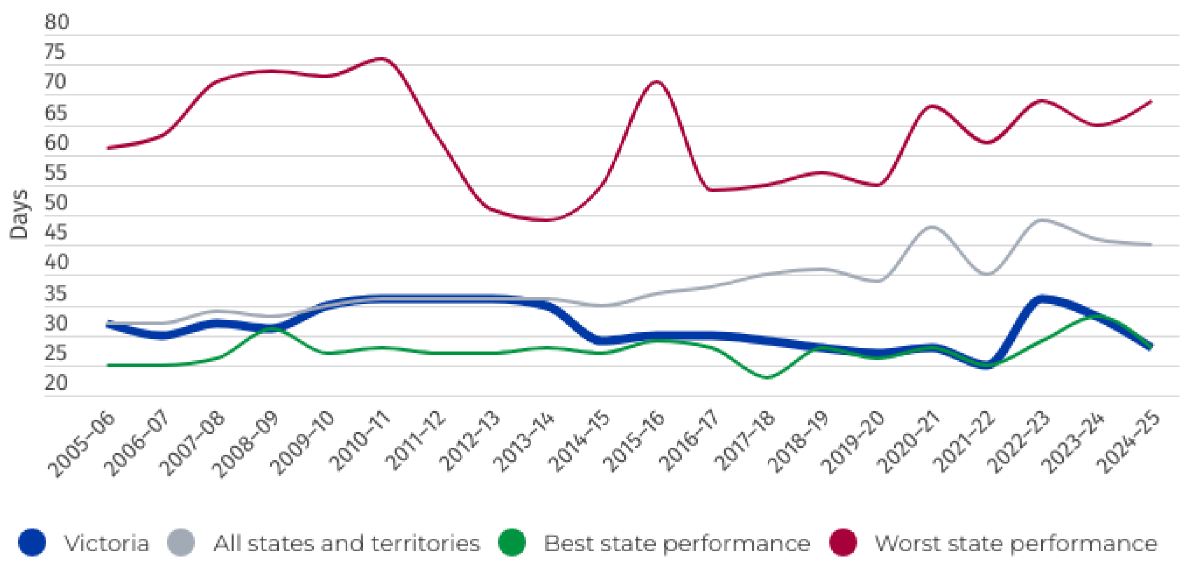


Source: AIHW.

Planned surgery performance[xx]

Victoria's performance in planned surgery shows mixed results. The state has improved its median waiting time for planned surgeries for the second consecutive year, now leading the nation at an impressive 28 days, according to a longstanding AMA metric. However, this figure is influenced by a high proportion of Category 1 surgeries, which made up 34.7 per cent of admissions, all admitted on time.

Figure 3 (Vic): Median wait time for planned surgery, days, 2005–06 to 2024–25

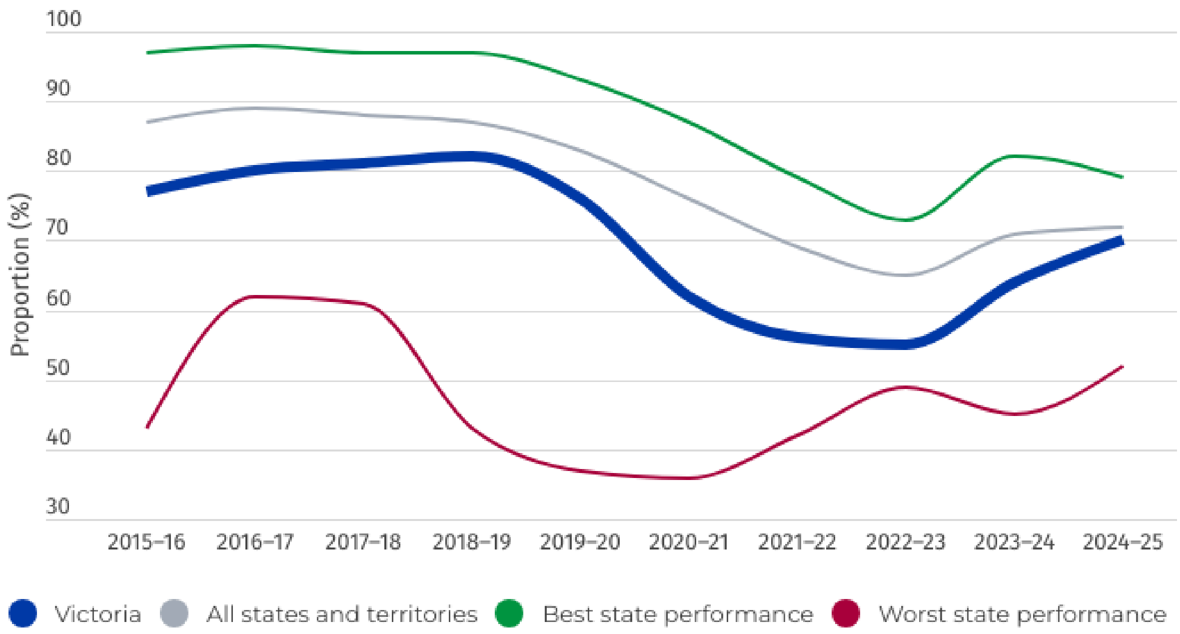


Source: AIHW.

As demonstrated by Figure 4, the proportion of Category 2 planned surgery patients admitted on time has been improving for the past two years, with 70 per cent of these patients receiving treatment within the recommended timeframe. On the other hand, patients who are not admitted within the recommended timeframe face much longer waits: a median of 281.9 days for patients who have not received Category 2 procedures on time (which should occur within 90 days), and 704 days for Category 3 procedures (recommended within 365 days).

While 84.4 per cent of all planned surgery patients receive their surgery within the suggested period, these figures reveal that many Victorians are waiting far too long for their planned surgeries.

Figure 4 (Vic): Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Source: AIHW.

Public hospital expenditure[xxi]

The most recent public hospital funding data are from 2023–24 and does therefore not reflect the new NHRA that was agreed to in January 2026. See note on the expected impact of the NHRA at the end of this chapter.

In Victoria, most public hospital funding (65.4 per cent) comes from the state government. This is notably higher than the national average of 61.4 per cent, even as most state and territories continue to take on most of the funding burden for our public hospital system.

Despite the federal government's average annual increase has been significant over the past decade — with an annual increase of 5.7 per cent on average (Table 3) — the fact that the overall Victorian Government contribution remains so much higher illustrates federal funding came from a much lower base. The federal funding increases were on average higher over the life of the second NHRA (7.1 per cent annual increase).

Table 3 (Vic): Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods

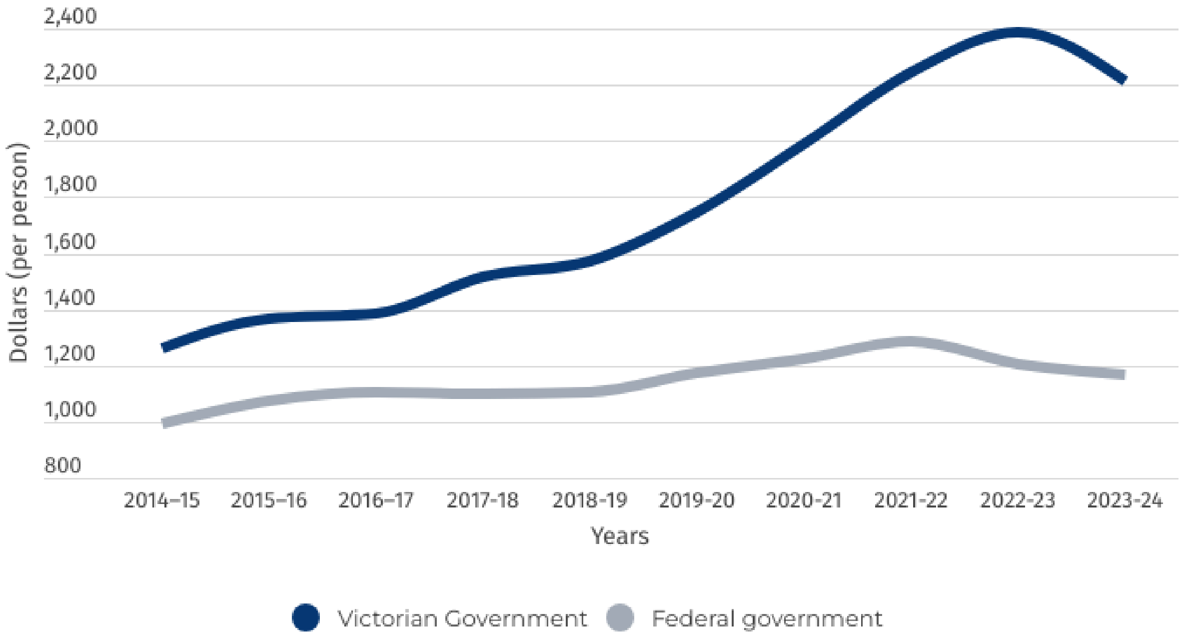
	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
Federal government	5.70%	4.32%	7.10%
Victorian Government	2.12%	3.12%	1.12%

Note: 2023–24 is the most recent data available.

Source: AIHW.

Figure 5 shows the difference in per-person funding between the Victorian and federal governments, with both funding sources falling over the last year, illustrating just how important signing the new NHRA was to Victoria.

Figure 5 (Vic): Public hospital funding, per person, by government source (constant prices), 2014–15 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Expected impact of the NHRA

The new NHRA is particularly significant for Victoria, where public hospitals have faced sustained pressure from rising demand, workforce shortages, and capacity constraints despite periods of increased investment. As with other jurisdictions, the public hospital expenditure data presented in this chapter reflects the period prior to the new agreement and therefore does not yet capture the additional federal funding now committed.

However, the NHRA provides Victoria with greater funding certainty over the next five years, creating an opportunity to move beyond short-term responses and toward more deliberate planning to address long-standing access and performance challenges.

For Victoria, this certainty shifts the focus of public hospital expenditure from headline funding levels to delivery. Previous experience shows funding growth alone has not been sufficient to prevent worsening performance in key areas, with capacity limitations continuing to constrain patient flow and timely access to care.

Now the federal government has lifted its funding effort, the states will need to continue to do so as well. The new agreement places an onus on the Victorian Government to translate funding certainty into a credible forward plan that aligns workforce supply, bed capacity and capital investment over the life of the NHRA. While the additional funding may limit how quickly performance can be turned around, Victorians can reasonably expect measurable improvement.

The AMA will closely monitor whether the new NHRA delivers sustained system-wide gains in Victoria, rather than temporary relief that fails to address underlying structural pressures.

Queensland

AMA Federal President's introduction

Queensland's public hospital system remains under significant strain. Demand continues to rise while capacity is constrained, leaving many Queenslanders waiting longer than they should for essential care.

There are some positive signs. Performance for urgent emergency department patients is improving, with more Category 3 patients seen within recommended timeframes, while the proportion of Category 2 patients receiving surgery within 90 days remains on an upward trajectory. These gains reflect the dedication of Queensland's doctors and health staff.

However, these improvements are outweighed by ongoing system pressures. The proportion of patients completing their emergency department visit within four hours has fallen to its lowest level in a decade, with only half of patients discharged or admitted within that timeframe. This decline highlights serious challenges with hospital flow and capacity.

Planned surgery results are similarly mixed. While Queensland performs better than the national average on some measures, waiting times remain far longer than a decade ago. Patients who miss clinically recommended timeframes may wait many months, risking poorer health outcomes and unnecessary suffering.

These results reinforce the AMA's call for increased hospital capacity, supported by sustainable funding and a strong workforce. Additional beds must be matched with sufficient doctors, nurses, and allied health professionals. While recent funding commitments are welcome, they must translate into real capacity on the ground. Further investment is urgently needed, particularly as Queensland's per-person public hospital spending remains the lowest in the nation.

Workforce shortages are a major constraint, especially in rural and regional Queensland, where more than half the population lives. Hospitals outside metropolitan areas face higher staff turnover and a 21 per cent shortfall in the rural and remote medical workforce. Without urgent action, Queensland hospitals will be unable to meet current and future demand.

Overall, declining performance reflects demand outstripping capacity, not a lack of effort from the health workforce. Queenslanders deserve timely access to care, and doctors deserve a system that supports safe, high-quality care without burnout.

Dr Danielle McMullen
President
Australian Medical Association

Key takeaways

In 2024–25, Queensland added 677 beds to their public hospital system.

Queensland's performance presents a nuanced overview. Two of the four metrics monitored by the AMA have demonstrated modest improvement over the last reporting period (Table 1), yet the proportion of patients completing their emergency department visit within four hours or less has declined to its lowest point in a decade.

Table 1 (Qld): Performance compared with the previous year, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Better	Worse	Worse	Better

Source: AMA comparison, AIHW.

Compared to the national average, Queensland performed better in three of the four indicators in 2024–25 (Table 2).

Table 2 (Qld): Performance compared with national average, 2024–25

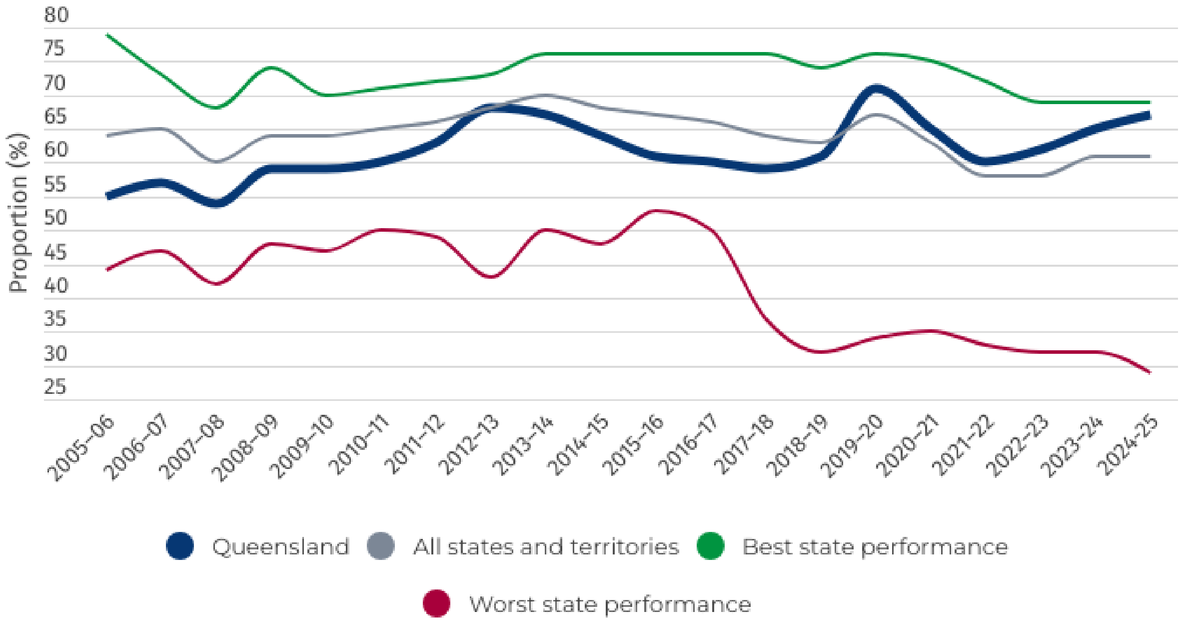
Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Better	Worse	Better	Better

Source: AIHW.

Emergency department performance[xxii]

Queensland's emergency department performance saw mixed results during the 2024–25 reporting period. Three years of consecutive improvement have resulted in the percentage of Category 3 emergency department presentations being seen within the recommended time rising to 67 per cent (Figure 1), close to the best in the country.

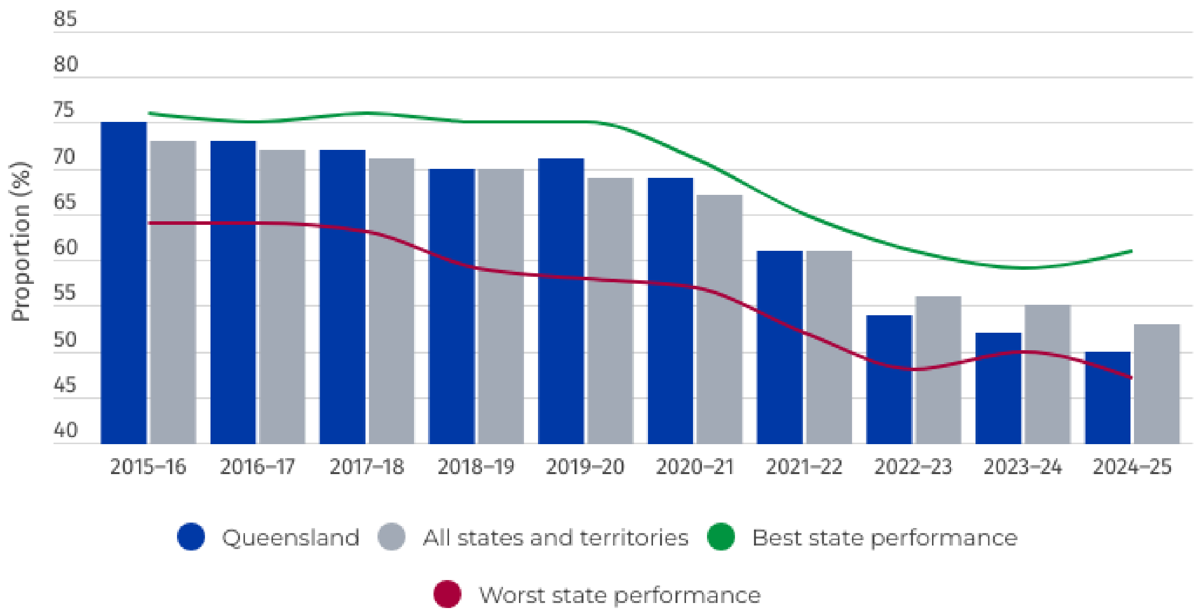
Figure 1 (Qld): Proportion of Category 3 (urgent) emergency department presentations seen within the recommended time (under 30 minutes), 2005–06 to 2024–25



Source: AIHW.

However, the proportion of Queenslanders completing their emergency department visits within four hours or less has fallen for the second year running to a new 10-year low, with only half (50 per cent) of patients being either discharged or admitted to hospital within four hours (Figure 2).

Figure 2 (Qld): Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25

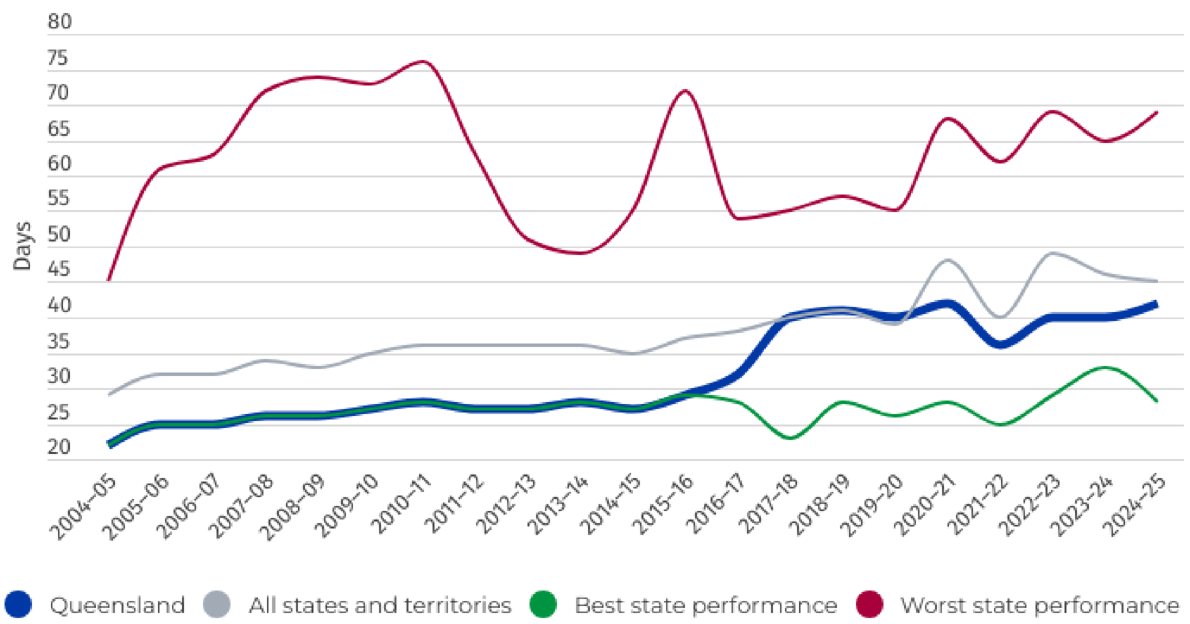


Source: AIHW.

Planned surgery performance[xxiii]

Although Queensland outperformed the national average in both planned surgery metrics monitored by the AMA for 2024–25, there is still room for further improvement. For the first 15 years of the 21st century, Queensland had the shortest median wait times in Australia; however, patients are now waiting nearly twice as long — 42 days — for planned surgeries compared with two decades ago (Figure 3).

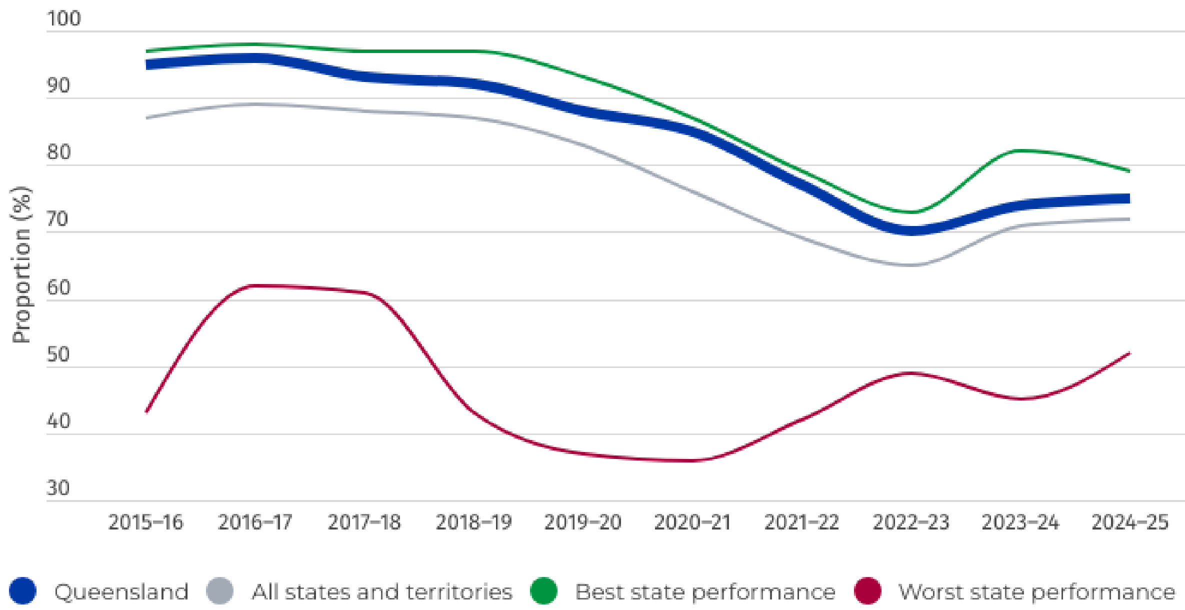
Figure 3 (Qld): Median wait time for planned surgery, days, 2005–06 to 2024–25



Source: AIHW.

In line with national trends, there has been a positive shift in the proportion of Category 2 patients seen on time, rising from 70 per cent in 2022–23 to 75 per cent in 2024–25.

Figure 4 (Qld): Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Source: AIHW.

Public hospital expenditure[xxiv]

The most recent public hospital funding data are from 2023–24 and does therefore not reflect the new NHRA that was agreed to in January 2026. See note on the expected impact of the NHRA at the end of this chapter.

In Queensland, most public hospital funding (54 per cent) comes from the state government; however, the Queensland Government's public hospital spending of $1,630 per person represents the lowest figure nationally.

Over the past decade, both federal and Queensland government spending has increased, although Queensland's funding has grown at almost twice the average annual rate — at 4.1 per cent compared with 2.1 per cent (Table 3). Again, the federal government's funding increased faster on average under the second NHRA than under the first, whereas the Queensland Government's funding grew more under the first agreement than the second.

Table 3 (Qld): Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods

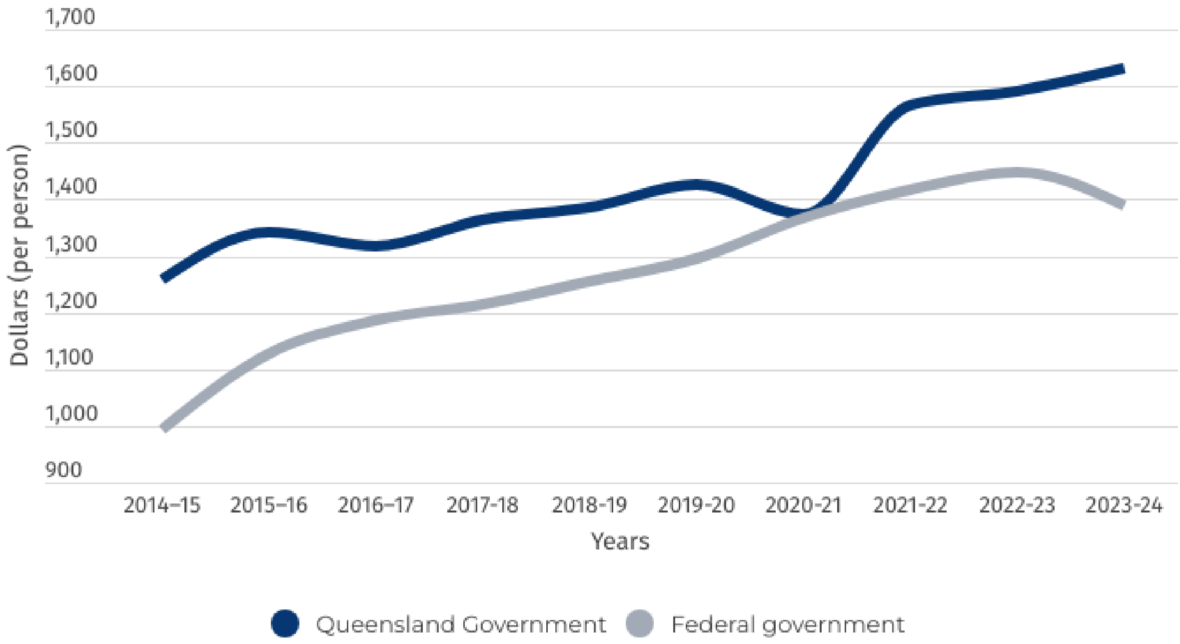
	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
Federal government	2.12%	0.94%	3.32%
Queensland Government	4.07%	6.12%	2.07%

Note: 2023–24 is the most recent data available.

Source: AIHW.

There was a rare moment in 2020–21 when federal and Queensland funding were on par on a per-person funding basis (Figure 5); however, the gap quickly re-established itself and even widened in 2023–24.

Figure 5 (Qld): Public hospital funding, per person, by government source (constant prices), 2014–15 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Expected impact of the NHRA

The new NHRA is a critical development for Queensland, where sustained population growth and rising demand continue to place pressure on public hospital capacity. The expenditure data presented in this chapter reflects the period prior to the new agreement and therefore does not capture the additional federal funding now committed.

However, the NHRA provides Queensland with greater funding certainty over the next five years, creating an opportunity to translate recent policy ambition into concrete, near-term improvements in capacity and access, rather than deferring delivery beyond the life of the agreement.

For Queensland, this certainty sharpens the focus on timing and delivery. Public hospital funding announcements — including commitments to expand capacity — are only meaningful if they result in additional beds, staff and services within the timeframe of the NHRA. The next five years represent a defined window in which governments must demonstrate progress toward their stated goals, even if final targets extend beyond it.

Now the federal government has lifted its funding effort, the states will need to continue to do so as well. Queensland faces a clear task: to align workforce planning and capital investment so that capacity growth is visible, measurable and within reach by the end of the agreement. From a low performance base, the public can reasonably expect improvement, and the AMA will closely monitor whether the new NHRA delivers tangible gains rather than postponing reform into the next decade.

Western Australia

AMA WA President's introduction

Western Australia's public hospitals continue to operate under sustained pressure, and the experience of patients and clinicians reflects a system creaking under the weight of its capacity needs. The challenges we face today are not new, nor are they isolated to particular sites or specialties. They are the result of long-term demand that outpaces investment, workforce strain, and hospitals routinely asked to do more than they are resourced to deliver.

Every day, doctors and nurses work to provide safe, high-quality, world-class care in environments stretched well beyond what is reasonable, and are often far from world-class. The impact is felt across Western Australia's emergency departments, inpatient wards, and planned surgery, and it contributes to delays that are frustrating for patients and exhausting for staff. These conditions make it harder to maintain timely access to care, and harder again to improve performance year on year.

There has been some recent movement in funding, and that is welcome. It goes without saying that any investment in infrastructure must be accompanied by a commitment to adequate staffing and recurrent funding. But the pressures identified in this year's report card show clearly that the system remains well short of where it needs to be. Incremental improvements will not be enough to restore the capacity lost over time.

Western Australia needs a sustained, long-term commitment from both levels of government to strengthen hospital capability, support the workforce, and ensure our health system can keep up with the needs of our community.

This report card provides an important opportunity for government to refocus on what matters: timely care, resourced hospitals, and a system that supports clinicians to deliver the standard of care Western Australians deserve.

Dr Kyle Hoath
President
AMA Western Australia

Key takeaways

In 2024–25, Western Australia added 195 beds to its public hospital system.

Western Australia continued to demonstrate the lowest performance nationally regarding the proportion of Category 3 emergency department presentations seen within the clinically recommended timeframe, reaching a historically low rate of 29 per cent. Additionally, there has been a significant decline in the percentage of emergency department patients treated within four hours.

Three of the four indicators monitored by the AMA were worse or unchanged compared with the previous year (Table 1) for Western Australian public hospitals.

Table 1 (WA): Performance compared with the previous year, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Worse	Worse	Better	Equal

Source: AMA comparison, AIHW.

While slight improvements have been observed in planned surgery wait times, the median wait time for patients in Western Australia aligns with the national average (Table 2), indicating that substantial progress is still necessary to achieve pre-COVID-19 standards.

Table 2 (WA): Performance compared with the national average, 2024–25

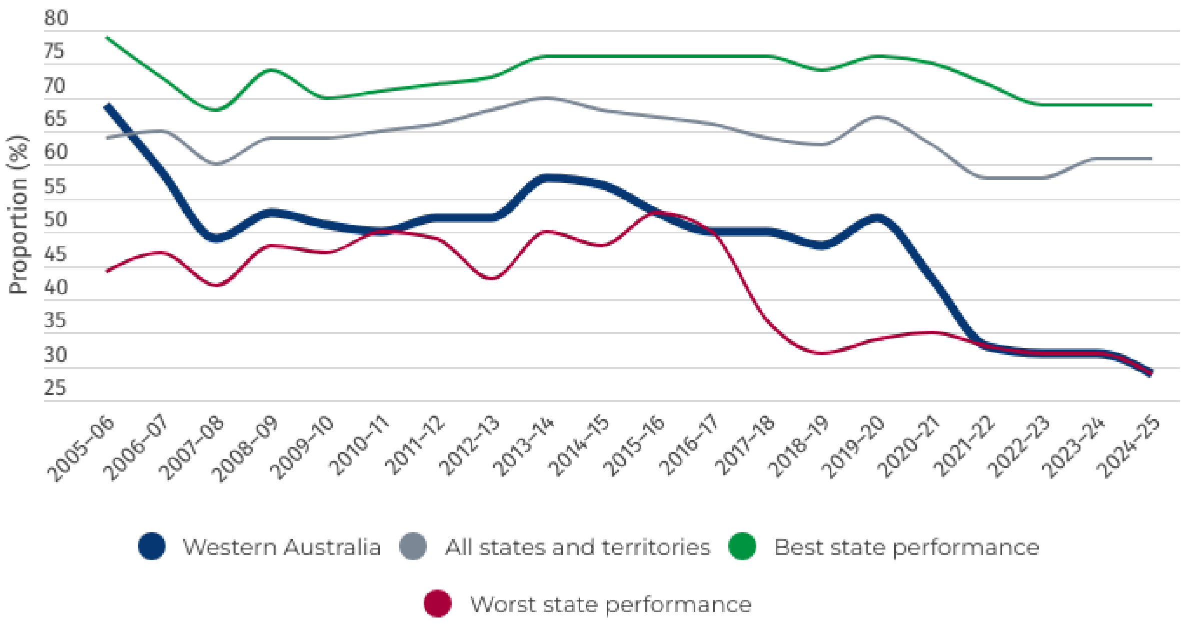
Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Worse **(worst)**	Better	Equal	Worse

Source: AIHW.

Emergency department performance[xxv]

Western Australia's emergency department performance has fallen to alarming levels. The proportion of Category 3 (urgent) patients seen within the recommended 30 minutes fell to only 29 per cent (Figure 1), a figure that is 32 percentage points below the national average and a record low for Western Australia.

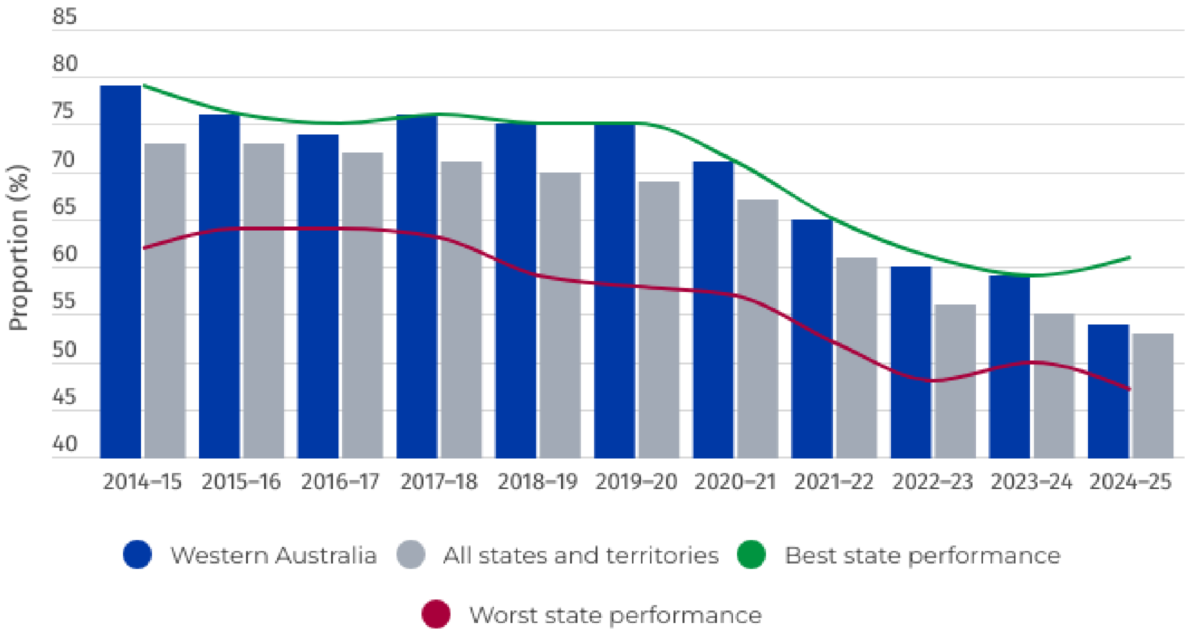
Figure 1 (WA): Proportion of Category 3 (urgent) emergency department presentations seen within the recommended time (under 30 minutes), 2005–06 to 2024–25



Source: AIHW.

Despite being the best-performing state regarding the four-hour rule in last year's AMA Public Hospital Report Card, Western Australia's performance has fallen from 59 per cent of presentations seen within four hours to 54 per cent in just one year (Figure 2).

Figure 2 (WA): Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25



Source: AIHW.

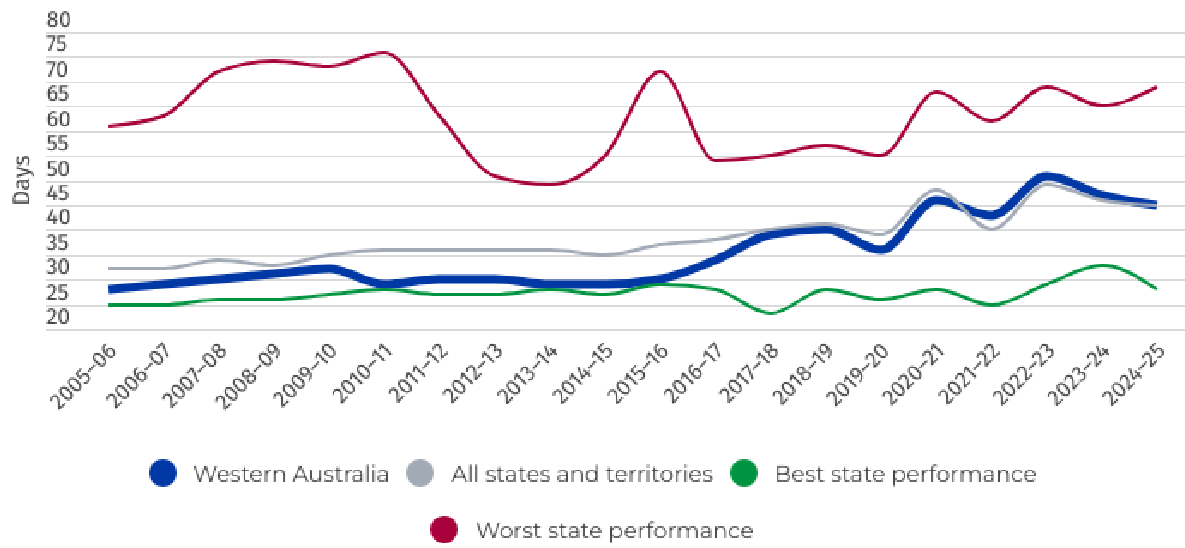
Planned surgery performance[xxvi]

Western Australia's planned surgery performance demonstrated modest progress in 2024–25; however, results remain significantly below historical norms.

The median waiting period for planned surgery decreased by two days, reaching 45 days in 2024–25 (Figure 3). Nonetheless, the average wait time for patients not admitted within the clinical timeframe is notably high:

- 197.4 days for Category 2 (recommended within 90 days)
- 502.3 days for Category 3 (recommended within 365 days).

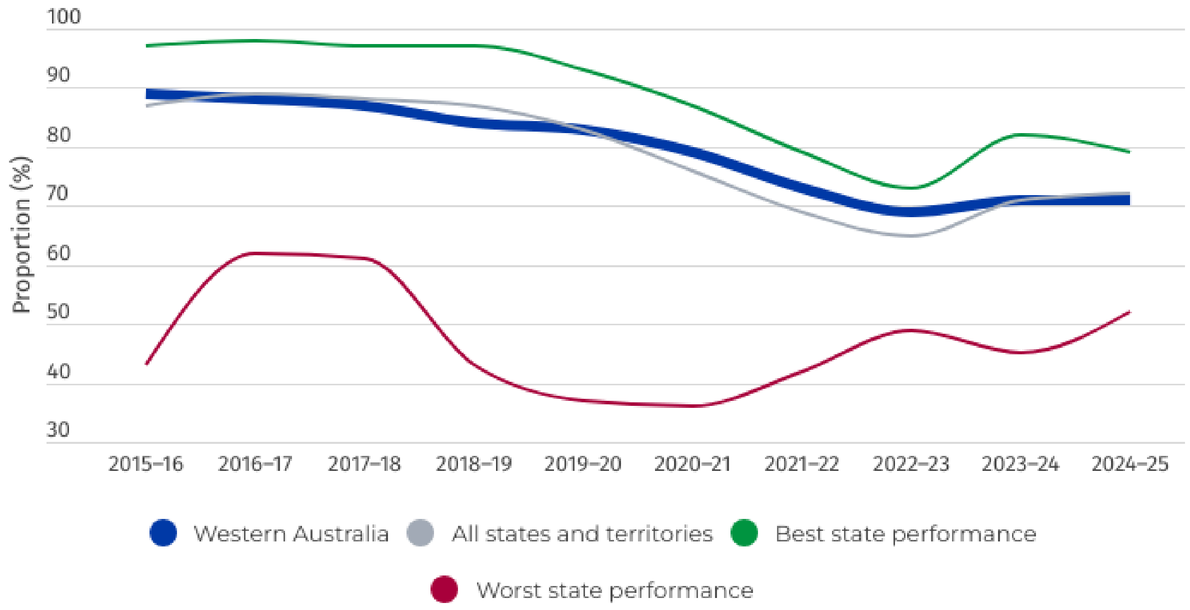
Figure 3 (WA): Median wait time for planned surgery, days, 2005–06 to 2024–25



Source: AIHW.

The proportion of Category 2 planned surgeries admitted within clinically recommended timeframes matches the national average at 71 per cent, unchanged from last year and reflecting a 12-percentage point decline compared with 2019–20 (Figure 4).

Figure 4 (WA): Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Source: AIHW.

Public hospital expenditure[xxvii]

The most recent public hospital funding data are from 2023–24 and does therefore not reflect the new NHRA that was agreed to in January 2026. See note on the expected impact of the NHRA at the end of this chapter.

In the most recent year available, the WA government provided 63.7 per cent of total spending on public hospitals, with 36.3 per cent coming from the federal government in 2023–24.

Over the past decade, the average annual increase in funding was similar for federal government (2.7 per cent) and the Western Australian Government (2.9 per cent), but as has been the trend in other states, the average annual funding increase was higher for the state government under the first NHRA, and higher for the federal government under the second NHRA (Table 3).

Table 3 (WA): Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods

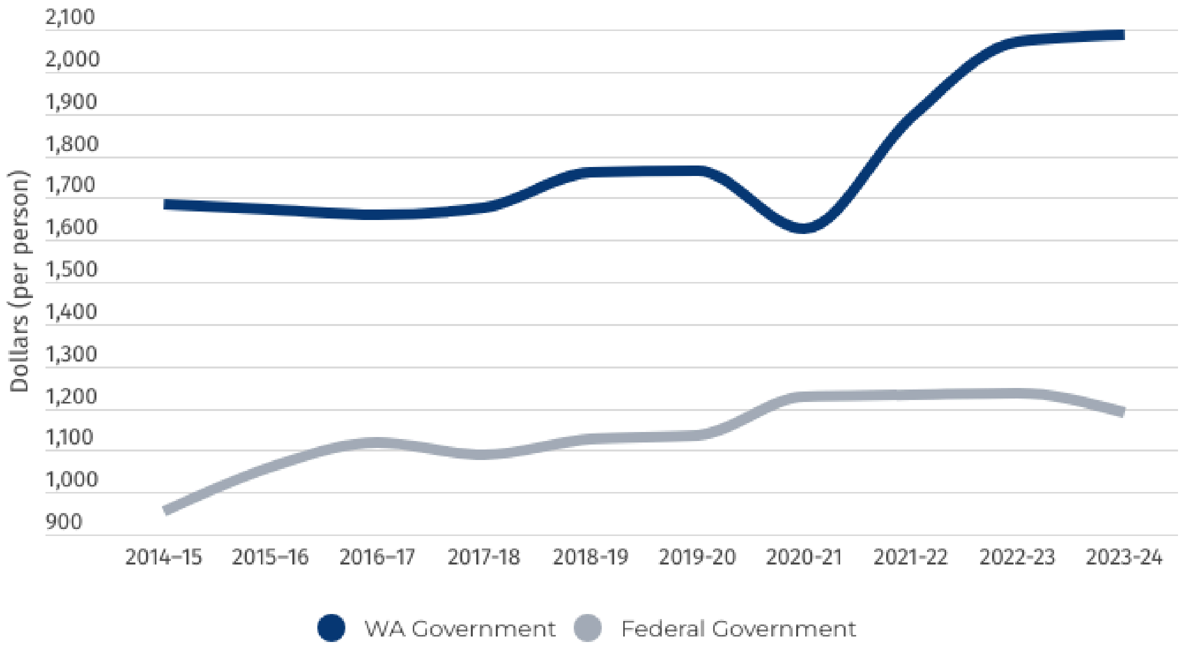
	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
Federal government	2.71%	1.95%	3.47%
WA Government	2.94%	4.82%	1.09%

Note: 2023–24 is the most recent data available.

Source: AIHW.

Despite this, Western Australia has increased its public hospital spending after a long decline in per-person expenditure and is now spending $2,089 per person on public hospitals (Figure 5).

Figure 5 (WA): Public hospital funding, per person, by government source (constant prices), 2014–15 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Expected impact of the NHRA

The new NHRA is a significant development for Western Australia, where public hospitals operate under sustained pressure driven by workforce shortages, geographic challenges, and growing demand. As with other jurisdictions, the public hospital expenditure data presented in this chapter reflects the period prior to the new agreement and therefore does not yet capture the additional federal funding now committed.

However, the NHRA provides Western Australia with greater funding certainty over the next five years, creating an opportunity to move beyond short-term stabilisation efforts and toward more durable improvements in capacity and access across the state's health system.

For Western Australia, funding certainty sharpens the focus on delivery in a system where capacity constraints are felt acutely by both patients and clinicians. Incremental investment to date has not been sufficient to resolve entrenched access pressures, particularly in emergency departments and in regional and remote settings.

Now the federal government has lifted its funding effort, the states will need to continue to do so as well. Western Australia faces a clear task: to translate the NHRA into a credible forward plan that aligns workforce supply, bed capacity and capital investment over the life of the agreement. While the scale of improvement may be constrained by ongoing workforce challenges, the public can reasonably expect measurable progress.

The AMA will closely monitor whether the new NHRA delivers sustained, system-wide gains in Western Australia, rather than continued reliance on temporary measures that fall short of addressing underlying structural pressures.

South Australia

AMA SA President's introduction

Ramping, bed block, emergency department waiting times and essential surgery waiting lists continue to dominate media attention as South Australians prepare for the state election on 21 March. The incumbent Labor government, elected in 2022 on a promise to fix ramping has failed to do so. In fact, the report card's analysis shows a deterioration in ambulance ramping times compared with when that promise was made. In 2024–25, ramping figures are the worst on record. There remains much to be done to address the escalating demands of an aging population, with higher rates of chronic and complex disease.

While the South Australian Government adopts an expansion strategy to create capacity, the AMA SA has focused its advocacy for clear, data-driven, clinician-informed plans to address the system pressures beyond merely creating additional hospital beds. We have advocated for real and substantial investments in community mental health, improving access to primary care and addressing the shortage of aged care places — agnostic of the argument this is purely a federal conundrum to solve. The additional $2 billion South Australia will receive through the National Health Reform Agreement is an opportunity to invest in the innovative models of care and different solutions to address these challenges.

Ramping is a manifest symptom of a fragmented health system that has not prioritised cost-effective, efficient and proven investments in primary care — despite the correction of the long-awaited freeze in Medicare rebates and bulk billing incentives. At the other end of the 'long ramp' through our emergency departments is the bottleneck to move people from our hospitals into appropriate accommodation in the community; the logjam in South Australia equates to the occupancy of a major metropolitan hospital. Access to primary and specialist care is limited in regional and remote areas.

The demand for healthcare professionals is greater than its supply — and the workforce challenges look greater when we consider the future needs of our ageing demographic. South Australia's new Women's and Children's Hospital is a welcome upgrade of an ageing facility but will not open its doors for at least five years.

Beyond addressing the clear and present challenge of ramping in our public hospital emergency departments, the AMA SA urges political and health policy leaders to invest in a bold, preventative and primary care strategy — the dividends will more than pay for itself. We want South Australians building ongoing relationships with GPs, who are the heart of effective community healthcare.

We need a resilient workforce strategy that will deliver adequate and staffed capacity in our public and private hospitals to complement these investments in initiatives that keep patients safely, and effectively, cared for in their communities.

When these systems are strengthened and integrated, our public and private hospitals will be empowered to deliver the world-class care South Australians know is achievable.

A/Prof Peter Subramaniam
President
AMA South Australia

Key takeaways

In 2024–25, South Australia added 687 beds to their public hospital system.

South Australia performed worse in three of the four categories monitored by the AMA compared with its own results from the previous year (Table 1).

Table 1 (SA): Performance compared with the previous year, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Better	Worse	Worse	Worse

Source: AMA comparison, AIHW.

Compared with the national average, South Australia's emergency departments and planned surgery services performed below the national average for all four indicators (Table 2).

Table 2 (SA): Performance compared with the national average, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Worse	Worse	Worse	Worse

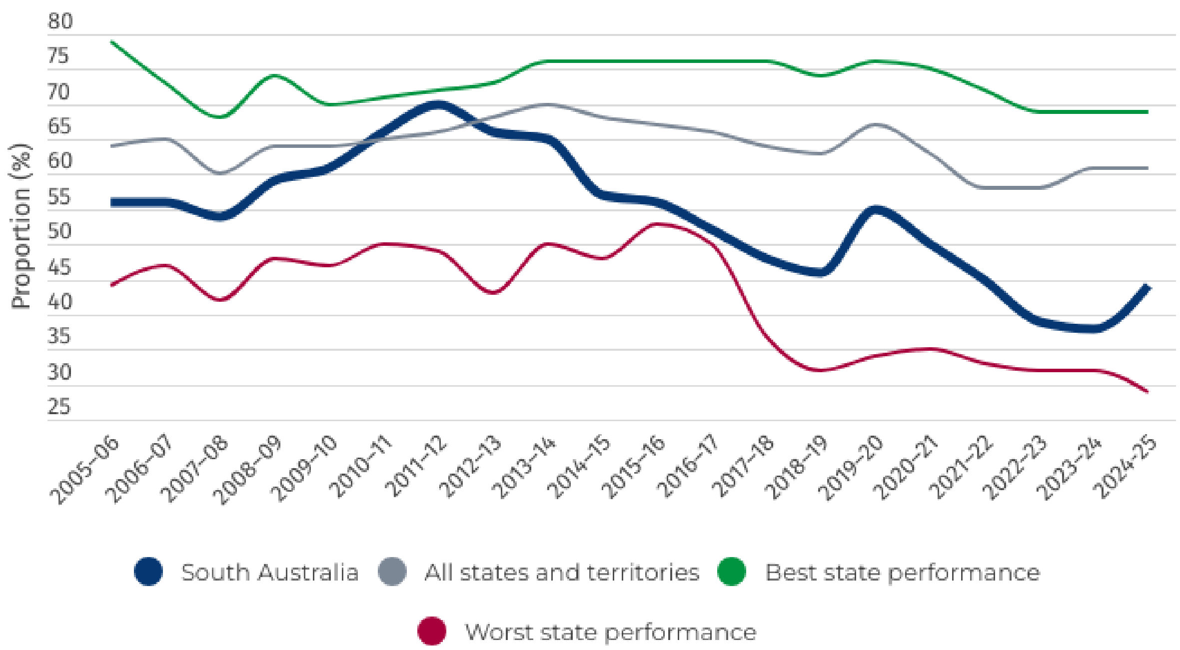
Source: AIHW.

Emergency department performance[xxviii]

South Australia's emergency department performance remains below the national average in 2024–25. Last year's Public Hospital Report Card showed South Australia's emergency departments were performing at the lowest levels in recent memory, with a further fall in one of the two metrics monitored by the AMA.

Forty-four per cent of emergency department presentations triaged as urgent were seen on time (Figure 1), a six percentage point increase from the previous year.

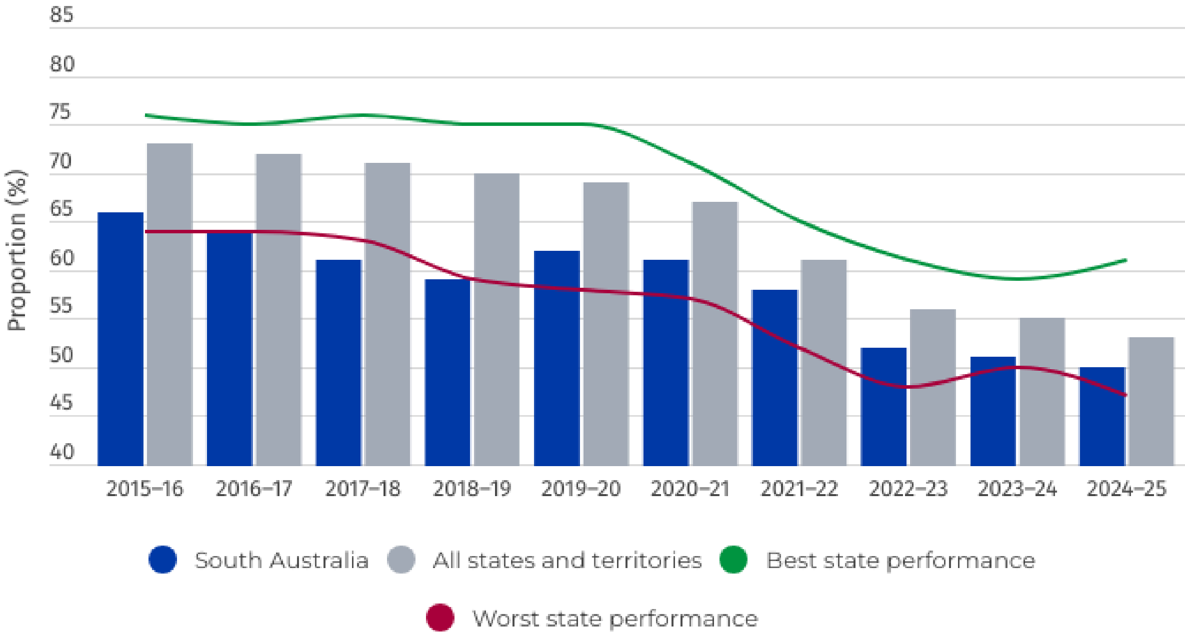
Figure 1 (SA): Proportion of Category 3 (urgent) emergency department presentations seen within the recommended time (under 30 minutes), 2005–06 to 2024–25



Source: AIHW.

Only half (50 per cent) of emergency department presentations were completed in four hours or less, a near worst-in-class performance, which represents a 12 per cent decline since 2019–20.

Figure 2 (SA): Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25

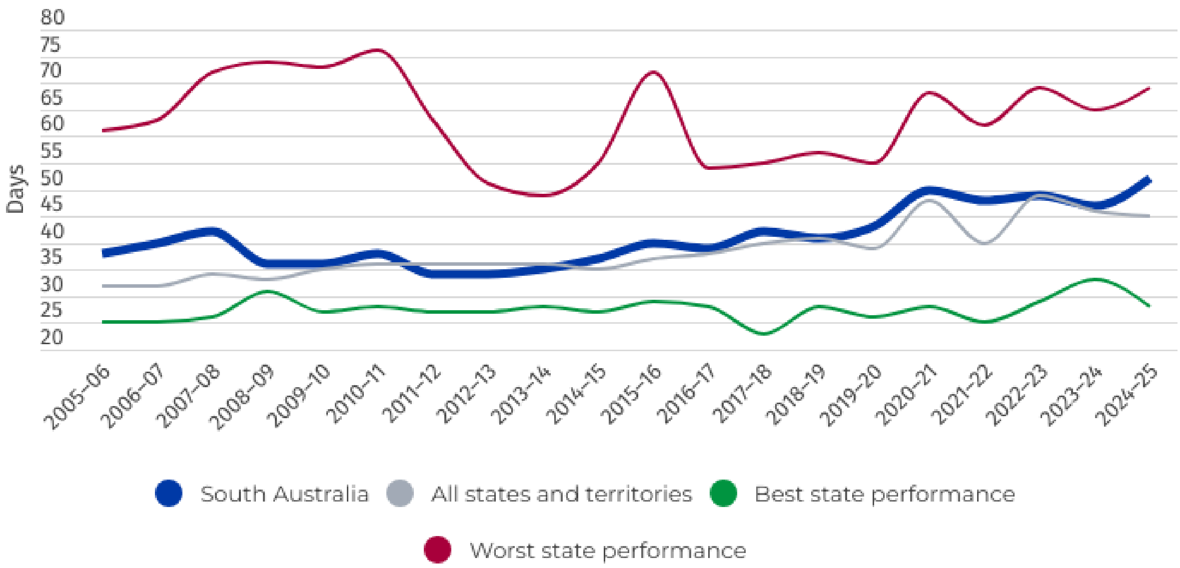


Source: AIHW.

Planned surgery performance[xxix]

In 2024–25, South Australia saw falls in performance for both planned surgery metrics monitored by the AMA. The median waiting time for planned surgery has risen from 47 to 52 days (Figure 3).

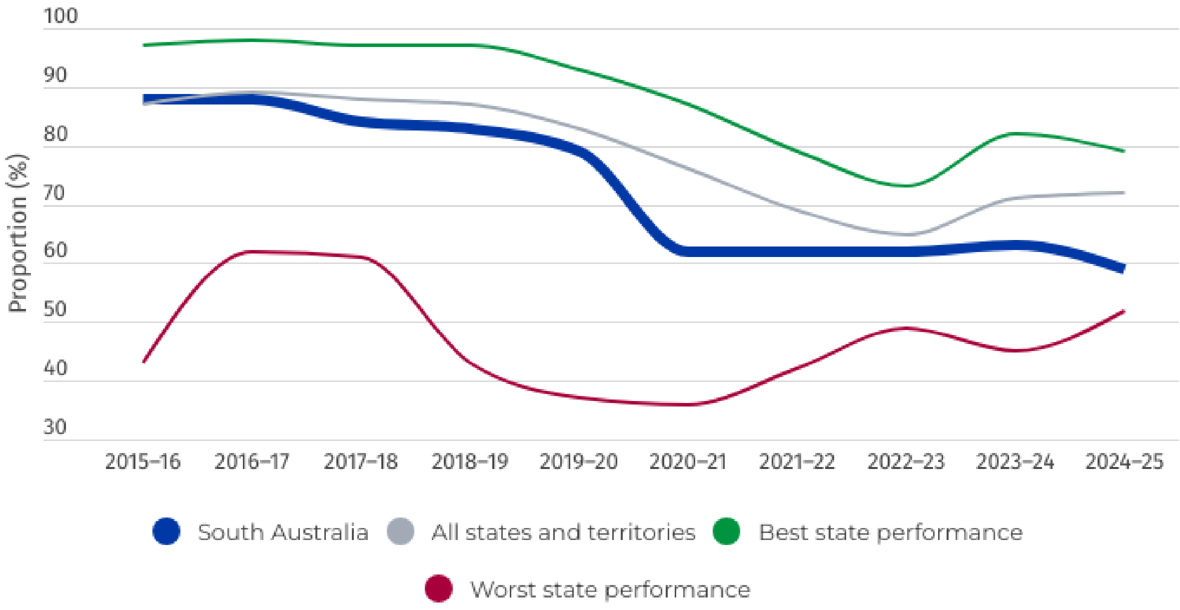
Figure 3 (SA): Median wait time for planned surgery, days, 2005–06 to 2024–25



Source: AIHW.

Unfortunately, the state also saw a further fall in the proportion of Category 2 patients being seen within the clinically recommended time, down from 79 per cent in 2019–20 to 59 per cent in 2024–25.

Figure 4 (SA): Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Source: AIHW.

Public hospital expenditure[xxx]

The most recent public hospital funding data are from 2023–24 and does therefore not reflect the new NHRA that was agreed to in January 2026. See note on the expected impact of the NHRA at the end of this chapter.

In South Australia, most public hospital funding (64.6 per cent) comes from the state government. This is largely in line with the national average of 61.4 per cent, as most state and territories continue to take on most of the funding burden for our public hospital system.

The average annual increase in public hospital funding has been very similar between the South Australian and federal governments over the past ten years, hovering around 2 per cent on average (Table 3).

Table 3 (SA): Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods

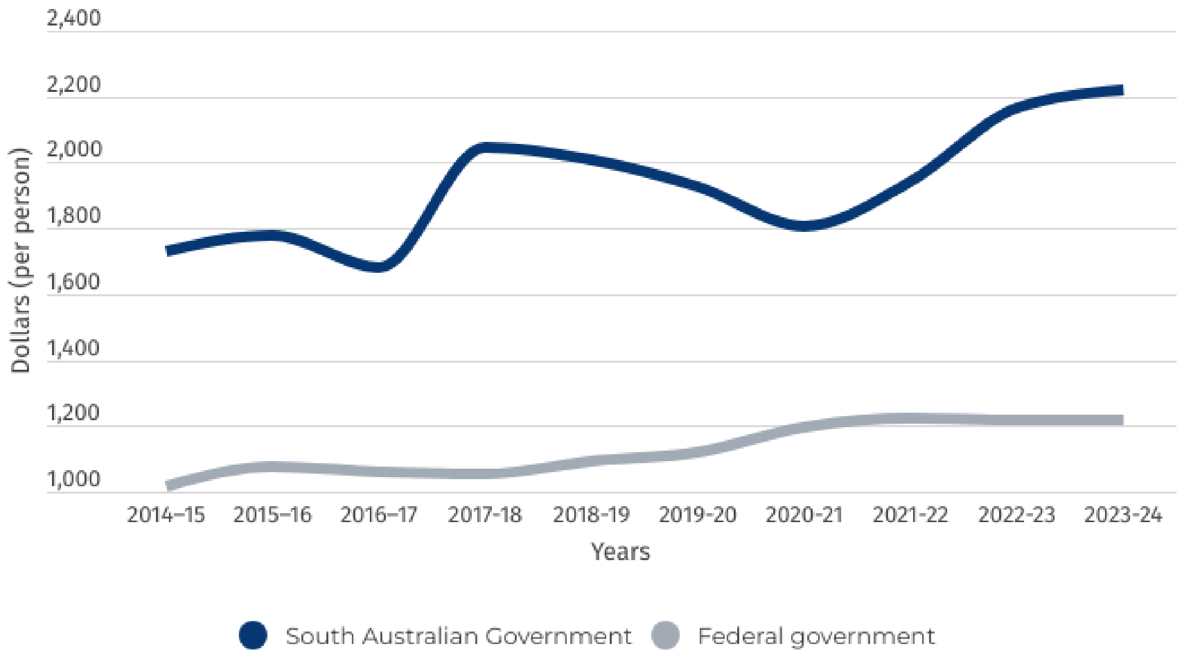
	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
Federal government	1.97%	1.91%	2.03%
SA Government	2.15%	2.16%	2.13%

Note: 2023–24 is the most recent data available.

Source: AIHW.

Despite this, the per-person hospital funding provided by the state government is much higher than the federal government, at nearly twice the amount per person in 2023–24 (Figure 5).

Figure 5 (SA): Public hospital funding, per person, by government source (constant prices), 2014–15 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Expected impact of the NHRA

The new NHRA represents an important moment for South Australia, where public hospitals continue to experience persistent access and performance pressures. As shown in this chapter, the state government provides close to two-thirds of public hospital funding in South Australia, broadly in line with the national pattern.

The expenditure data presented here reflects the period prior to the new agreement and therefore does not capture the additional federal funding now committed. Nonetheless, the NHRA provides South Australia with greater funding certainty over the next five years, creating an opportunity to move beyond incremental, short-term measures and toward more sustained system improvement.

For South Australia, funding certainty sharpens the focus on delivery in a system where emergency department performance and workforce pressures have remained entrenched despite ongoing investment. One-off funding boosts and marginal activity increases have not been sufficient to reverse these trends.

Now the federal government has lifted its funding effort, the states will need to continue to do so as well. South Australia faces a clear task: to translate the NHRA into a credible forward plan that aligns workforce supply, bed capacity and capital investment over the life of the agreement. While the scale of improvement may be constrained by existing system pressures, the public can reasonably expect measurable progress.

The AMA will closely monitor whether the new NHRA delivers meaningful and durable gains in access and performance for South Australians, rather than perpetuating a cycle of temporary relief without structural change.

Tasmania

AMA Tasmania President's introduction

Tasmania's public hospital results this year show a system under sustained and backbreaking pressure. Performance has declined across every key indicator measured by the AMA and continues to sit below national benchmarks. These results reflect what doctors see daily in the public system and what patients experience when they wait longer for care.

Emergency departments continue to struggle to meet recommended timeframes, with Tasmania again recording the lowest national performance against the four-hour measure. Planned surgery outcomes have also deteriorated, with longer waits and fewer patients receiving care within clinically appropriate timeframes. This is not simply a performance issue. It reflects a system operating beyond capacity, without effective plans to get ahead of demand.

Recent moves to reduce transfer-of-care timeframes risk shifting pressure rather than addressing the causes of emergency department congestion. Patient flow will not improve without tackling access block, workforce shortages and ongoing aged care pressures that delay discharge. Delays in radiology and pathology testing and reporting continue to slow diagnosis and treatment, underscoring the need for stronger systems and better integration.

While additional funding through the National Health Reform Agreement is welcome and again presents an opportunity to argue Tasmania is an ideal test state for a single-funded model, the state government cannot continue to shoulder the financial burden alone. NHRA funding must deliver real improvements in access and capacity. Without structural reform, increased funding will not resolve underlying system pressures.

Tasmania must also have an honest and mature conversation about sustainable healthcare funding, including tax reform and broader revenue measures. Long-term stability requires long-term thinking.

Most importantly, we must now commit to deliberate, long-term system planning. Alongside funding reform, this requires fit-for-purpose infrastructure for the future, a sustainable and supported medical workforce, and stronger community-based models of care, guided by a comprehensive, clinically-led statewide clinical service plan. Doctors must be involved at every step. The system cannot continue to rely on goodwill to compensate for structural and governance failures.

Tasmania needs a clear long-term strategy that supports its workforce and ensures no Tasmanian is left waiting for the care they deserve.

Dr Michael Lumsden-Steel
President
AMA Tasmania

Key takeaways

In 2024–25, Tasmania added 41 beds to their public hospital system.

Tasmania's public hospitals continue to face a systemic crisis, as all four AMA-monitored indicators declined in 2024–25 compared with the previous year (Table 1).

Table 1 (Tas): Performance 2024–25 compared with the previous year

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Worse	Worse	Worse	Worse

Source: AMA comparison, AIHW.

Tasmania's 2024–25 performance also remained below the national average across all metrics (Table 2).

Table 2 (Tas): Tasmanian performance 2024–25 compared with national average (below or above)

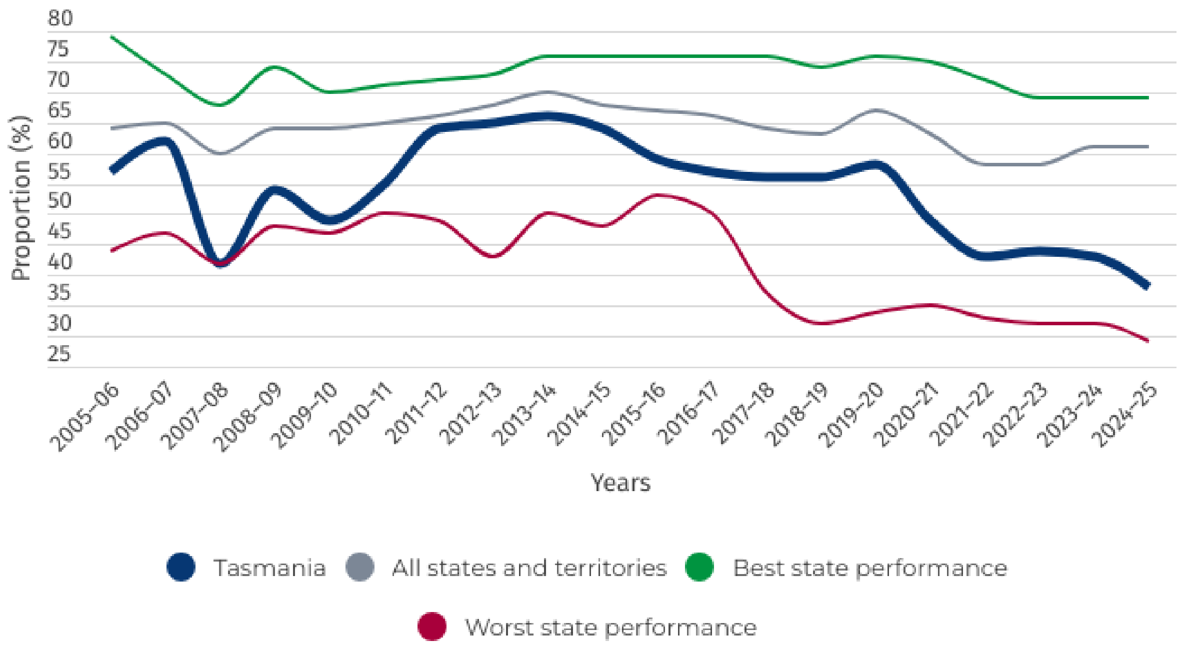
Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Worse	Worse **(worst)**	Worse	Worse

Source: AIHW.

Emergency department performance[xxxi]

Tasmania's ability to treat and discharge emergency department patients within the recommended timeframe is well below average and fell for the second consecutive year. In 2024–25, only 38 per cent of Category 3 presentations were seen within the recommended timeframe, down from 43 per cent last year and 20 percentage points lower than the 58 per cent figure of 2019–20 (Figure 1).

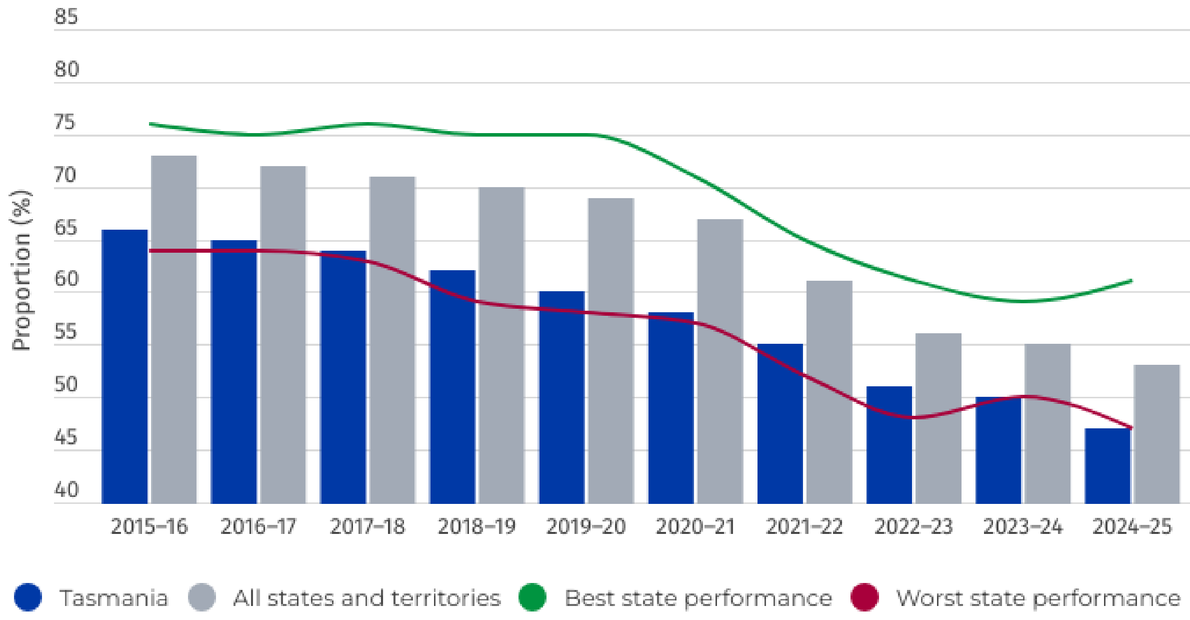
Figure 1 (Tas): Proportion of Category 3 (urgent) emergency department presentations seen within the recommended time (under 30 minutes), 2005–06 to 2024–25



Source: AIHW.

Tasmania remains at the bottom of the national scorecard when it comes to the four-hour rule, with only 47 per cent of emergency department visits being completed within four hours or less.

Figure 2 (Tas): Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25



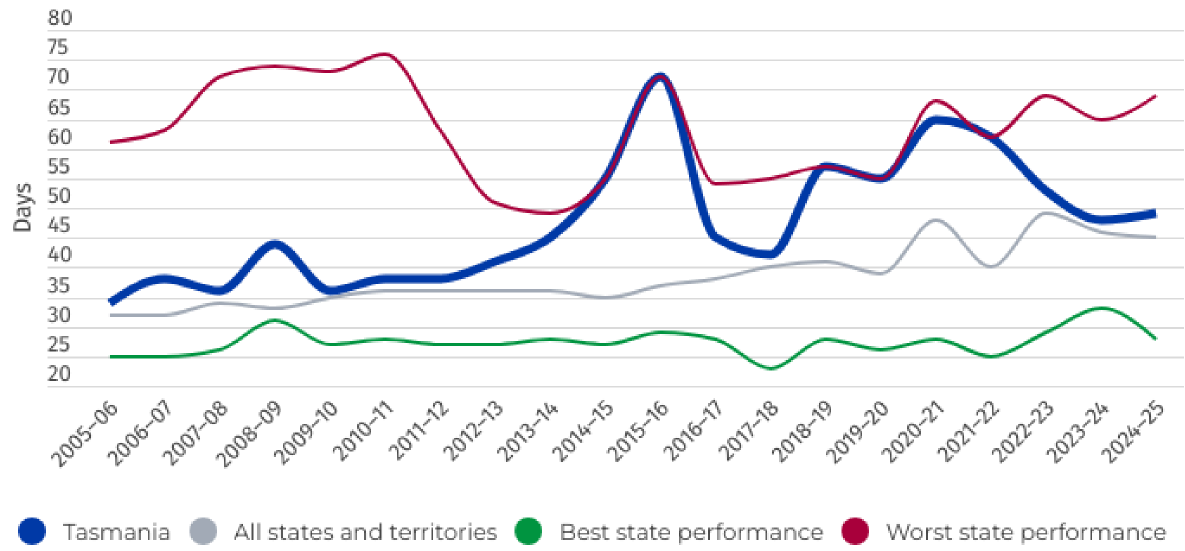
Source: AIHW.

Planned surgery performance[xxxii]

After four years in a row of improvement across both metrics monitored by the AMA, Tasmania has seen a setback in both the median wait time for planned surgery (increasing from 48 to 49 days, Figure 3) and percentage of Category 2 patients admitted within the recommended 90 days (54 per cent to 53 per cent) in 2024–25 (Figure 4).

Despite these being only small falls in performance, this is a concerning sign for Tasmanian patients who require medically necessary surgery.

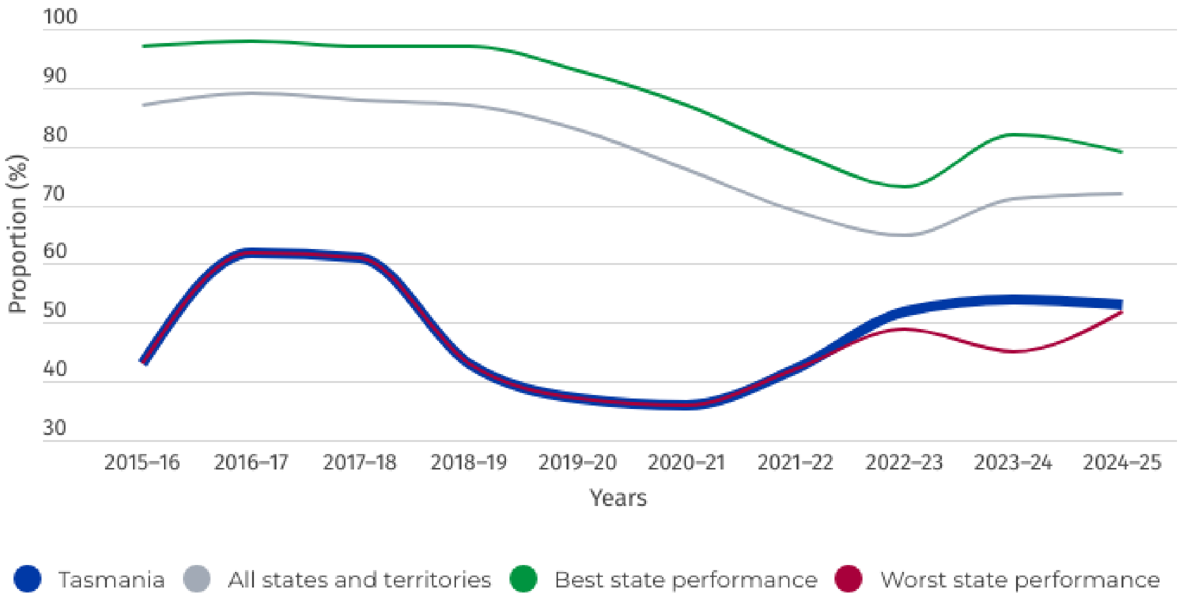
Figure 3 (Tas): Median wait time for planned surgery, days, 2005–06 to 2024–25



Source: AIHW.

For those who are not admitted within the clinical timeframe, the average wait time is alarmingly high at 264.7 days for Category 2 (recommended to occur within 90 days) and 548.4 days for Category 3 (within 365 days).

Figure 4 (Tas): Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Source: AIHW.

Public hospital expenditure[xxxiii]

The most recent public hospital funding data are from 2023–24 and does therefore not reflect the new NHRA that was agreed to in January 2026. See note on the expected impact of the NHRA at the end of this chapter.

In Tasmania, most public hospital funding (65.4 per cent) comes from the state government. This is notably greater than the national average of 61.4 per cent, as state and territory governments continue to take on most of the funding burden for our public hospital system.

The federal government has, on average, increased public hospital funding annually by a significantly larger margin (nearly 10 per cent annually) than the Tasmanian government (1.2 per cent) over the past decade (Table 3).

Table 3 (Tas): Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods

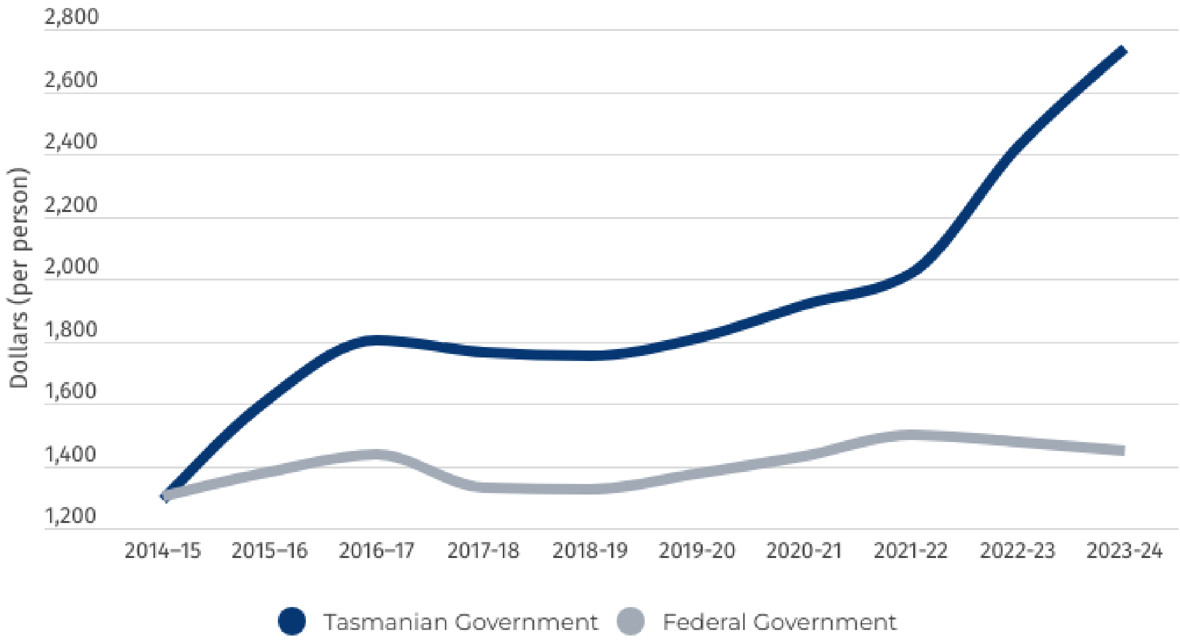
	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
Federal government	9.95%	10.57%	9.33%
Tasmanian Government	1.24%	0.66%	1.83%

Note: 2023–24 is the most recent data available.

Source: AIHW.

Despite the high average annual increases, however, on a per-person basis, the Tasmanian Government contributes nearly twice the amount in funding (more than $2,700 per person) than the federal government (more than $1,400) (Figure 5).

Figure 5 (Tas): Public hospital funding, per person, by government source (constant prices), 2014–15 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Expected impact of the NHRA

The new NHRA is particularly consequential for Tasmania, where the public hospital system operates with limited scale and a high sensitivity to funding uncertainty, largely due to Tasmania's size of population.

As with other jurisdictions, the public hospital expenditure data presented in this chapter reflects the period prior to the new agreement and therefore does not capture the additional federal funding now committed. However, the NHRA provides Tasmania with greater funding certainty over the next five years, which is essential for a system that has historically borne disproportionate risk when funding arrangements fall short or are delayed.

For Tasmania, funding certainty heightens expectations around timely delivery. Unlike larger states, Tasmania has little capacity to absorb prolonged delays in workforce expansion, bed availability or capital investment. Short-term funding measures and temporary fixes have repeatedly proven insufficient to stabilise performance in a system already operating close to its limits.

Now the federal government has lifted its funding effort, the states will need to continue to do so as well. Tasmania faces a clear task: to translate the NHRA into a credible, near-term plan that delivers tangible capacity and access improvements within the life of the agreement. While the scale of improvement may be constrained by workforce and geographic challenges, the public can reasonably expect progress.

The AMA will closely monitor whether the new NHRA provides Tasmania with genuine system resilience, rather than continuing a cycle of stop-gap measures that leave the state exposed to ongoing risk.

Australian Capital Territory

AMA ACT President's introduction

Once again, doctors, nurses, and health professionals across Australian Capital Territory (ACT) public hospitals have stepped up to assess and care for patients from the ACT and surrounding region under increasingly challenging conditions. Demand for emergency department care and planned surgery continues to rise, driven by an ageing population, increasing medical complexity, population growth, and the downstream impacts of constrained access to care elsewhere in the system.

At the same time, patients continue to face significant barriers to accessing general practice and non-GP specialist care, as workforce pressures persist across the health sector.

Overall, the ACT is showing early signs of improvement across those measures where data are publicly reported. We expect this progress to be supported by stronger transparency and a healthier system culture following the Health System Inquiry.

The AMA continues to strongly advocate for sustained and targeted investment in workforce, clinics, and planned surgery capacity, so that waiting times can be reduced as funding under the latest National Health Reform Agreement begins to flow through to the ACT health budget.

Dr Kerrie Aust
President
AMA Australian Capital Territory

Key takeaways

In 2024–25, the ACT added 112 beds to its public hospital system.

ACT public hospitals have shown varied performance in 2024–25. Despite a year-on-year improvement in two indicators monitored by the AMA, and one indicator remaining stagnant (Table 1), the ACT retains the title of the lowest proportion of Category 2 planned surgery patients admitted on time for the third year in a row. Despite this, there has been an improvement in this indicator from the previous year.

Table 1 (ACT): Performance compared with the previous year, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Equal	Better	Worse	Better

Source: AIHW.

ACT public hospitals were worse compared with the national average in three of the metrics (Table 2), but was the best performer nationally for the 4-hour rule metric.

Table 2 (ACT): Performance compared with national average, 2024–25

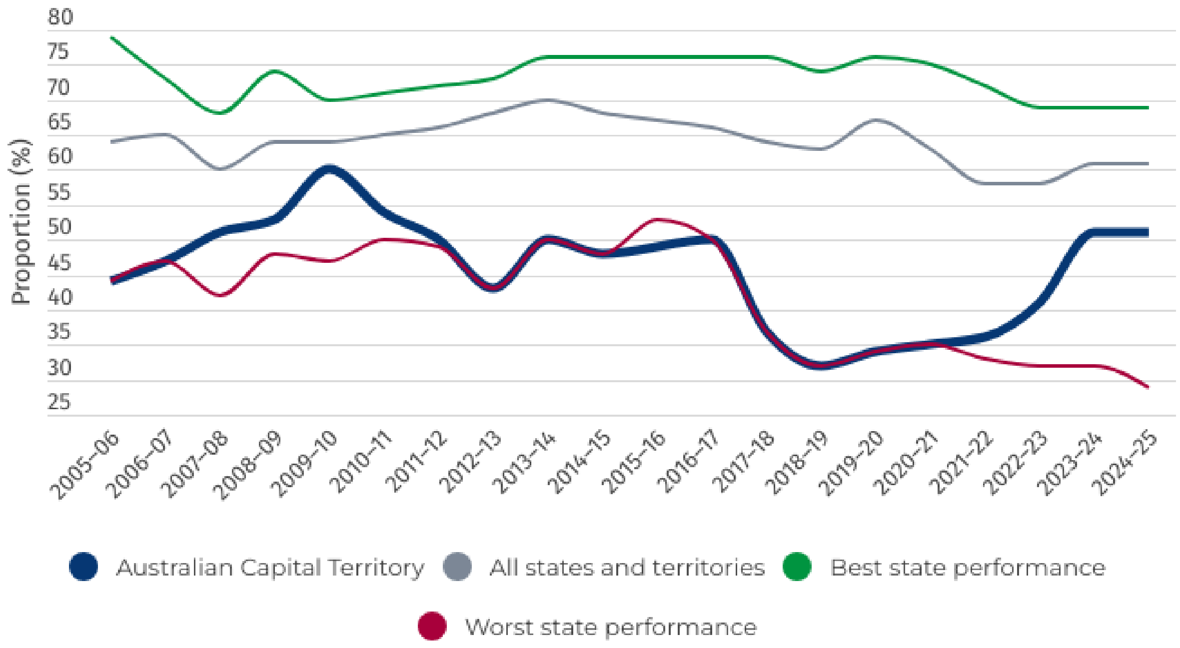
Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery on time
Worse	Better **(best)**	Worse	Worse **(worst)**

Source: AIHW.

Emergency department performance[xxxiv]

The ACT has shown a net improvement in emergency department performance in 2024–25. The proportion of presentations classified as urgent seen on time remained steady at 51 per cent, which remains higher than the trough in performance in this metric between 2016–17 and 2022–23, where the proportion fell to 32 per cent (Figure 1).

Figure 1 (ACT): Proportion of Category 3 (urgent) emergency department presentations seen within the recommended time (under 30 minutes), 2005–06 to 2024–25

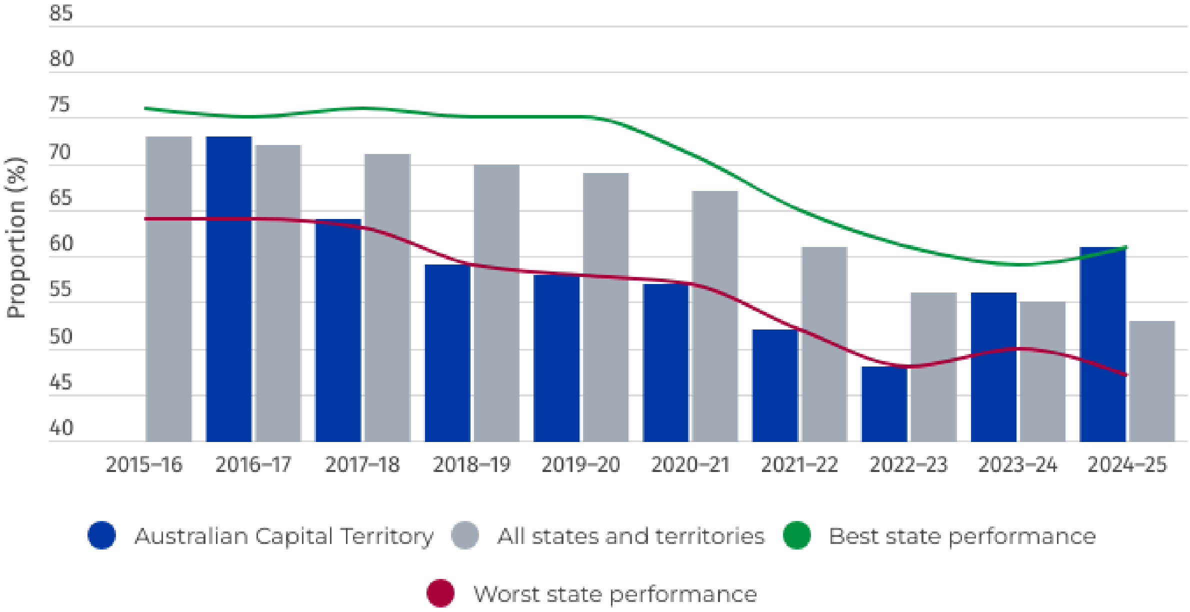


Source: AIHW.

The proportion of emergency department presentations being seen within four hours or less, the territory has improved from worst performer nationally in 2022–23 (48 per cent) to best performer in 2024–25 (61 per cent) (Figure 2), indicating a particular focus across the ACT on this performance metric.

However, it should be noted that this "best in class" performance is lower than the worst performing state just ten years ago, highlighting the drastic fall in performance of Australia's emergency departments nationwide.

Figure 2 (ACT): Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25



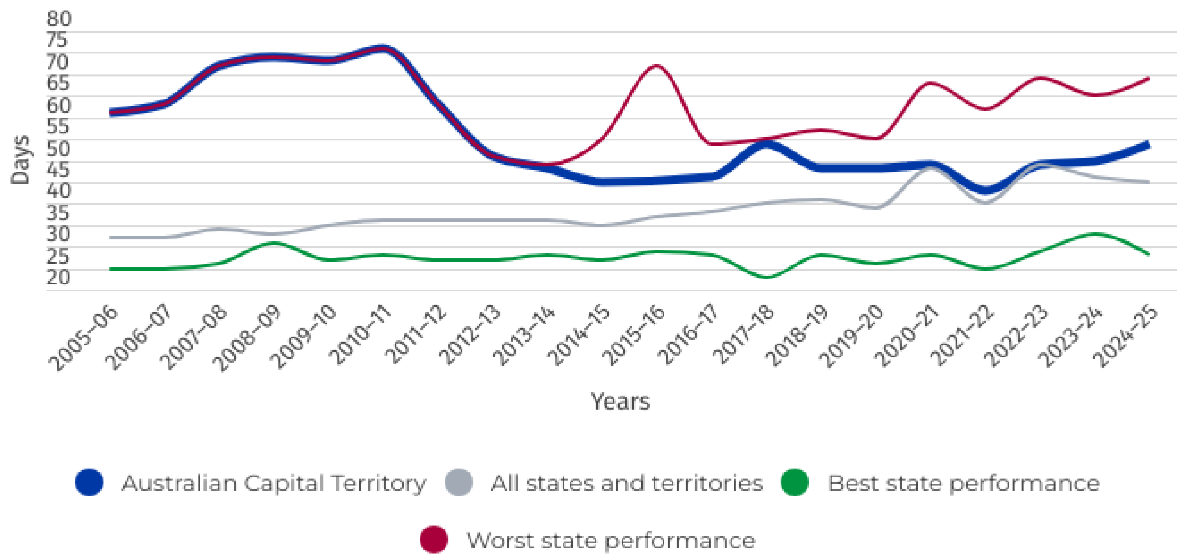
Source: AIHW.

Planned surgery performance[xxxv]

In 2024–25, 48 per cent of Category 2 patients did not receive their surgery on time in the ACT (recommended to occur within 90 days). For those patients, the average wait time was alarmingly high at 237 days, an increase of 23 days from the year prior.

Furthermore, more than 31 per cent of ACT Category 3 patients were not admitted in the clinically recommended time of 365 days: these patients are waiting on average 551.9 days before receiving treatment.

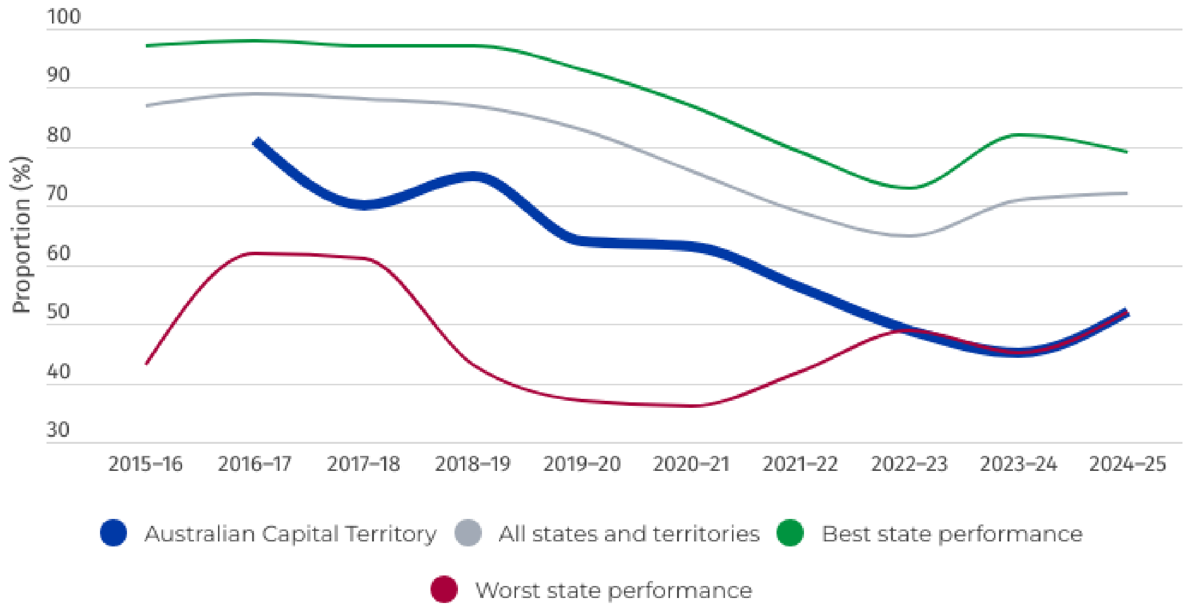
Figure 3 (ACT): Median wait time for planned surgery, days, 2005–06 to 2024–25



Source: AIHW.

In the ACT, the proportion of Category 2 planned surgery patients being admitted within the recommended time improved for the first time in six years during 2024–25 (Figure 4). The ACT's performance on this measure increased from 45 per cent to 51.8 per cent in the past reporting period, although is still significantly lower than in the past.

Figure 4 (ACT): Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Source: AIHW.

Public hospital expenditure[xxxvi]

The most recent public hospital funding data are from 2023–24 and does therefore not reflect the new NHRA that was agreed to in January 2026. See note on the expected impact of the NHRA at the end of this chapter.

In the ACT, most public hospital funding (67 per cent) comes from the ACT government. This is the equal highest proportion in the country, and far above the national average of 61.4 per cent.

Over the past decade, the average annual increase in public hospital funding from the federal government (3.4 per cent) outpaced the average annual increase from the ACT government (2.1 per cent); however, when looking at the breakdown of these, the federal contribution mainly happened under the second NHRA (Table 3).

Table 3 (ACT): Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods

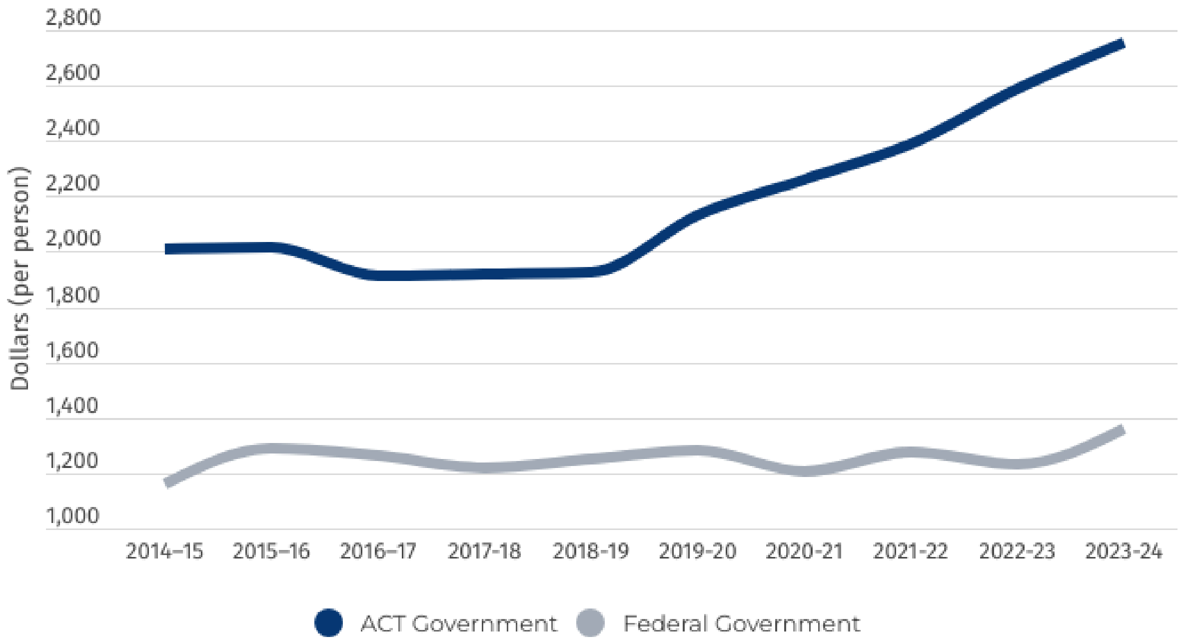
	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
Federal government	3.35%	-0.56%	7.41%
ACT Government	2.06%	2.43%	1.68%

Note: 2023–24 is the most recent data available.

Source: AIHW.

In 2023–24, the ACT Government spent nearly twice as much (about $2,800) as the federal government (just under $1,800) on a per capita basis.

Figure 5 (ACT): Public hospital funding, per person, by government source (constant prices), 2014–15 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Expected impact of the NHRA

The new NHRA is an important development for the ACT, where the public hospital system operates at scale but with limited redundancy and little capacity to absorb funding volatility.

As with other jurisdictions, the public hospital expenditure data presented in this chapter reflects the period prior to the new agreement and therefore does not capture the additional federal funding now committed.

However, the NHRA provides the ACT with greater funding certainty over the next five years, which is particularly significant for a system that has recently faced rising operating pressures alongside major capital investment.

For the ACT, funding certainty changes the balance between short-term cost containment and longer-term service planning. Recent experience shows that efficiency measures alone are unlikely to deliver sustained improvements in access and performance, particularly in areas such as elective surgery where pressures remain pronounced.

Now the federal government has lifted its funding effort, the states will need to continue to do so as well. The ACT faces a clear task: to translate the NHRA into a credible forward plan that aligns workforce growth, service configuration and new infrastructure over the life of the agreement. While the scale of improvement may be constrained by system size and demand growth, the public can reasonably expect measurable progress.

The AMA will closely monitor whether the new NHRA supports durable performance gains in the ACT, rather than perpetuating a cycle of short-term fiscal adjustment without lasting improvement.

Northern Territory

AMA NT President's introduction

The data on hospital performance in the Northern Territory paints a stark and concerning picture. This is a system in crisis that continues to be under-funded and under-resourced year after year. In almost all metrics we have seen a deterioration in targets and performance.

The cause is simple. The Northern Territory continues to be short-changed on a federal level, with the Northern Territory Government having to chip in more than its fair share when compared with other jurisdictions. This is despite having some of the heaviest burden of disease in Australia with some of the longest distances to travel to reach healthcare of any kind.

While the new NHRA funding arrangement brings certainty, it is ultimately kicking the can down the road for the Northern Territory. This funding only serves to "keep the lights on" and doesn't allow for any form of repair after years of neglect. Until our pricing and funding models distribute resources based on clinical need, we will continue to see deteriorating results in the Northern Territory. This presents a challenge for all governments. We must ensure the Northern Territory receives its fair share of federal funding, and the Northern Territory Government must heed the warnings of doctors who continue to be challenged by inefficiencies in the Northern Territory health system.

We cannot have a healthy population and a healthy economy with a sick healthcare system. It is time for urgent economic reform in how we support our public hospitals and health services in Australia, and we desperately need this reform to begin in the Northern Territory.

Dr John Zorbas
President
AMA Northern Territory

Key takeaways

In 2024–25, the Northern Territory added 11 beds to its public hospital system.

The territory's public hospital performance declined across all four categories monitored by the AMA compared with the previous year for which data were available (in the NT, the last available planned surgery data were from 2022–23) (Table 1).

Table 1 (NT): Performance compared with the previous year, 2024–25

Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery wait
Worse	Worse	Worse	Worse

Source: AIHW.

Compared with the national average, Northern Territory public hospitals performed better in two of the four indicators, but worse than the national average in the other two (Table 2).

Table 2 (NT): Performance compared with the national average, 2024–25

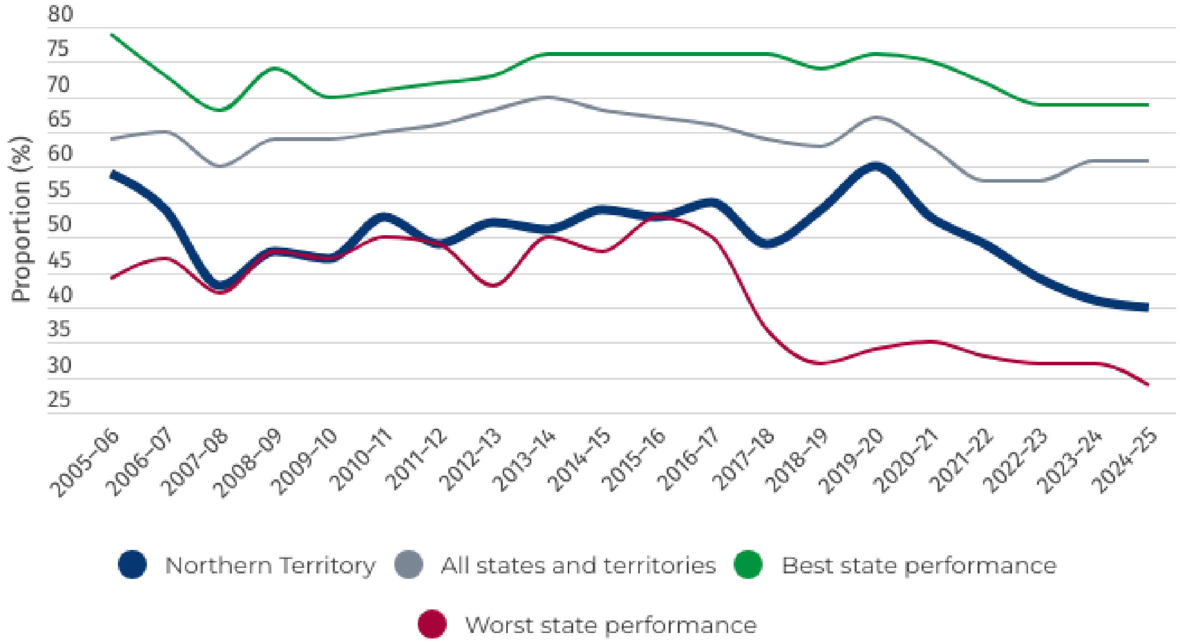
Category 3 on time	4-hour rule	Median surgery wait	Category 2 surgery wait
Worse	Better	Better	Worse

Source: AIHW.

Emergency department performance[xxxvii]

Worryingly, only 40 per cent of Category 3 (urgent) emergency department presentations in the NT were being seen within the recommended 30 minutes in 2024–25 (Figure 1). This represents the fifth consecutive annual decline — equating to 20 percentage points since 2019–20. This 2024–25 finding was the lowest proportion in the past 20 years, highlighting a crisis in capacity within NT's emergency departments.

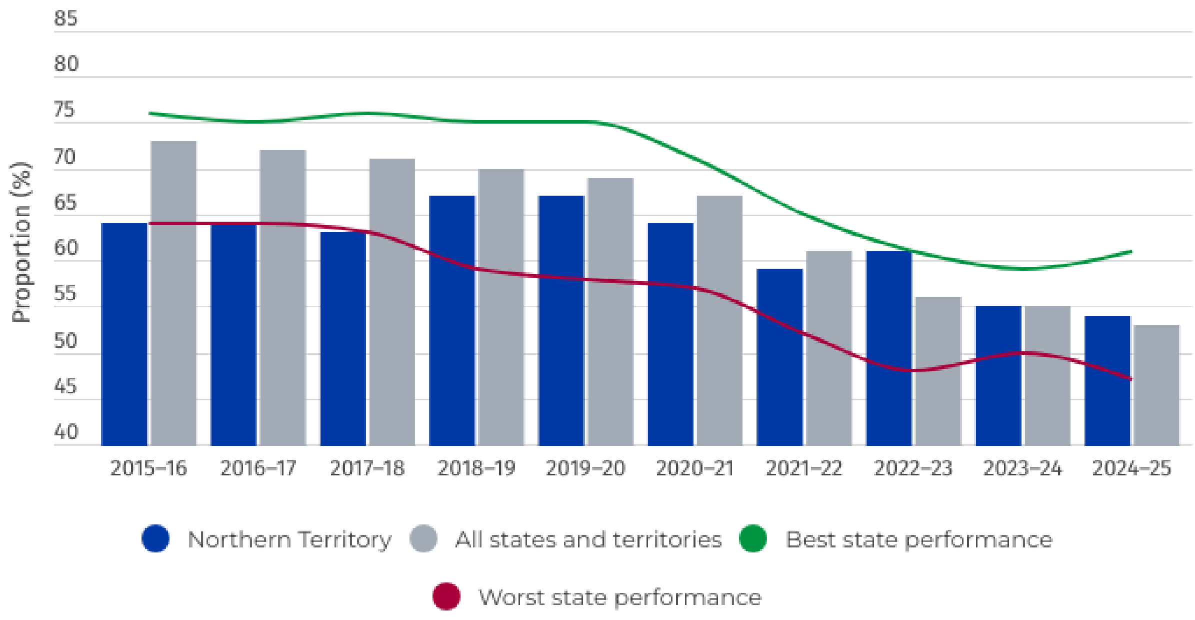
Figure 1 (NT): Proportion of Category 3 (urgent) emergency department presentations seen within the recommended time (under 30 minutes), 2005–06 to 2024–25



Source: AIHW.

Furthermore, in the Northern Territory, the proportion of emergency department presentations being seen within four hours has fallen to 54 per cent in 2024–25, representing the lowest figure for the Northern Territory in the past ten years (Figure 2).

Figure 2 (NT): Proportion of emergency department visits completed in four hours or less, 2015–16 to 2024–25



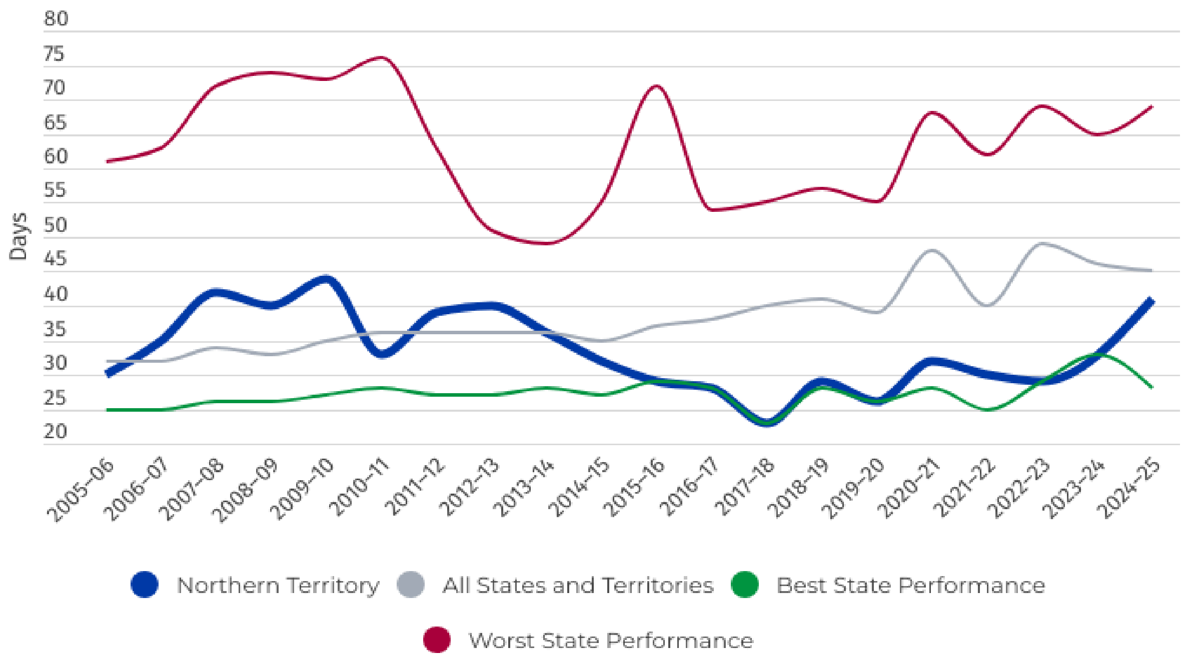
Source: AIHW.

Planned surgery performance[xxxviii]

The median wait time for planned surgery in the NT increased rapidly over the past two years, from 29 days in 2022–23 to more than 40 days in 2024–25, nearly doubling since 2017–18 (Figure 3), a strong indication Northern Territory public hospitals are not keeping up with the demand for care in the territory.

Note that Northern Territory data on planned surgery was not made available last year (2023–24) and remains unavailable at the time of writing.

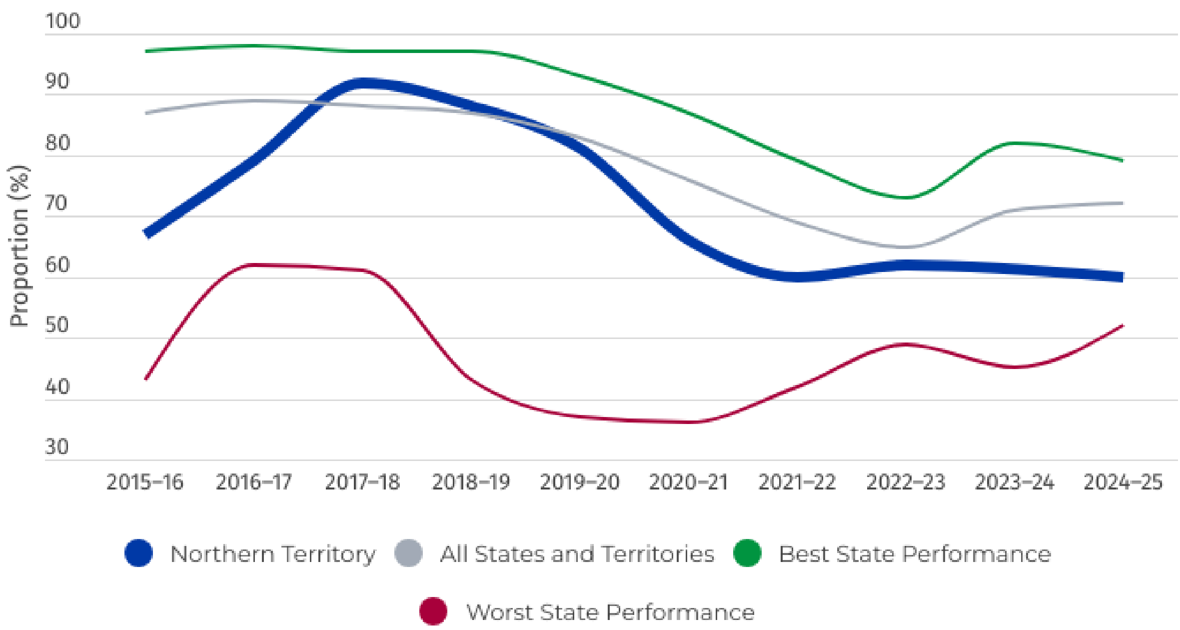
Figure 3 (NT): Median wait time for planned surgery, days, 2005–06 to 2024–25



Source: AIHW.

In the Northern Territory, the proportion of Category 2 planned surgery patients seen within the recommended timeframe (90 days) remains lower than the national average, having fallen from a peak of 92 per cent in 2017–18 to 60 per cent in 2024–25 (Figure 4). For those patients who are not seen on time (40 per cent of the entire Category 2 cohort), the average total wait time before receiving surgery is well over a year (425) days, signifying a critical backlog in the territory's planned surgery system.

Figure 4 (NT): Proportion of Category 2 planned surgery patients admitted within recommended time (90 days), 2015–16 to 2024–25



Note: no data available for 2023-24 for NT

Source: AIHW.

Public hospital expenditure[xxxix]

The most recent public hospital funding data are from 2023–24 and does therefore not reflect the new NHRA that was agreed to in January 2026. See note on the expected impact of the NHRA at the end of this chapter.

In the Northern Territory, most of public hospital funding (67 per cent) comes from the Northern Territory Government. This is far above the national average of 61.4 per cent.

Over the past decade, the annual average increase in funding provided by the Northern Territory Government has far outpaced the average annual increase in federal funding — at 7.1 per cent and 1.6 per cent respectively (Table 3). Having said that, the average annual increase of federal funding was significantly higher under the second NHRA.

Table 3 (NT): Average annual percentage increase in public hospital funding by government source, per person, constant prices, various time periods

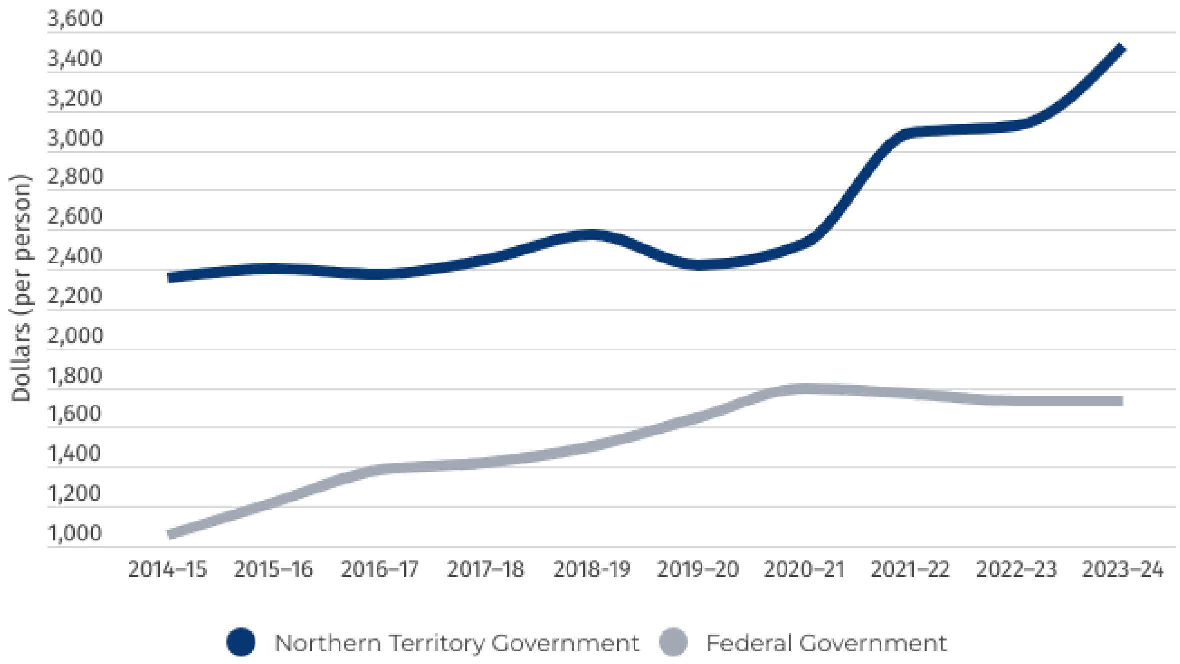
	2013–14 to 2023–24	2013–14 to 2018–19	2018–19 to 2023–24
Federal government	1.62%	-3.04%	6.50%
NT Government	7.07%	11.42%	2.90%

Note: 2023–24 is the most recent data available.

Source: AIHW.

On a per-person basis, the Northern Territory funds the vast majority of public hospital care, and the gap between state and federal funding was increasing (Figure 5).

Figure 5 (NT): Public hospital funding, per person, by government source (constant prices), 2014–15 to 2023–24



Note: 2023–24 is the most recent data available.

Source: AIHW.

Expected impact of NHRA

The new NHRA is particularly significant for the Northern Territory, where public hospitals face sustained pressure from a high burden of disease, geographic isolation and limited system capacity. As shown in this chapter, the majority of public hospital funding in the Northern Territory continues to be provided by the territory government, well above the national average.

The public hospital expenditure data presented here reflects the period prior to the new agreement and therefore does not capture the additional federal funding now committed. However, the NHRA provides the Northern Territory with greater funding certainty over the next five years, which is essential for a system that has historically operated under chronic strain and funding volatility.

For the Northern Territory, funding certainty elevates expectations around stability as much as improvement. Persistent access pressures, frequent bed block, and the compounding effects of workforce shortages and unmet aged care and disability needs mean there is little scope for short-term or marginal responses.

Now the federal government has lifted its funding effort, the states will need to continue to do so as well. The Northern Territory faces a clear task: to translate the NHRA into a credible forward plan that strengthens workforce supply, increases functional capacity, and improves patient flow across the system over the life of the agreement. While structural challenges mean gains may be incremental, the public can reasonably expect progress.

The AMA will closely monitor whether the new NHRA delivers greater resilience and equity for the Northern Territory's public hospital system, rather than perpetuating a cycle of crisis management that leaves patients and clinicians under ongoing pressure.

References

Note: some figures and statistics have been calculated internally by the AMA using the referenced sources.

[i] Organisation for Economic Co-operation and Development (2025). *OECD Employment outlook 2025.* Retrieved 15/2/2026 from: https://www.oecd.org/en/publications/2025/07/oecd-employment-outlook-2025_5345f034/full-report/setting-the-scene-demographic-change-economic-growth-and-intergenerational-inequalities_9d481169.html.

[ii] Australian Institute of Health and Welfare (2025). *Admitted patient care, 2023–24.* Chapter 3: Who used these services? Table S3.2. Retrieved 23/2/2026 from: https://www.aihw.gov.au/getmedia/60fa67a9-fb7a-4782-b858-e860a1d703f2/3-admitted-patient-care-2023-24-tables-access_1.xlsx.

[iii] Australian Institute of Health and Welfare (2025). *Hospital resources 2023–24.* Table 4.5. Retrieved 14/12/2025 from: https://www.aihw.gov.au/getmedia/ac3ddea8-a142-461c-a780-a2341d93fd49/hospital-resources-tables-2023-24.xlsx.

[iv] Australian Bureau of Statistics (2024). *National, state and territory population: June 2024.* National, state and territory populations, Table 6. Retrieved 14/12/2025 from: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/jun-2024/31010do001_202406.xlsx.

[v] Australian Institute of Health and Welfare (2025). *Admitted patient care 2023–24.* Chapter 3 Who used these services? Table S3.2. Retrieved 14/12/2025 from: https://www.aihw.gov.au/getmedia/60fa67a9-fb7a-4782-b858-e860a1d703f2/3-admitted-patient-care-2023-24-tables-access_1.xlsx.

[vi] Australian Bureau of Statistics (2024). *National, state and territory population: June 2024.* National, state and territory populations, Table 6. Retrieved 14/12/2025 from: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/jun-2024/31010do001_202406.xlsx.

[vii] Australian Institute of Health and Welfare (2025). *Hospital resources 2023–24.* Table 4.5. Retrieved 14/12/2025 from: https://www.aihw.gov.au/getmedia/ac3ddea8-a142-461c-a780-a2341d93fd49/Hospital-resources-tables-2023-24.xlsx.

[viii] Australian Bureau of Statistics (2024). *National, state and territory population: June 2024.* National, state and territory populations, Table 6. Retrieved 14/12/2025 from: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/jun-2024/31010do001_202406.xlsx.

[ix] Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed.

This graph also uses historical AIHW data archived by the AMA.

[x] Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed.

This graph also uses historical AIHW data archived by the AMA.

[xi] Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed.

This graph also uses historical AIHW data archived by the AMA.

[xii] Australian Institute of Health and Welfare (2025). *Elective surgery waiting times 2024–25.* Data tables, Table 4.3. Retrieved 14/12/2025 from: https://www.aihw.gov.au/getmedia/9a15c07a-2d13-4eec-8609-a237cd7c9d0b/Elective-surgery-waiting-times-2024-25.xlsx.

This graph also uses historical AIHW data archived by the AMA.

[xiii] Australian Institute of Health and Welfare (2025). *Elective surgery waiting times 2024–25.* Retrieved 14/12/2025 from: https://www.aihw.gov.au/getmedia/9a15c07a-2d13-4eec-8609-a237cd7c9d0b/Elective-surgery-waiting-times-2024-25.xlsx

[xiv] Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24.* Retrieved 14/12/2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xv] Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24.* Accessed 14 December 2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xvi] All data in this section are taken from:

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xvii] All data in this section are taken from:

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xviii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24.* Retrieved 14/12/2025 from:

https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xix] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xx] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxi] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24*." Retrieved 14/12/2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xxii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxiii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxiv] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24*. Retrieved 14/12/2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xxv] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxvi] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxvii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24*. Retrieved 14/12/2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xxviii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxix] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxx] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24*. Retrieved 14/12/2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xxxi] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxxii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxxiii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24*. Retrieved 14/12/2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xxxiv] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxxv] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxxvi] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24*. Retrieved 14/12/2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview

[xxxvii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxxviii] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Emergency department care.* Retrieved 14/12/2025 from: https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed

[xxxix] All data in this section are taken from

Australian Institute of Health and Welfare (2025). *Health expenditure Australia 2023–24*. Retrieved 14/12/2025 from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2023-24/contents/main-visualisations/overview