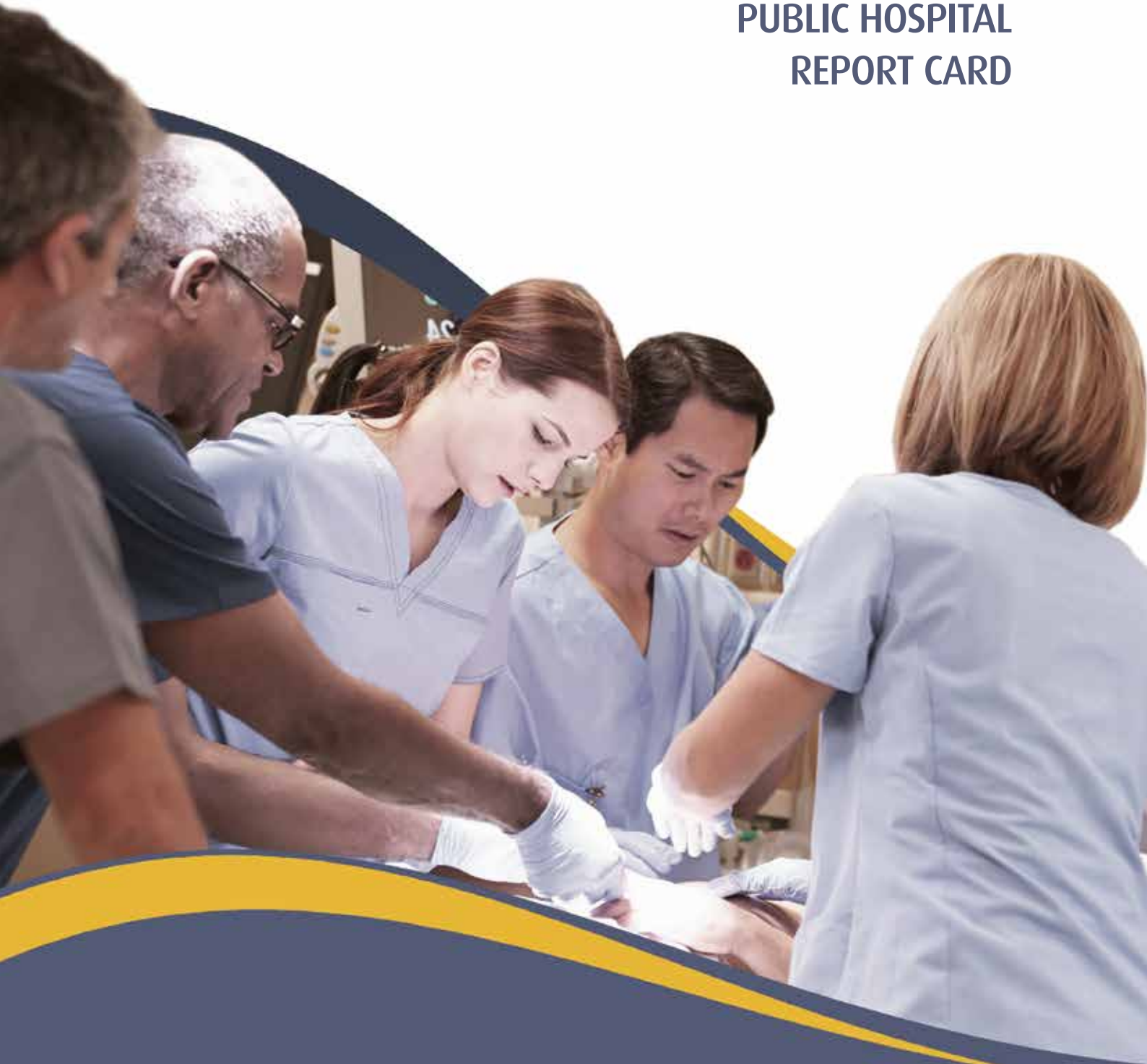


# 2018

## PUBLIC HOSPITAL REPORT CARD



AN AMA ANALYSIS OF AUSTRALIA'S PUBLIC HOSPITAL SYSTEM

**AMA**

# 2018

## PUBLIC HOSPITAL REPORT CARD

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# INTRODUCTION

The *AMA Public Hospital Report Card* presents key data on public hospitals published by the Commonwealth, year on year. It uses published data to assess the performance and capacity of our public hospitals to meet the community's need for hospital services.

Every year, the AMA uses this report card to highlight that public hospitals are a critical part of our health system. Our health system cannot improve without properly resourced public hospitals.

In 2015-16, there were more than 6 million episodes<sup>1</sup> of admitted patient care in Australia's public hospitals. In the same year, public hospitals managed 93 per cent<sup>2</sup> of the 8.7 million presentations to emergency.

The doctors, nurses, and other staff who work in our hospitals are some of the most skilled in the world. They are a saviour for many Australians in their time of need. Regardless of the time of day, or night, people need help. For many Australians, particularly in rural and regional areas, it is the only acute service available.

Our hospitals are increasingly required to meet the needs of more and more Australians. Between 2011-12 and 2015-16 the number of separations rose by 3.3 per cent on average each year<sup>3</sup>, more than double the average population growth of 1.6 per cent over the same period.

We frequently talk about the increasing burden on the health system – an ageing population, increasing levels of chronic disease, reduced access to services in certain regions. To tackle this, the AMA has consistently called for increased funding across the health system to help address this – investment in prevention, general practice, and private health. The strategy should be about coordinated investment in all parts of the health system that will deliver better

health outcomes, at the earliest opportunity. Intermittent funding favouritism to one part, at the expense of the others, ignores the importance of achieving a finely balanced interconnected Australian health system.

If we don't get that right – and the truth is that there are problems with the other three pillars of our universal healthcare system – it is the public hospital system that must pick up the pieces when things go wrong. It is, and always will be, critical. For this reason, the *AMA Public Hospital Report Card's* analysis of hospital funding and performance paints a bleak picture.

## Current funding and performance

The report highlights that public hospitals continue to face a funding crisis – one that is rapidly eroding their capacity to provide essential services to the public.

In previous editions the AMA has commented on the need for a return to greater levels of funding, as has been promised in the past.

The AMA welcomed the additional \$2.9 billion over three years in Commonwealth funding announced at COAG in April 2016 – but this was still far short of what is needed. Between 2014-15 and 2015-16 Commonwealth recurrent funding for public hospital services increased in real terms by 8.4 per cent to \$20.1 billion<sup>4</sup>, and while the AMA welcomed this one-off boost, it was off a very low base. The Federal long-term average annual growth rate of 2.8 per cent over the last five years and 4.3 per cent over the decade is too low<sup>5</sup>.

It is disappointing the 2020 hospital funding agreement tabled at COAG in February 2018 is 'business as usual'. That is, the Commonwealth will continue to fund 45 per cent of the efficient price of hospital services delivered. The Commonwealth

1 AIHW Australian Hospital Statistics; Admitted patient care 2015-16 Table 2.1  
2 AIHW Australian Hospital Statistics, Australian hospitals at a glance 2015-16 p12  
3 AIHW Australian Hospital Statistics; Admitted patient care 2015-16 Table 2.1  
4 AIHW, Health Expenditure Australia 2015-16 Table A10  
5 *ibid*

will contribute to growth in the volume of hospital services (adjusted by CPI and population) up to 6.5% per annum.

Of course, Commonwealth funding is only one part of the story.

There was negative growth of 0.1 per cent between 2013-14 and 2014-15 in State and Territory recurrent hospital spending. Thankfully, this is showing signs of improving, rising by 3.8 per cent in real terms in 2015-16. This puts State and Territory combined year on year real growth on par with the Commonwealth, at 4.3 per cent over the decade .

This medium and long term annual growth in State and Territory funding is well within the 6.5% cap on efficient growth that has applied from 1 July 2017, and will be continued under the 2020 funding agreement, now signed by two States at COAG in February 2018.

Substandard funding levels are reflected in the performance of our public hospitals – and against key measures, the performance of our public hospitals is essentially frozen at the unsatisfactory levels of previous years.

Bed number ratios for the general population are static<sup>7</sup> and for the high user group aged over 65, bed ratios continue to fall – now at their lowest level since 1992-93.

Pressure on public hospital emergency departments (ED) continues to increase. Waiting times have worsened and, in most cases, remain well below the 80 per cent target set in 2012-13 – a target now abandoned by governments. Nationally, one third of the 2.8 million patients who presented to ED and needed urgent treatment in 2016-17 were not seen within the recommended 30 minutes. Three jurisdictions treated around half of these urgent ED patients within the 30 minute clinically indicated timeframe.

After three years of no improvement in

the percentage of ED patients who leave emergency within four hours, this year's report highlights a worsening to 72 per cent. It is of concern that the patients least likely to leave ED within four hours are the sickest. In 2016-17 only 57 per cent of resuscitation patients, 58 per cent of emergency patients and 64 per cent of urgent patients left emergency within four hours.<sup>8</sup>

Elective surgery performance in 2016-17 is mixed. Nationally the proportion of elective surgery patients treated within clinically indicated treatment timeframes of 90 days improved by five per cent, but performance by jurisdiction varied. From a very low baseline of 43 per cent of Tasmanian elective surgery patients treated within 90 days in 2015-16, there was an improvement to 62 per cent in 2016-17. This notable spike of improvement is welcome - recognising that of course there is still a long way to go. The Northern Territory lifted its performance on this measure from 67 per cent to 79 per cent. This improvement is acknowledged and welcome, but these two smaller jurisdictions and all other jurisdictions bar two (NSW and Qld) are still failing to treat close to all urgent elective surgery patients within the 90 day clinically indicated timeframe.

Without sufficient funding to increase capacity, public hospitals will never meet the targets – past or future – set by governments, and patients will wait longer for treatment.

## Health is an Investment

Health is the best investment that Governments can make. Funding for public hospitals is an essential investment in the health of the Australian population, and therefore in the capacity of Australians to participate in the workforce and as members of society.

In the past, Governments have justified extreme health savings measures, including cuts to public

6 *ibid*

7 AIHW Australian Hospital Statistics: Hospital resources 2015-16, Table 2.7

8 AIHW Australian Hospital Statistics: Emergency department care 2016-17, Table 6.6

9 AIHW, Health Expenditure Australia, 2015-16 Table 3.3

hospital funding, on the basis that Australia's health spending is unsustainable. This falsehood needs to be dismissed, once and for all. There is no evidence to support the contention that Australia has a health spending crisis.

The Government's own health expenditure figures (2015-16)<sup>9</sup> show total health expenditure in Australia (from all sources) has seen three years of modest, sustainable growth, with 3.6 per cent growth in 2015-16, 2.7 per cent in 2014-15 and 3.2 per cent in 2013-14. For the last three years, annual growth has been well below the 4.7 per cent long-term average of the last decade. These growth rates fail to accommodate the reality of predictable and unavoidable growth in demand for public hospital services – especially as health technology advances, average lifespans increase, and the growing burdens of chronic disease escalate. Better managing the nation's health will provide an economic, as well as, a social benefit.

According to the health expenditure report, health spending was 10 per cent of Australia's GDP in 2015-16, which is stable and sustainable when compared with the 10-year average of 9.4 per cent.<sup>10</sup> Australia is below the OECD average and achieves better health outcomes for its significantly lower proportional spend than the USA (17 per cent), and also spends proportionally less than many other countries including the Netherlands, Switzerland, Sweden, Germany and France (all around 11 per cent)<sup>11</sup>.

The Commonwealth Government's total health expenditure continues to reduce as a percentage of the total Commonwealth Budget over the longer term. In the 2017-18 Commonwealth Budget, health was 16.12 per cent of total expenditure, unchanged from the previous year, but down from 18.09 per cent in 2006-07<sup>12</sup>.

The year on year growth in the volume of health goods and services purchased is stagnant – less than 1 per cent. And has been the case for the last four years to 2015-16<sup>13</sup>.

## A Time for Change

The Commonwealth Government had an important opportunity in 2018 to offer an increased level of hospital funding in the 2020 funding agreement. While some State Governments share the blame for under-funding their public hospitals, the Commonwealth's offer to contribute up to 6.5 per cent growth in hospital episodes year on year will not be realised unless State and Territory Governments can find the additional funding to pay the remaining 55 per cent of every additional public hospital episode.

The new funding agreement also imposes new responsibilities on State Governments and public hospitals to become involved in co-ordinating the care of public patients post discharge - especially patients with complex and chronic disease.

The AMA supports increased care coordination on discharge but hospital involvement in this activity will add costs to hospital budgets.

Jurisdictional jostling to gain the upper hand in funding negotiations is only going to let down those who need essential public hospital services.

If the Commonwealth fails to fund primary care properly, it will pay, along with the States and Territories, in increased hospital costs. If the States and Territories fail to put their fair share of funding into public hospitals, then we will experience worse patient outcomes and deteriorating performance which, under current and future funding arrangements, will reduce the year on year growth in Commonwealth funding.

No one wins by playing politics with public hospital funding.

There is also no reason why Governments cannot work out a sensible, practical agreement to ensure public hospitals have sufficient and certain funding over the long term to meet the public's requirements for hospital services, while also seeking new models of care coordination and improvement with primary care.

10 AIHW, Health Expenditure Australia, 2015-16 Table 2.2

11 OECD Statistics, Health Expenditure and Financing <http://stats.oecd.org/Index.aspx?DataSetCode=SHA#> accessed 20 November 2017

12 Commonwealth Budget, Budget Overview 2006-07, 2014-15, 2015-16, 2017-18

13 AIHW Health Expenditure Australia 2015-16, Table 2.5

## Promote performance, not punishment

The new funding agreement continues to 'dock' funding to hospitals for what are deemed 'avoidable readmissions' and 'acquired complications'. We all want hospitals to improve. Doctors take the health of their patients more seriously than anything else. Therefore, the idea that a financial disincentive, applied against the hospital, will somehow 'encourage' doctors and staff to take better care of patients than they already do is ludicrous.

Some complications are unavoidable. Patients are unique and respond to treatment differently. And where complications do arise, albeit rarely, they are almost always due to not having the resources, the staff, or the time. If hospitals are overstretched and under-resourced, errors are more likely to occur and less likely to be recognised or remediated.

Imposing safety and quality penalties to the base year on which Commonwealth growth funding is calculated will not assist these hospitals to lift performance. It will instead entrench a spiralling decline in the hospital's capacity to undertake the internal changes needed to focus on safety and avoid future penalties. The answer is to help struggling hospitals improve.

Embedding in a future hospitals funding agreement the creation of better linkages and improved coordination of care with primary care providers could represent a positive step forward. There is no doubt there is scope to improve the management of people with chronic and complex conditions, in a unified model. Focussing on improving patient reported outcomes and decreasing avoidable demand for public hospital services can be smart policy, if done properly.

These future directions are all worthy concepts, on paper. No one will argue against patient reported outcomes, reduced incidents of low value care and avoidable admissions, or better coordination between a Federally funded primary care system and State and Territory run hospital networks.

What matters is how they are implemented. GPs and our public hospital doctors are overburdened already, but continually expected to take on more. They will need support if there are to be additional requirements put on them. Simply diverting public hospital funding away from essential 'in-hospital services' will not improve patient outcomes and hospital efficiencies, nor will it deliver 'value-based' care. Hospital involvement in integrated care will require additional funds, time, staff and infrastructure. And any moves to focus on patient reported outcomes will need substantial new investment in data infrastructure, definitions and consistency, along with appropriate governance.

Any approach to use the same methods of the past – of simply reducing funding when activity in hospitals doesn't meet the desires of Governments – will be fiercely resisted. And of course, any changes to try to limit private patients in public hospitals must be carefully considered, so as to not in any way impact the rights of private practice, nor undermine the value proposition of private health insurance.

Our public hospitals need adequate, long term funding to improve their performance. Integrating linkages across sectors to improve patient outcomes, and reduce admissions offers potential. But this potential will be difficult to realise unless these new responsibilities are adequately funded and co-designed with those who keep our hospitals working, day in and day out.

This report card is not an attack on any one Government. Rather, it is a call to use the opportunity of a new hospital agreement to properly fund our public hospital system, and empower the hard working doctors, nurses and staff to deliver even better value services to all Australians.



**Dr Michael Gannon**

President

March 2018

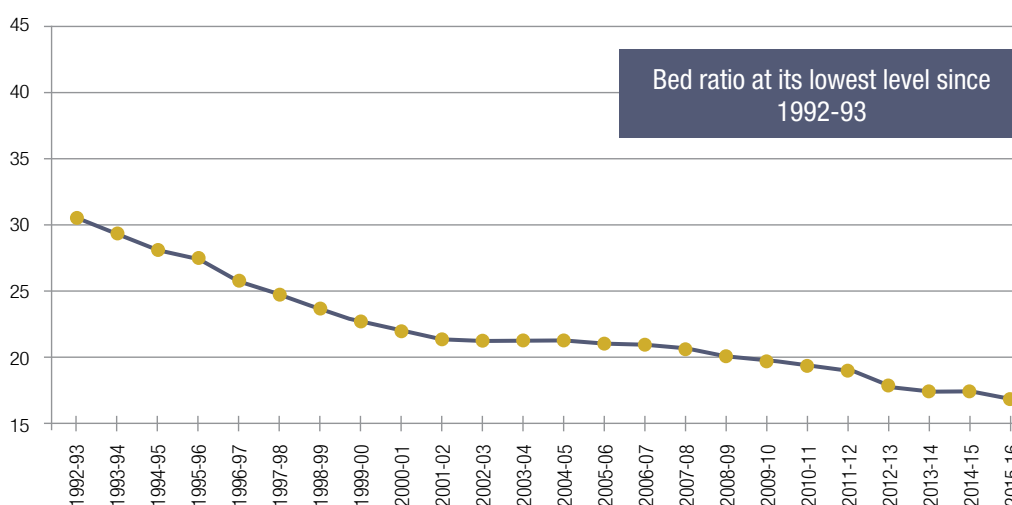
# 1. NATIONAL PUBLIC HOSPITAL PERFORMANCE

## Public hospital capacity

One of the best measures of public hospital capacity is to compare the number of available beds with the size of the population. Nationally, the number of hospital beds grew by 617 in 2015-16. However, in 2015-16, bed numbers as a ratio per 1000 of the general population was static at 2.6 (2.56) – practically unchanged from 2.57 the previous year (2014-15)<sup>14</sup>.

The likelihood of requiring a hospital bed increases with age. On this measure, the ratio of public hospital beds for every 1000 people aged older than 65 years decreased in 2015-16 to 16.9, from 17.2 the previous year. The new low in 2015-16 continues the 23 year trend of year-on-year decline.

**Graph 1: Number of approved/available public hospital beds per 1000 population aged 65 and over**



Sources: Australian Hospital Statistics: ABS: Australian Demographic Statistics March 2017

Public hospital capacity is not keeping pace with population growth and is likely, therefore, to not be able to match the growing demand for hospital services.

14 AIHW Australian Hospital Statistics – Hospital Resources 2015-16, Table 2.7

## Emergency department waiting and treatment times

When the National Health Reform Agreement - National Partnership on Improving Public Hospital Services was terminated in the 2014-15 Federal Budget with effect from 1 July 2015, the emergency department targets and associated performance payments were also abolished<sup>15</sup>.

Public hospital emergency department performance is now measured against the following two indicators:

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

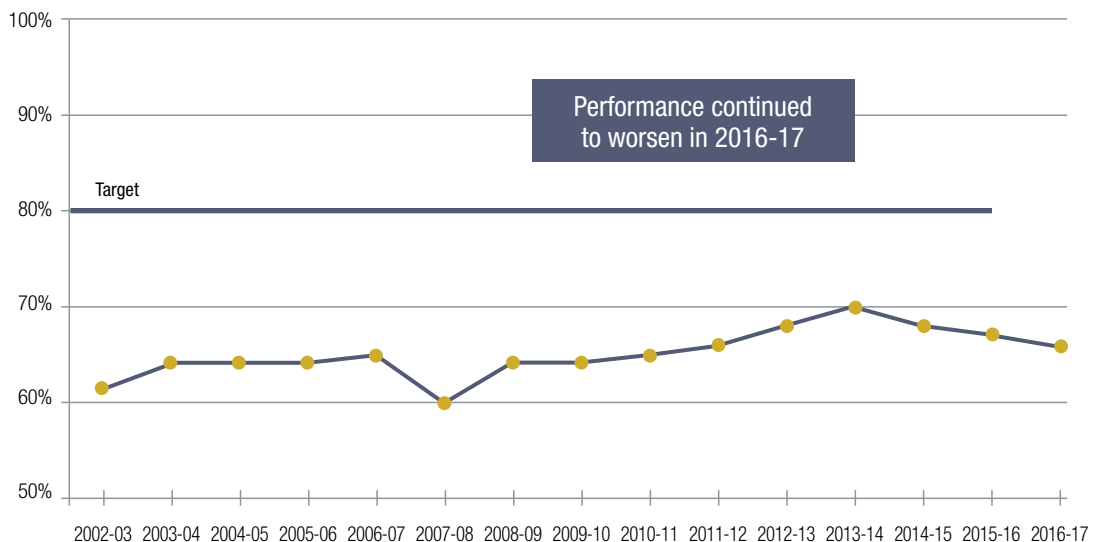
### Patients seen within clinically recommended times

Pressure on public hospital emergency departments continues to increase. In 2016-17, there were 7.8 million presentations to Australian public hospital emergency departments<sup>16</sup>. The number of presentations has risen on average 2.6 per cent each year between 2012-13 and 2016-17<sup>17</sup>.

The stress on public hospitals is shown in the performance statistic in Graph 2 below. Nationally, in 2016-17, only 66 per cent of emergency presentations classified as urgent were seen within the recommended 30 minute timeframe<sup>18</sup>. This is down from 67 per cent the previous year.

One third of the 2.8 million patients who needed urgent treatment<sup>19</sup> were not seen within the recommended 30 minutes. This is notable.

**Graph 2: Percentage of Category 3 (urgent) emergency department patients seen within recommended time**



Source: The State of our Public Hospitals (DoHA 2004-2010); AIHW Australian Hospital Statistics: Emergency Department Care (2010-11 – 2016-17)

15 PBO submission to the Senate Select Committee on Health, 3 February 2016, p4

16 AIHW Australian Hospital Statistics: Emergency Department Care 2016-17, Table 2.5

17 AIHW Australian Hospital Statistics: Emergency Department Care 2016-17, Table 2.5 (adjusted for changes in coverage)

18 Australian Hospital Statistics: Emergency department care 2010-11 to 2016-17, Table 5.2

19 AIHW Australian Hospital Statistics: Emergency Department Care 2016-17, Table S5.1: Emergency presentation(a) statistics by public hospital peer group and triage category, public hospital emergency departments, states and territories, 2016-17, data table: Excel spreadsheet, viewed 11 January 2018 <<https://www.aihw.gov.au/getmedia/26f61fe3-8611-4861-8ad2-b32b409b6d95/aihw-hse-194-data-tables.xlsx.aspx>>



Hospital performance against this measure had been trending upward, from a low of 60 per cent in 2007-08 to a peak of 70 per cent in 2013-14. In May 2014 the government announced that the National Health Reform National Partnership on improving Public Hospital Services – and the associated performance payments – would be terminated with effect from 1 July 2015. Since then, performance has trended downward.

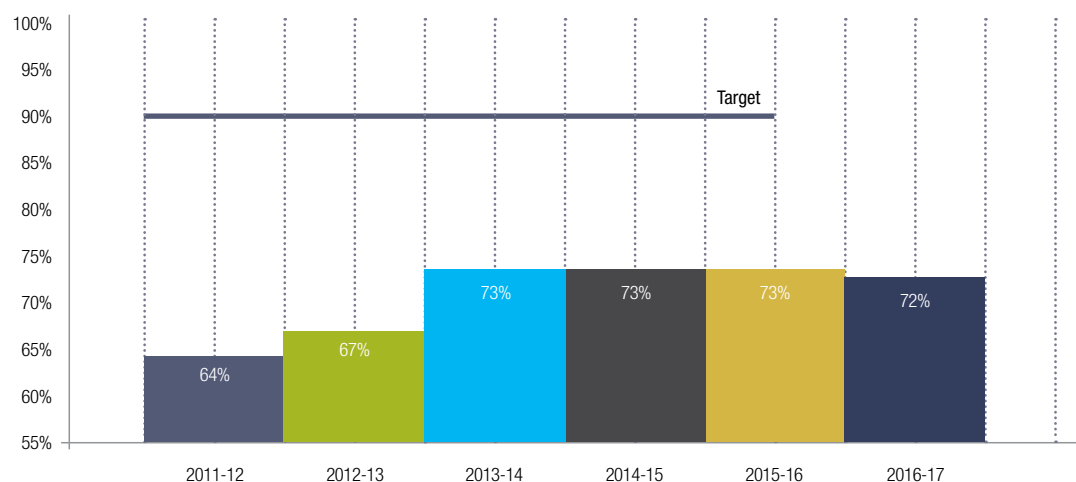
## Patients leaving within four hours

The proportion of emergency department presentations completed within four hours is a National Health Agreement performance indicator. This performance measure is considered indicative of whether ‘Australians receive appropriate high quality and affordable hospital and hospital related care.’<sup>20</sup>

Patients are considered to have completed their visit to the emergency department when they physically leave (regardless of whether they were admitted to the hospital, were referred to another hospital, were discharged, or left the hospital at their own risk), not when the non-admitted component of care ends.<sup>21</sup>

In 2016-17 the percentage of people (all triage categories) who completed their emergency presentation within four hours or less fell to 72 per cent, down from 73 per cent in each of the previous three years.

**Graph 3: National performance – proportion of presentations to emergency with a length of stay 4 hours or less – Australia**



Source: AIHW Australian Hospitals Statistics: Emergency department care 2011-12 to 2016-17 Table 6.5  
National Emergency Admission Targets were abolished with effect from 1 July 2015

When the proportion of patients leaving emergency within four hours is considered by clinical urgency, the 2016-17 data shows patients least likely to meet this performance target are the sickest. For example, only 57 per cent of resuscitation patients, 58 per cent of emergency patients, and 64 per cent of urgent patients left the emergency department within four hours.<sup>22</sup> This suggests there could be systemic barriers or resource constraints that prevent the most seriously ill patients from being transferred out of a busy emergency department to an appropriate ward for ongoing care.

<sup>20</sup> AIHW Australian Hospital Statistics: Emergency Department Care 2016-17, Part 6.2 p64

<sup>21</sup> *ibid*

<sup>22</sup> AIHW Australian Hospital Statistics: Emergency Department Care 2016-17, Table 6.6

## Elective surgery waiting and treatment times

Elective surgery is any form of surgery considered medically necessary, but which can be delayed for at least 24 hours.

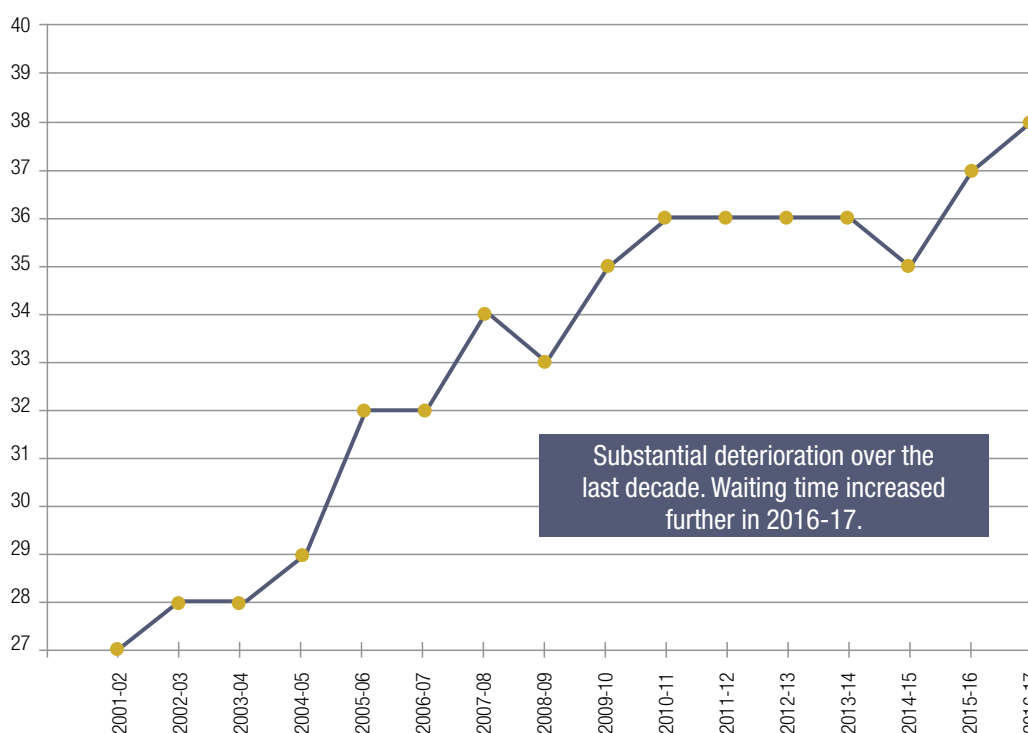
Since 1 July 2015, there have been no national agreed targets for elective surgery treatment timeframes linked to Commonwealth performance funding<sup>23</sup>. The decision to set targets for public hospitals now rests with hospital managers in each jurisdiction. The AIHW continues to publish the following two indicators that measure the performance of public hospitals to provide timely care to patients requiring elective surgery:

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

### Median waiting time

The graph below shows that nationally, the median waiting time – the time within which half of all patients waiting for elective surgery are treated – continues to trend higher, topping 38 days in 2016–17. This is the longest median waiting time since 2001–02.

**Graph 4: Median waiting time for elective surgery (days) - national**



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: Elective Surgery Waiting Times 2007-08 to 2016-17, Table 4.2

<sup>23</sup> National Health Reform Agreement - National Partnership on Improving Public Hospital Services was terminated in the 2014-15 federal budget with effect from 1 July 2015

The 2016-17 result should not be surprising given elective surgery admissions per 1,000 of the general population, after adjusting for population growth, increased on average by 1 per cent per year over the last five years<sup>24</sup>. Increased demand and static bed ratios per 1,000 general population, combined with declining bed ratios for the growing number of high users aged 65 and over, is clearly hindering the ability of public hospitals to meet demand.

## Elective surgery within clinically recommended timeframes

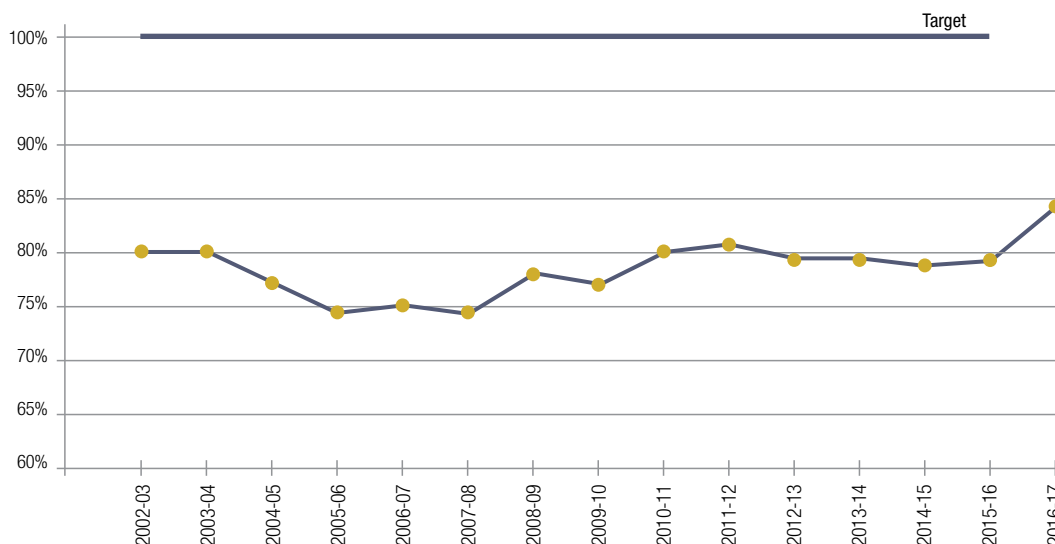
There are three elective surgery clinical urgency categories:

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

In 2016-17, at a national level (all States and Territories), the allocation of elective surgery admissions across the three clinically indicated categories was relatively even. Category 1 accounted for 28 per cent of elective surgery admissions, Category 2 (38 per cent) and Category 3 (34 per cent).

On average across all States and Territories, 84 per cent of elective surgery patients allocated to Category 2 were admitted within the clinically recommended timeframe (90 days). While this is a five per cent improvement in national performance compared to the previous year, approximately one in 10 patients in 2016-17 who were clinically indicated to receive treatment within 90 days waited longer than recommended<sup>25</sup>. Performance varies substantially between jurisdictions (see part 2 of this report).

**Graph 5: Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – all States and Territories**



Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National Emergency Access and Elective Surgery Targets 2012; AIHW Australian Hospital Statistics 2015-16 and 2016-17: Elective Surgery Waiting Times.

24 AIHW Australian Hospital Statistics: Elective Surgery Waiting Times 2016-17, p(vii)

25 The allocation of patients between clinical urgency categories may vary between States and Territories. AIHW Australian Hospital Statistics: Elective Surgery Waiting Times 2016-17, p56.

## The hidden waiting list

Elective surgery waiting list data hide the actual times that patients are waiting to be treated in the public hospital system.

The time that patients wait - from when they are referred by their general practitioner to actually seeing a specialist for assessment - is not counted. It is only after patients have seen the specialist that they are added to the official waiting list. This means that the publicly available elective surgery waiting list data actually understate the real time people wait for surgery. Some people wait longer for assessment by a specialist than they do for surgery.

The AMA is pleased to note the AIHW is working towards the collection and publication of this data to provide Australians with a picture of waiting times for elective surgery that corresponds with their actual experience<sup>26</sup>.

## Commonwealth funding

In its 2014-15 Budget, the Commonwealth Government made savings of \$1.8 billion over four years from 2014-15 by abandoning the funding guarantees made under the *National Health Reform Agreement 2011*, and revising Commonwealth Public Hospital funding arrangements from 1 July 2017.

In April 2016, COAG signed an interim *Heads of Agreement on Public Hospital Funding* setting out arrangements for public hospital funding up to June 2020. The Agreement included additional Commonwealth funding of \$2.9 billion over this period. In March 2017, COAG signed a further Addendum to the National Health Reform Agreement in which the Commonwealth commits to meet 45 per cent of public hospital services from 2017-18 onwards (with growth funding capped at 6.5 per cent per annum).

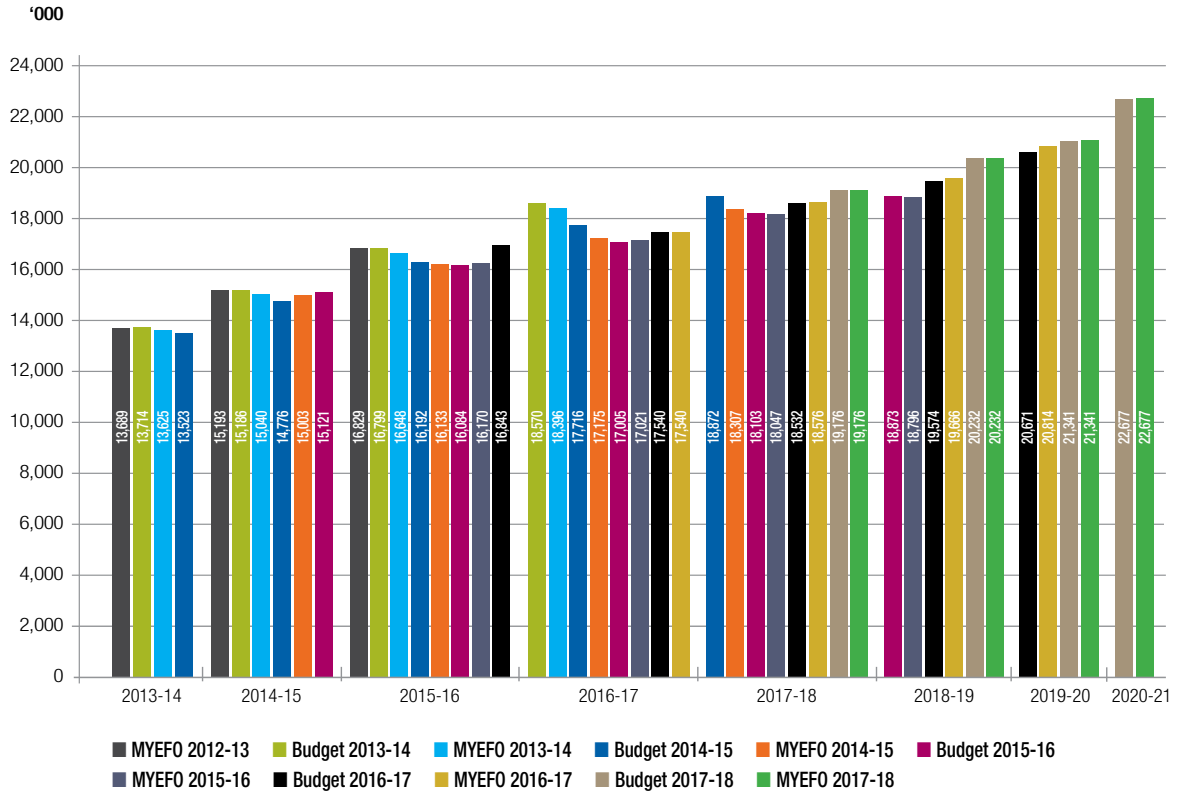
Within this capped Commonwealth funding envelope, from 1 July 2017 some States and Territories have agreed to pilot new innovative models of coordinated care across the admitted/primary sector boundary for people with chronic and complex conditions. Data collection and reporting requirements on these new initiatives are imposed.

Funding penalties associated with safety and quality will also apply. From 1 July 2017, there is zero Commonwealth funding for every admitted sentinel event and, from 1 July 2018, reduced Commonwealth funding for admitted episodes associated with a hospital acquired complication and avoidable readmissions.

The following graph tracks Commonwealth funding for public hospitals as reported in the Commonwealth Budget and Mid-Year Economic Financial Outlook (MYEFO) papers. Note: 2017-18 Budget and MYEFO figures are the same due to the 'knock on' effect of a delay in finalising Commonwealth funding in previous years.

<sup>26</sup> AIHW Australian Hospital Statistics: Elective Surgery Waiting Times 2016-17 p29

**Graph 6 Commonwealth funding for public hospitals**



Sources: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

## 2. STATE-BY-STATE PUBLIC HOSPITAL PERFORMANCE

This section includes performance information for each State and Territory using available data sources.

A summary of State and Territory performance is shown in Table 1. It represents 2016-17 performance compared to the previous year.

**Table 1: State and Territory Performance 2016-17 compared to previous year**

State/Territory	Improved access to emergency treatment – urgent category (within 30 mins) 2016-17	Improvement in proportion of patients leaving emergency within 4 hours	Improvement in median wait time for elective surgery (all categories) 2016-17	Improvement in Elective Surgery Category 2* – patients seen on time 2016-17	MYEFO 2017-18 increased Commonwealth funding for 2017-18 over budget 2017-18 <sup>27</sup>
NSW	static	static	✓	static	not finalised
VIC	✗	static	static	✓	not finalised
QLD	✗	✗	✗	✓	not finalised
WA	✗	✗	✗	✗	not finalised
SA	✗	✗	✓	static	not finalised
TAS	✗	✗	✓	✓	not finalised
ACT	n/a	n/a	n/a	n/a	not finalised
NT	✓	static	✓	✓	not finalised

AIHW Australian Hospital Statistics: elective surgery waiting times 2015-16 to 2016-17; AIHW Australian Hospital Statistics: emergency department care 2015-16 to 2016-17

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

✓ or ✗ indicates a change of 1% or more compared to 2015-16. \*

SA performance between 2015-16 and 2016-17 fell by 0.9%.

ACT 2015-16 data not supplied.

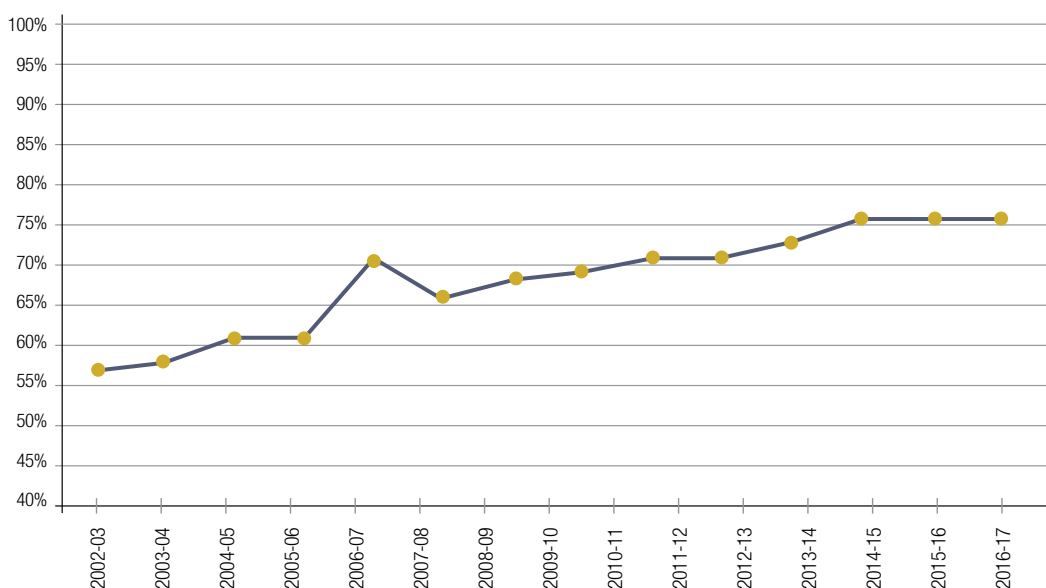
<sup>27</sup> Temporarily in abeyance until Commonwealth payments to States for previous years are finalised.

# NEW SOUTH WALES

## Emergency department

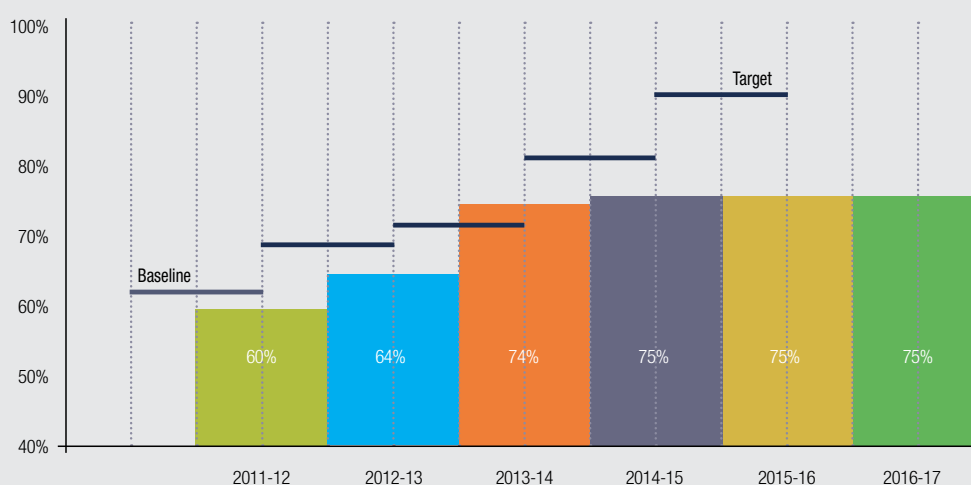
### Waiting times

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – NSW



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: emergency department care (2010-11 – 2016-17)

### Percentage of emergency department visits completed in four hours or less – NSW

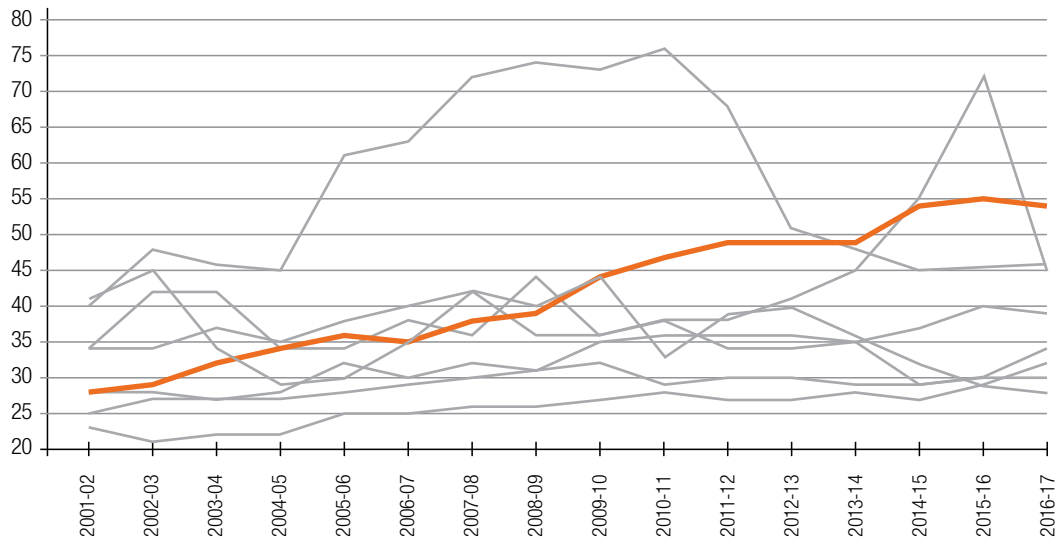


Source: Australian Hospitals Statistics 2011-12 to 2016-17: emergency department care (AIHW)  
National Emergency Access Targets were abolished with effect from 1 July 2015

## Elective surgery

### Waiting times

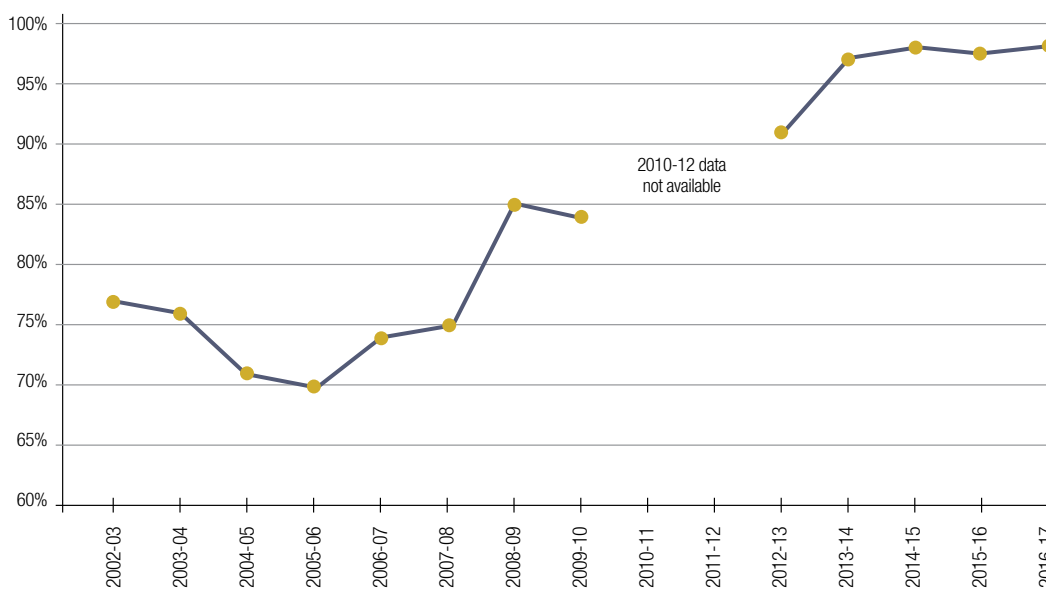
Median waiting time for elective surgery (days) – NSW (compared to other states)



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: elective surgery waiting times (2007-08 to 2016-17)

### Category 2 patients

Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – NSW

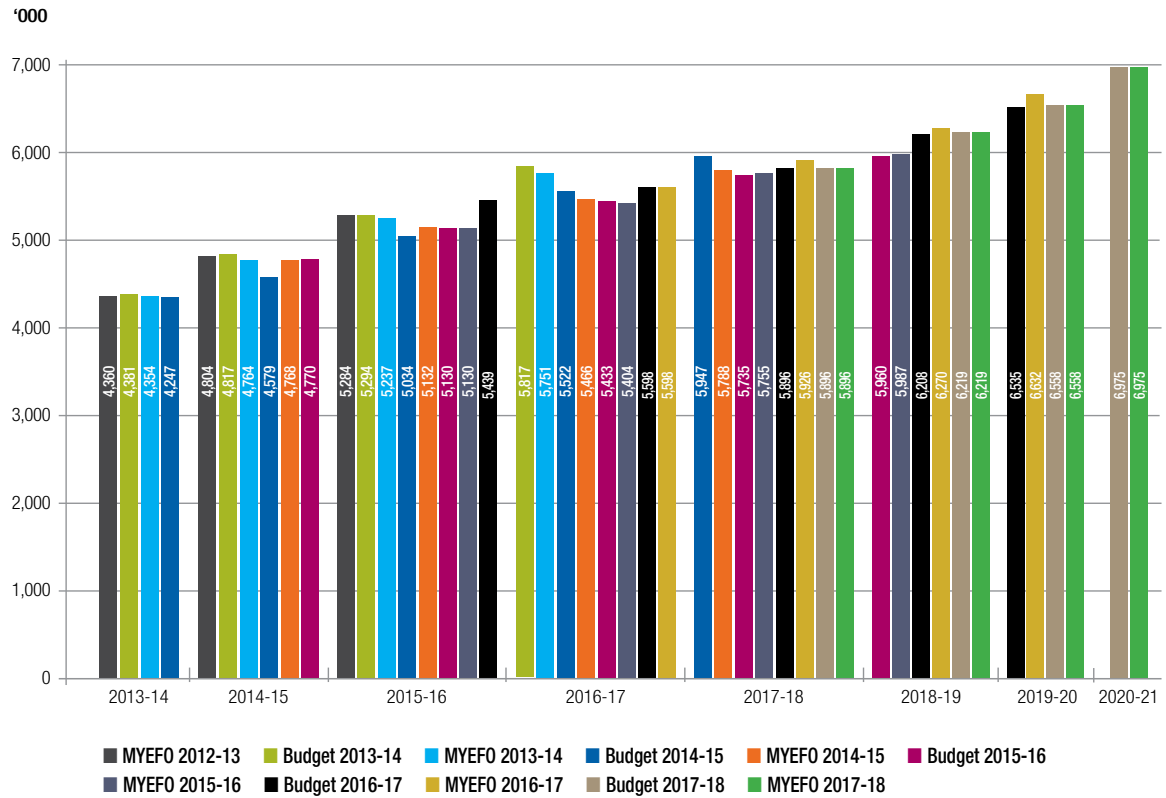


Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National emergency access and elective surgery targets 2012; AIHW Australian Hospital Statistics 2015-16 – 2016-17: Elective surgery waiting times.



# Commonwealth Funding

## Public Hospitals – NSW



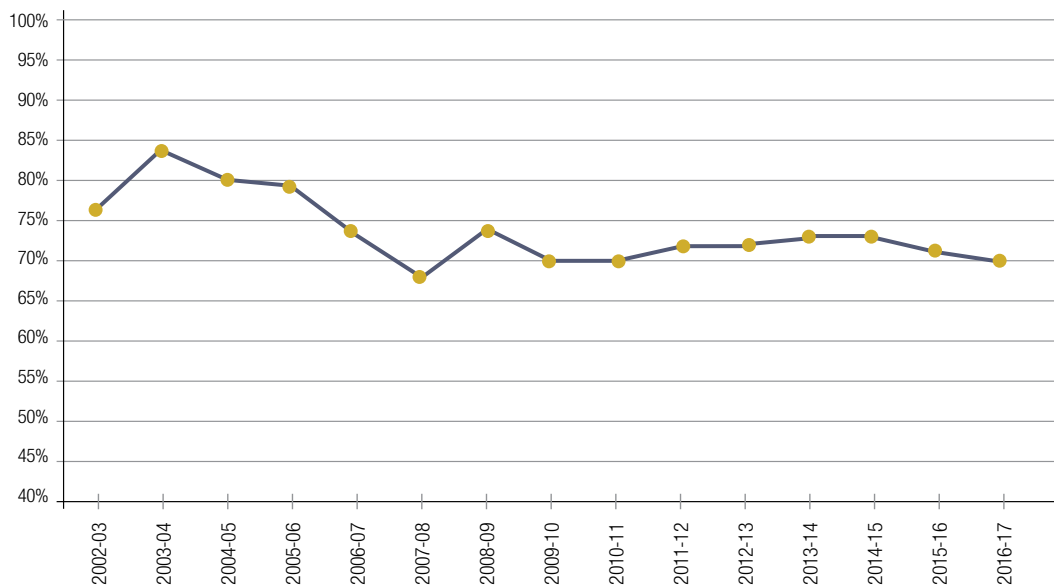
Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

# VICTORIA

## Emergency department

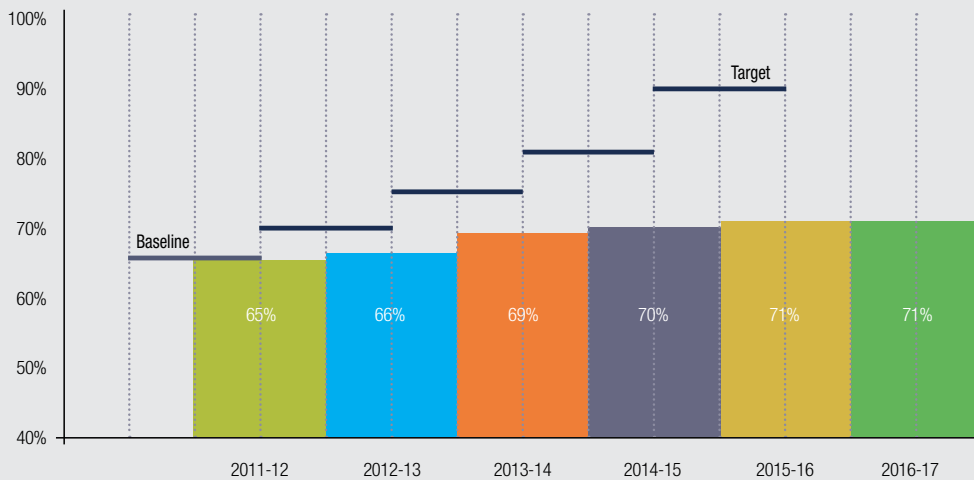
### Waiting times

Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (<30 minutes) – VIC



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: emergency department care (2010-11 – 2016-17)

### Percentage of emergency department visits completed in four hours or less – VIC

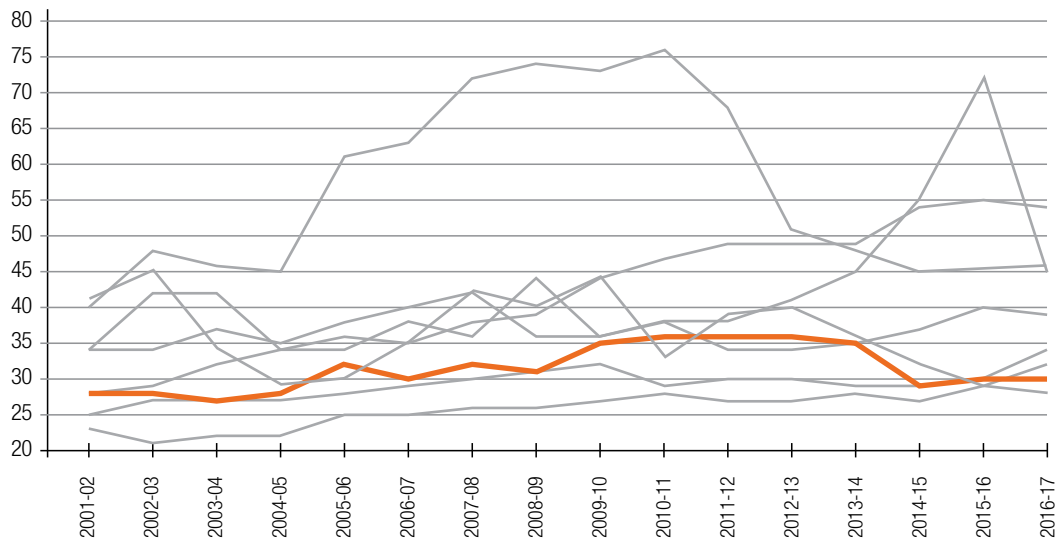


Source: Australian Hospitals Statistics 2011-12 to 2016-17: emergency department care (AIHW)  
National Emergency Access Targets were abolished with effect from 1 July 2015

## Elective surgery

### Waiting times

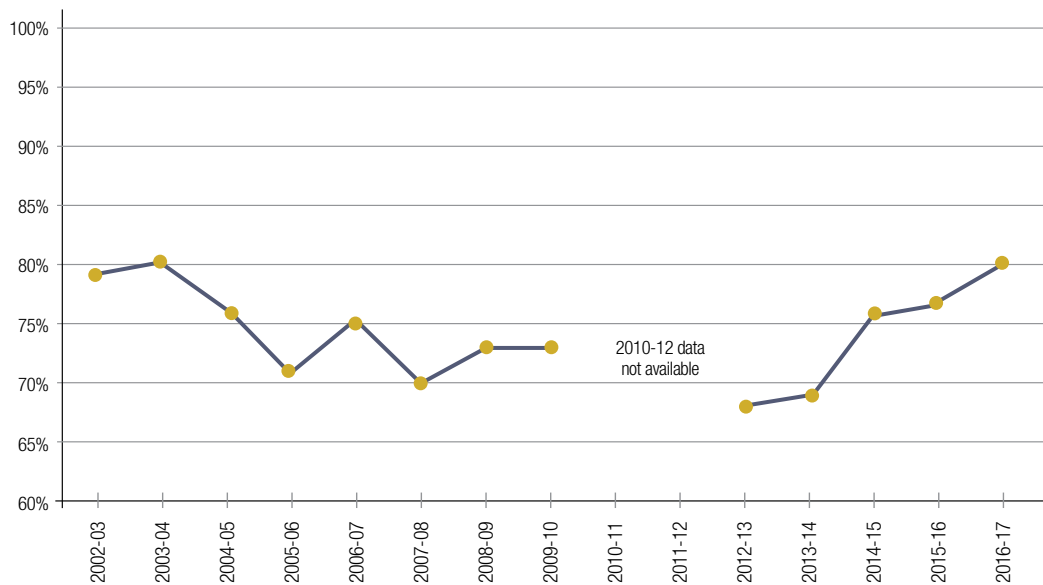
#### Median waiting time for elective surgery (days) – VIC (compared to other states)



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: elective surgery waiting times (2007-08 to 2016-17)

### Category 2 patients

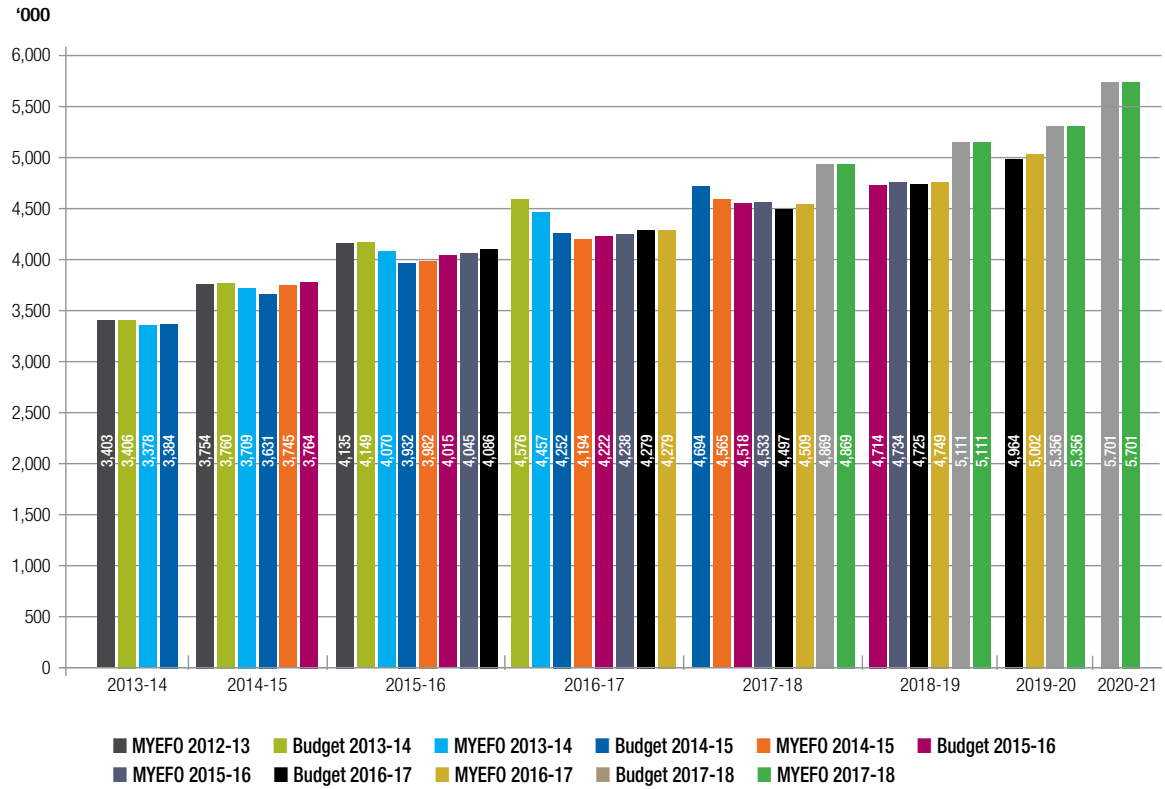
#### Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – VIC



Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National emergency access and elective surgery targets 2012; AIHW Australian Hospital Statistics 2015-16 to 2016-17: Elective surgery waiting times

## Commonwealth Funding

### Public Hospitals – Victoria



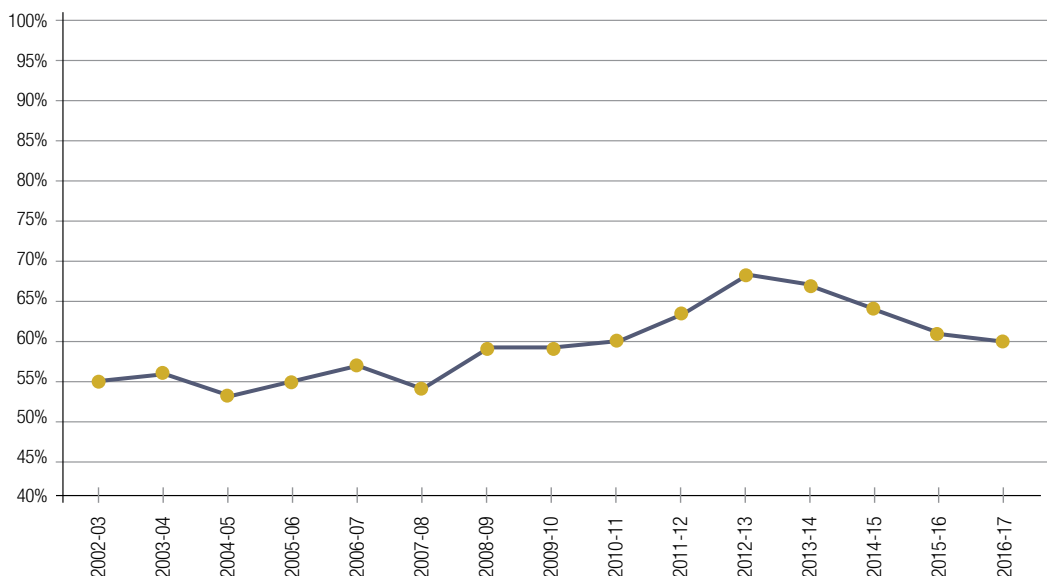
Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

# QUEENSLAND

## Emergency department

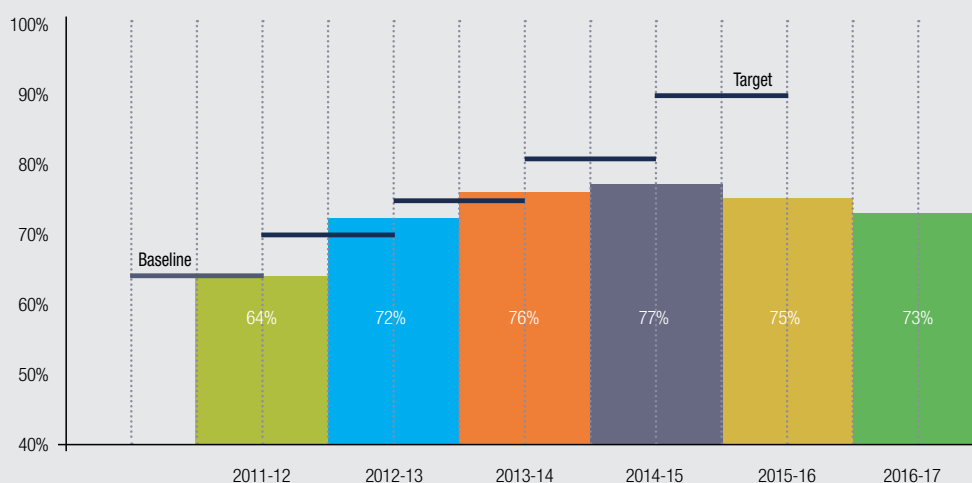
### Waiting times

Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (<30 minutes) – QLD



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: emergency department care (2010-11 – 2016-17)

### Percentage of emergency department visits completed in four hours or less – QLD

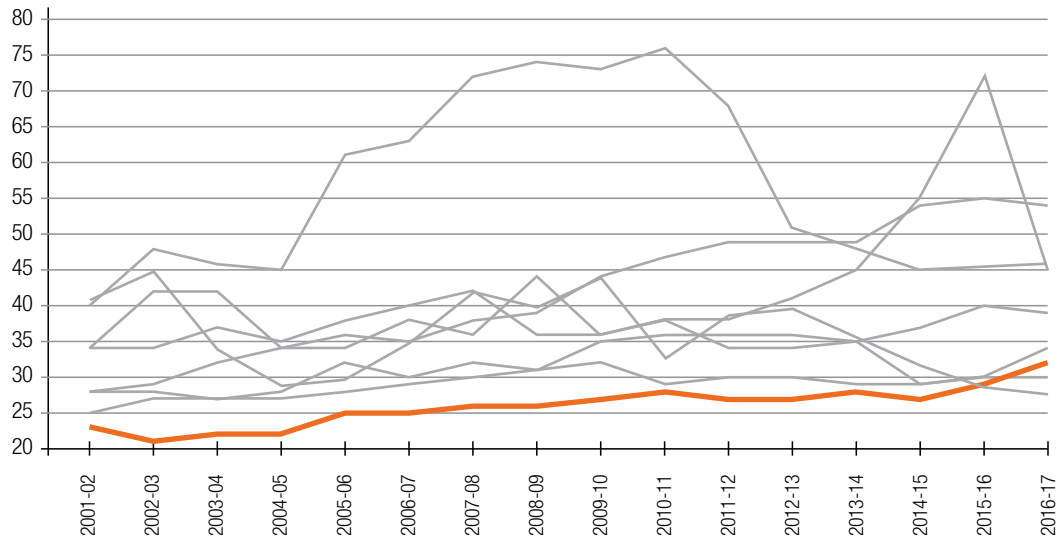


Source: Australian Hospitals Statistics 2011-12 to 2016-17: emergency department care (AIHW)  
National Emergency Access Targets were abolished with effect from 1 July 2015

## Elective surgery

### Waiting times

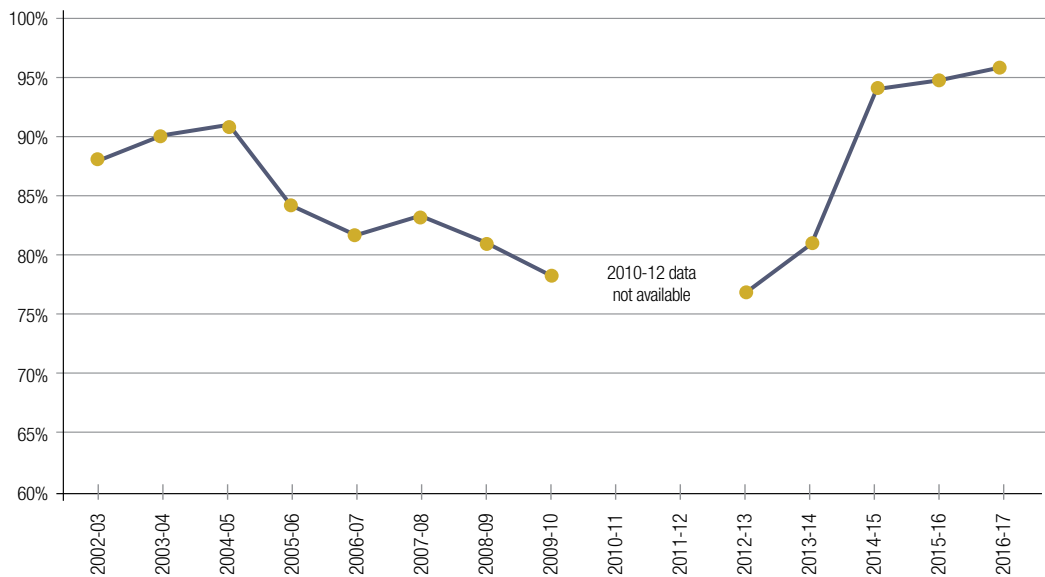
Median waiting time for elective surgery (days) – QLD (compared to other states)



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: elective surgery waiting times (2007-08 to 2016-17)

### Category 2 patients

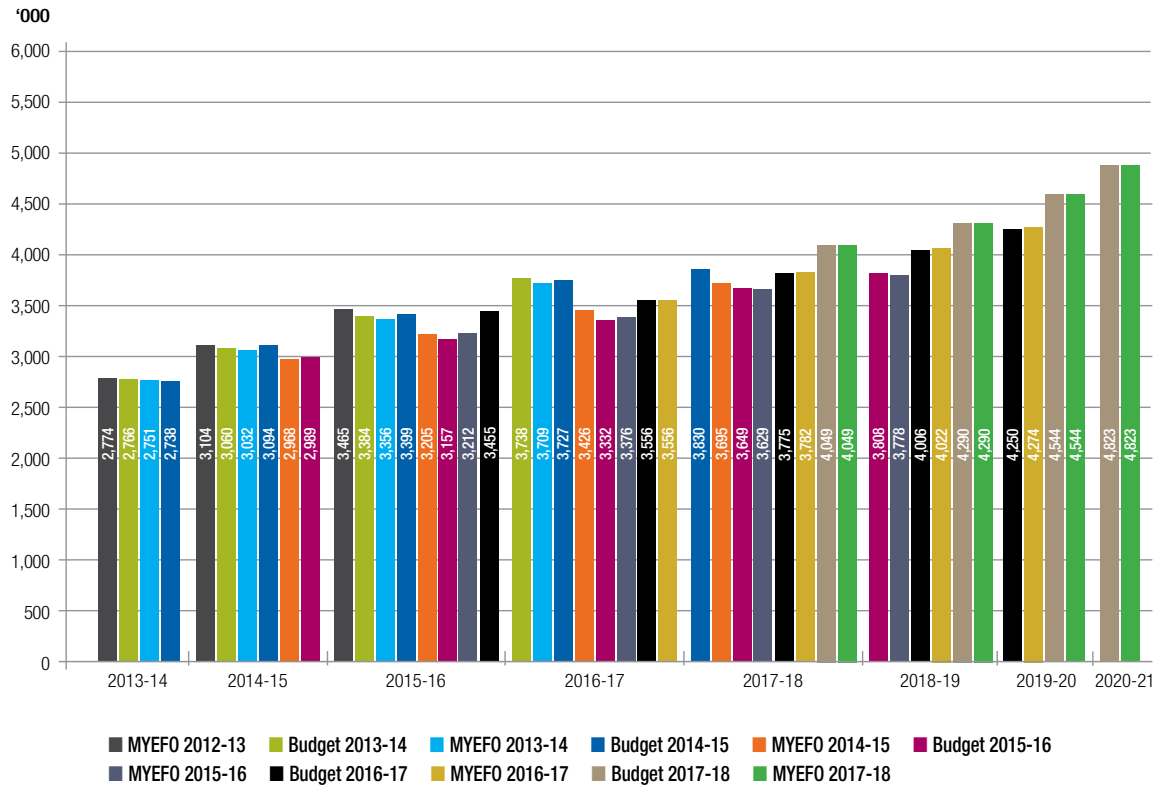
Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – QLD



Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National emergency access and elective surgery targets 2012; AIHW Australian Hospital Statistics 2015-16 and 2016-17: Elective surgery waiting times

# Commonwealth Funding

## Public Hospitals – QLD



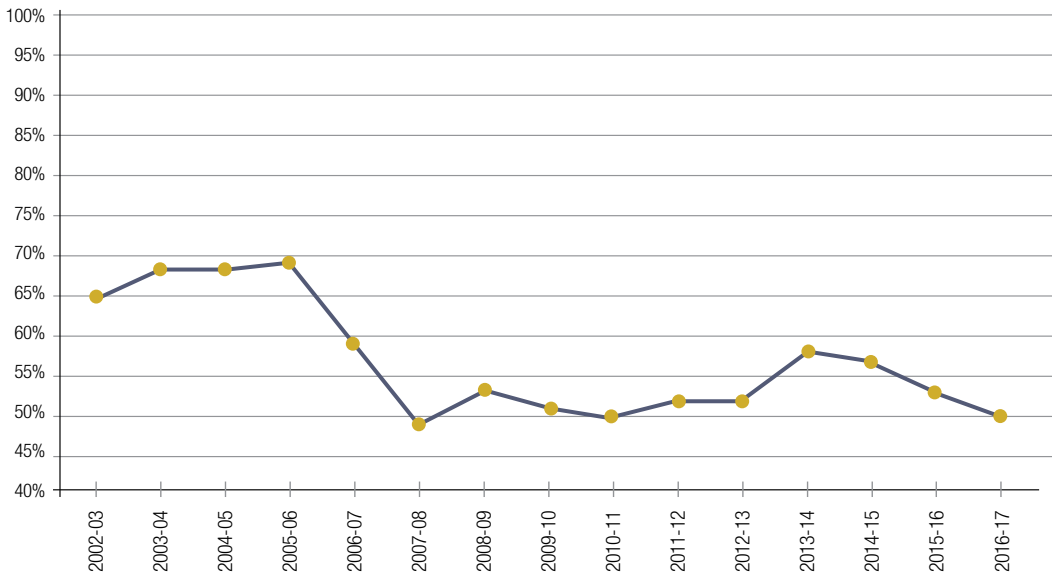
Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

# WESTERN AUSTRALIA

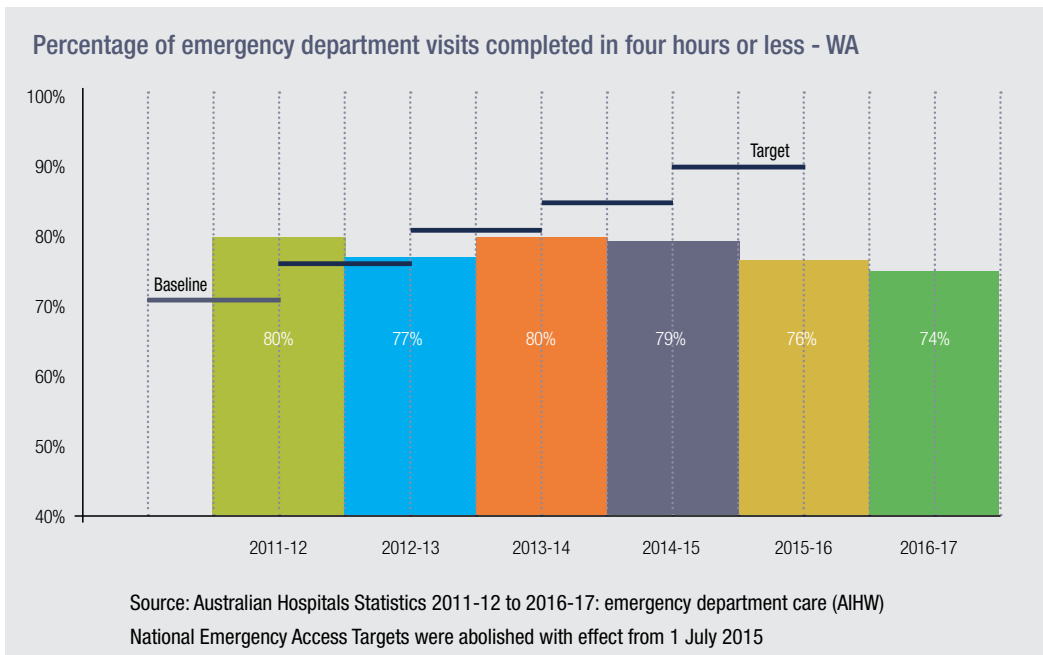
## Emergency department

### Waiting times

Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (<30 minutes) – WA



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: emergency department care (2010-11 – 2016-17)



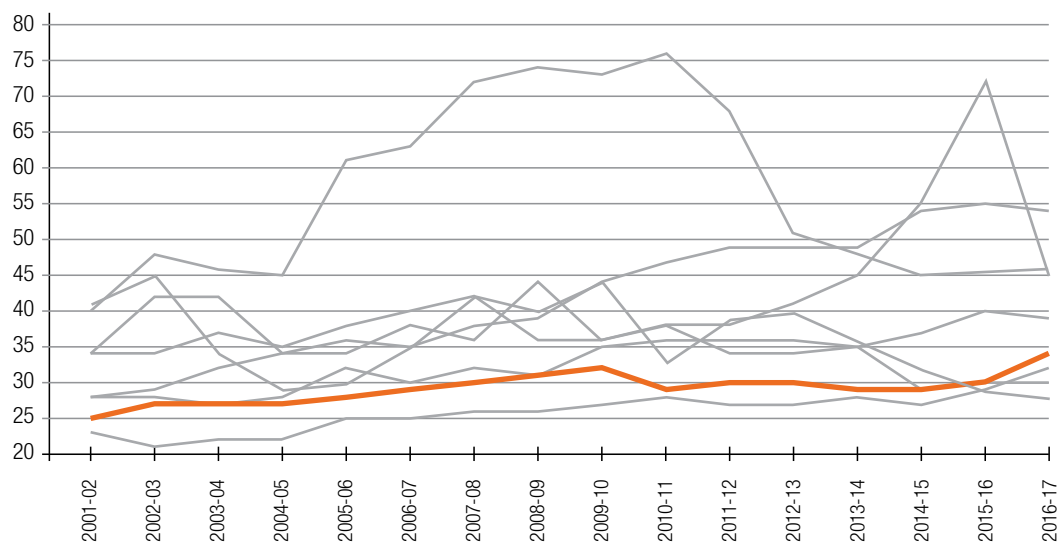
Source: Australian Hospitals Statistics 2011-12 to 2016-17: emergency department care (AIHW)  
National Emergency Access Targets were abolished with effect from 1 July 2015



## Elective surgery

### Waiting times

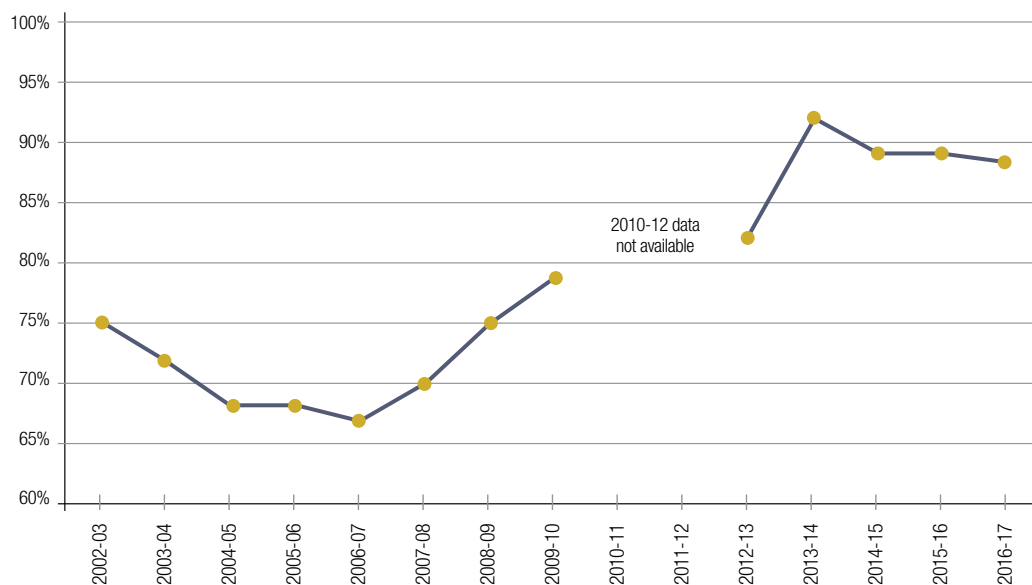
#### Median waiting time for elective surgery (days) – WA (compared to other states)



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: elective surgery waiting times (2007-08 to 2016-17)

### Category 2 patients

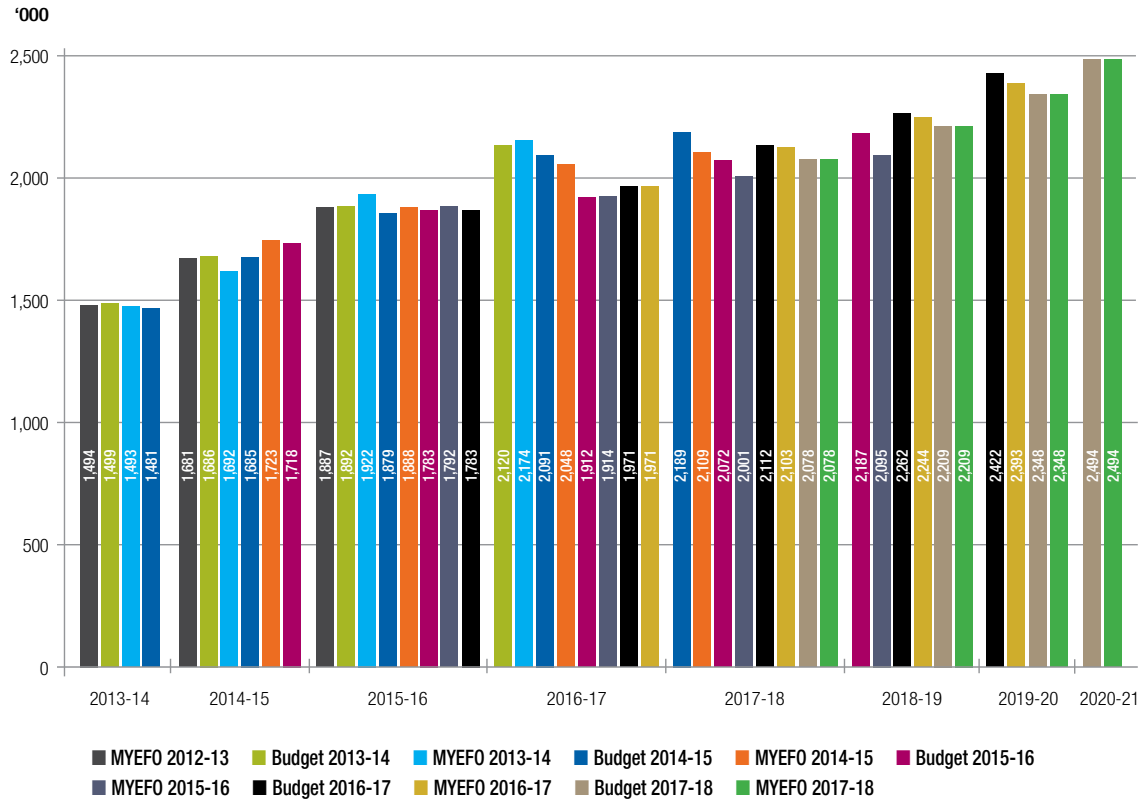
#### Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – WA



Sources: 004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National emergency access and elective surgery targets 2012; AIHW Australian Hospital Statistics 2015-16 – 2016-17: Elective surgery waiting times

## Commonwealth Funding

### Public Hospitals – WA



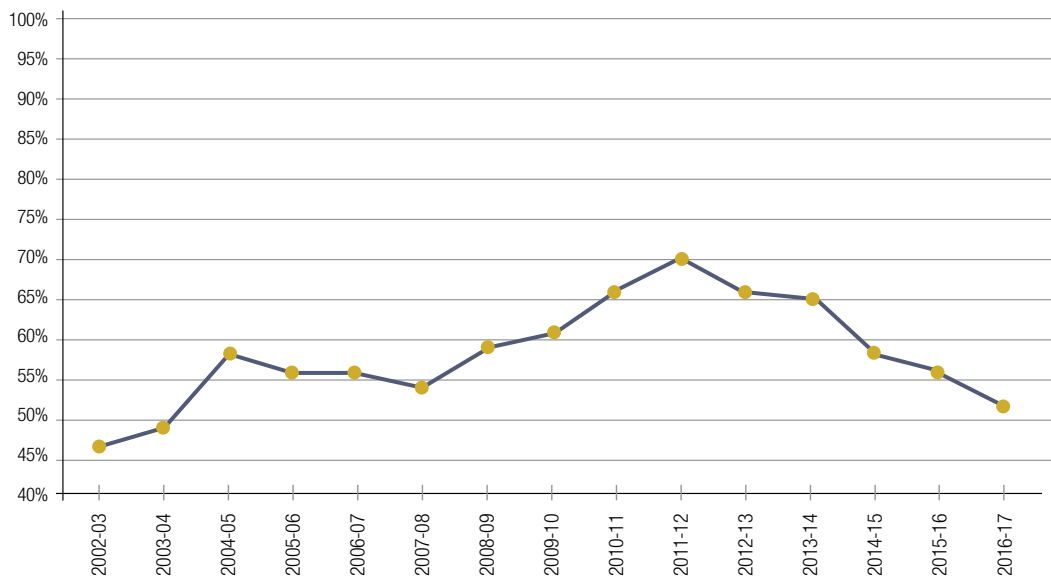
Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

# SOUTH AUSTRALIA

## Emergency department

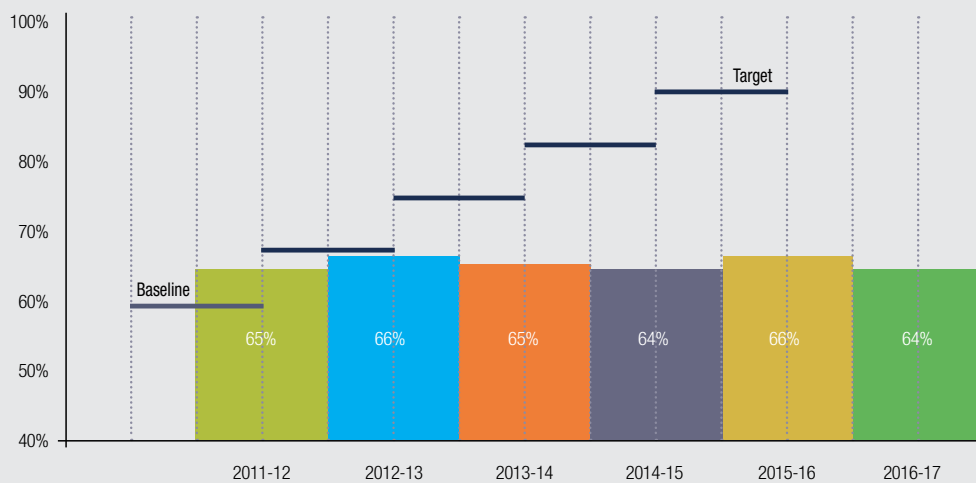
### Waiting times

Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (<30 minutes) – SA



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: emergency department care (2010-11 – 2016-17)

### Percentage of emergency department visits completed in four hours or less – SA

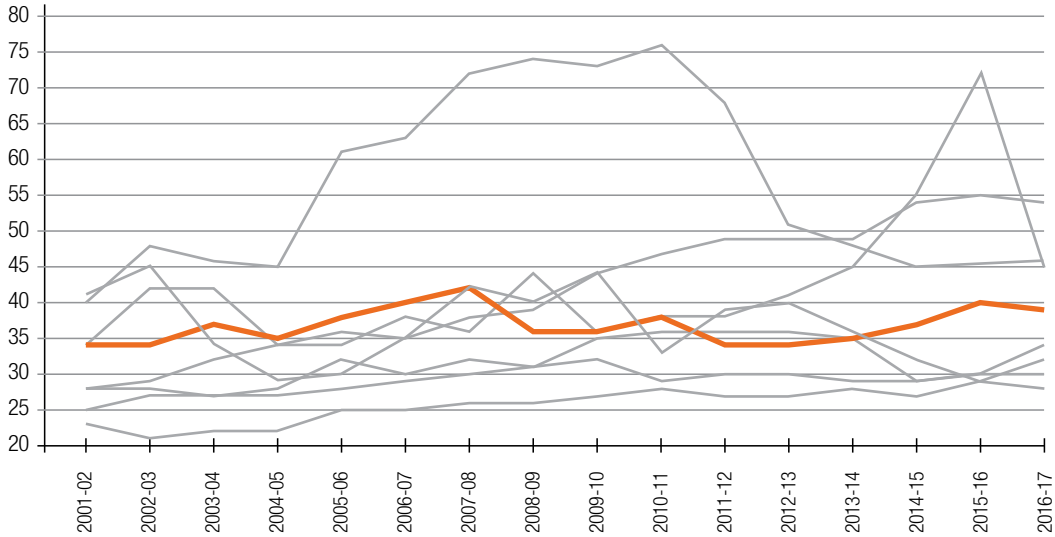


Source: Australian Hospitals Statistics 2011-12 to 2016-17: emergency department care (AIHW) National Emergency Access Targets were abolished with effect from 1 July 2015

## Elective surgery

### Waiting times

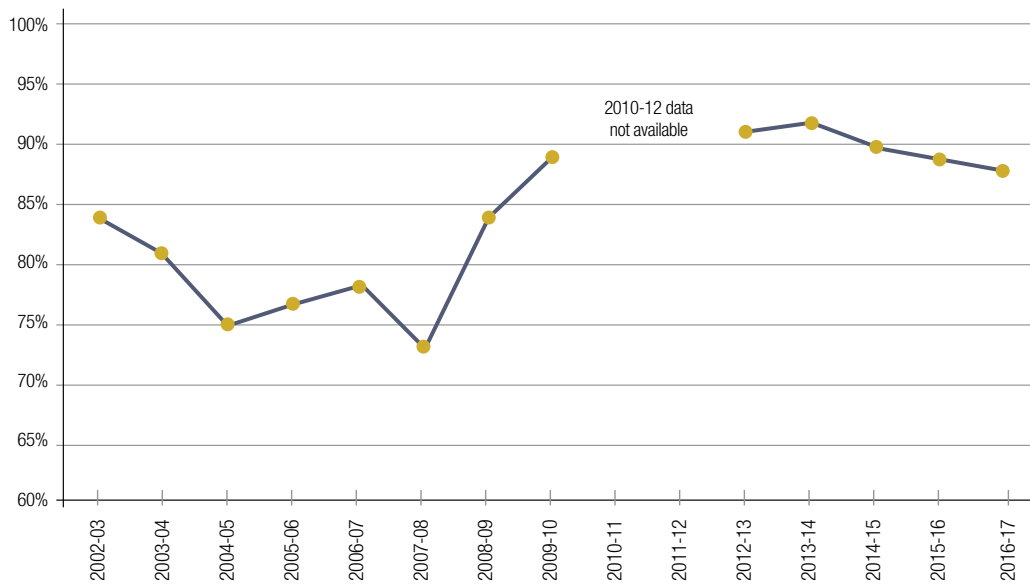
#### Median waiting time for elective surgery (days) – SA (compared to other states)



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: elective surgery waiting times (2007-08 to 2016-17)

### Category 2 patients

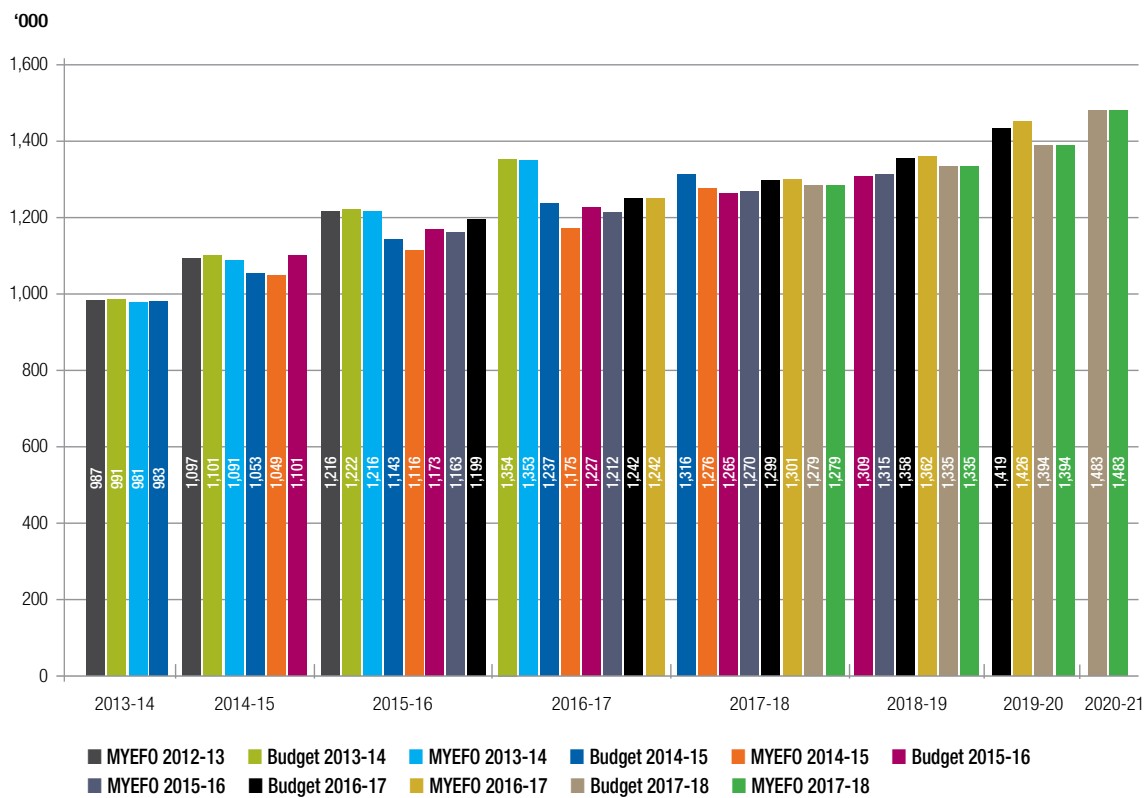
#### Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – SA



Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National emergency access and elective surgery targets 2012; AIHW Australian Hospital Statistics 2015-16 – 2016-17: Elective surgery waiting times

## Commonwealth Funding

### Public Hospitals – SA



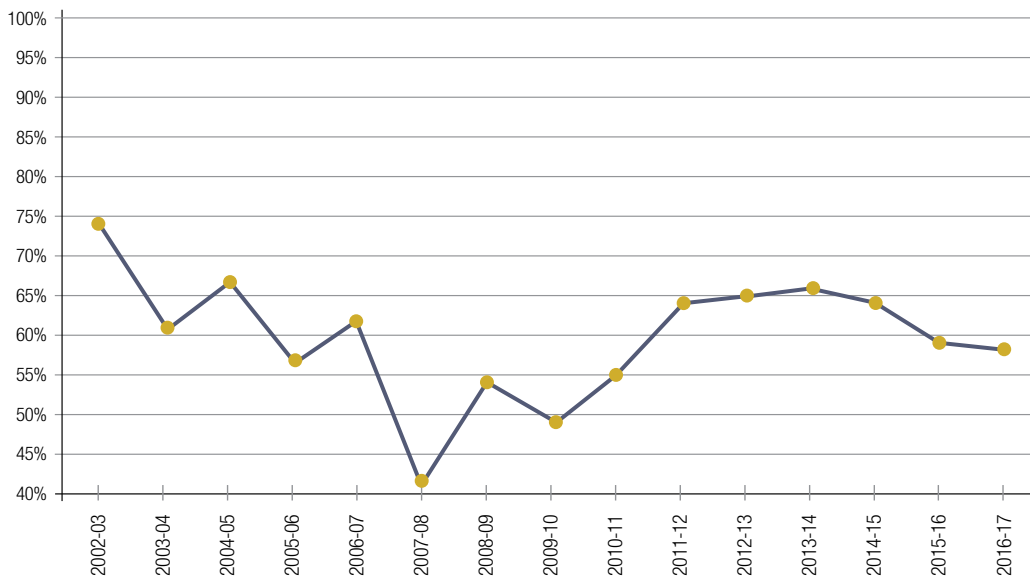
Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

# TASMANIA

## Emergency department

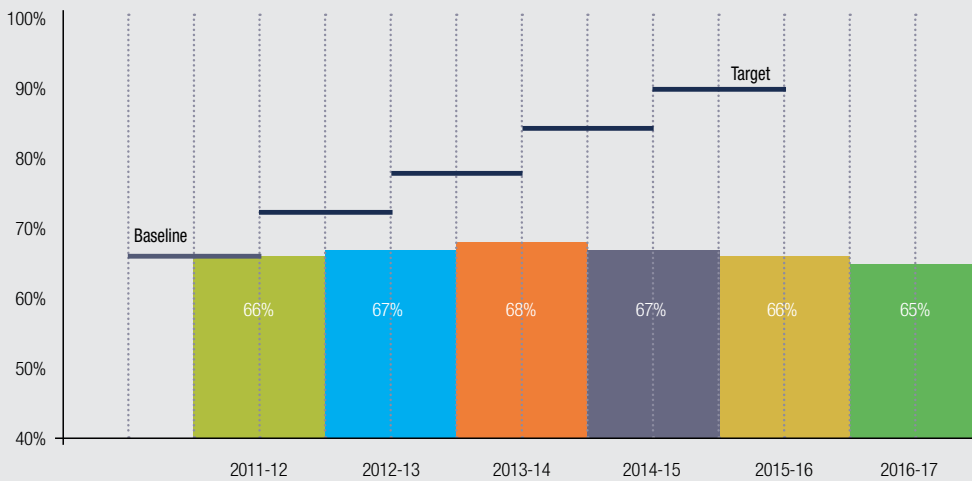
### Waiting times

Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (<30 minutes) – TAS



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: emergency department care (2010-11 – 2015-16)

Percentage of emergency department visits completed in four hours or less – TAS

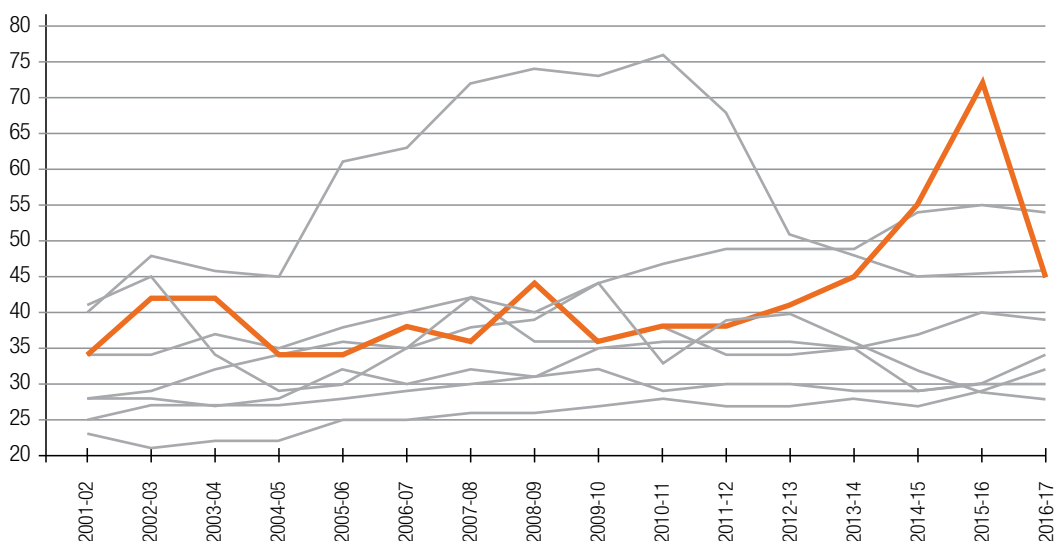


Sources: Australian Hospitals Statistics 2011-12 to 2016-17: emergency department care (AIHW)  
 Note: National Emergency Access Targets were abolished with effect from 1 July 2015

## Elective surgery

### Waiting times

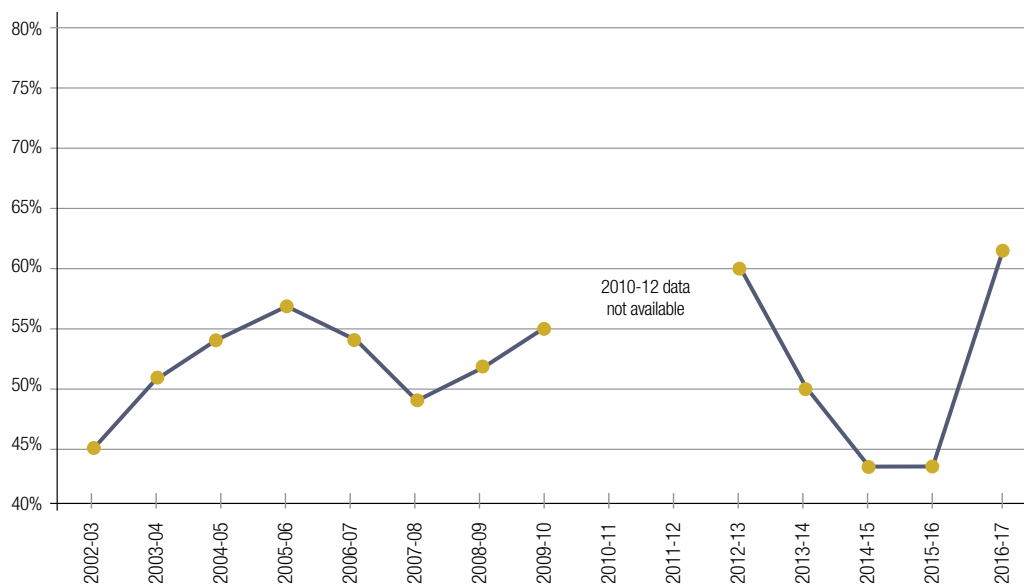
Median waiting time for elective surgery (days) – TAS (compared to other states)



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: elective surgery waiting times (2007-08 to 2016-17)

### Category 2 patients

Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – TAS

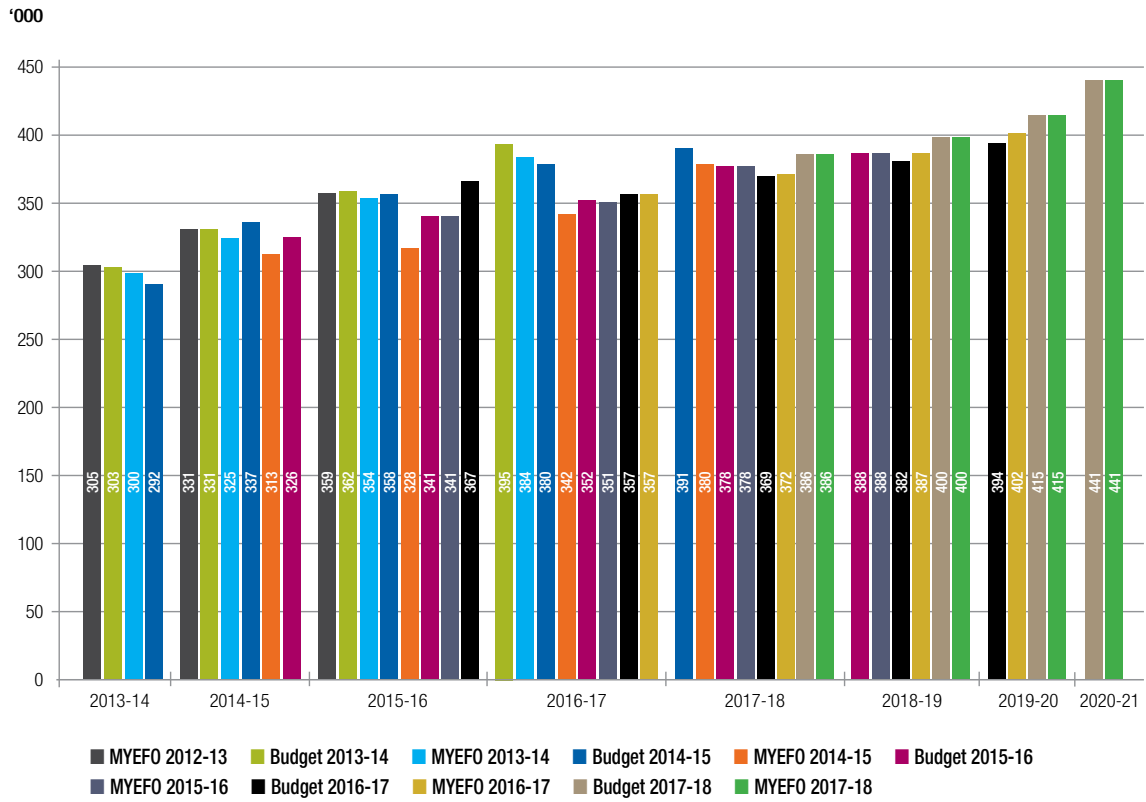


Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National emergency access and elective surgery targets 2012; AIHW Australian Hospital Statistics: Elective surgery waiting times 2015-16 – 2016-17

Note: The AMA notes the advice from the Tasmanian government in regard to the observed spike in the elective surgery statistics in 2015-16, which they attributed to their significant investment to reduce elective surgery waiting times, getting patients off waiting lists and in doing so increasing measured median waiting times.

## Commonwealth Funding

### Public Hospitals – TAS



Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

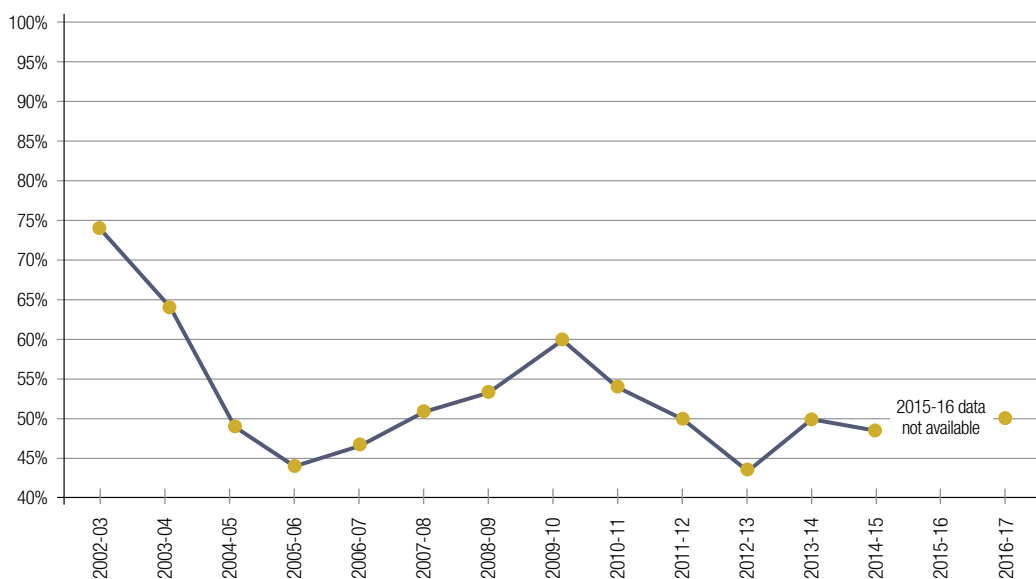


# AUSTRALIAN CAPITAL TERRITORY

## Emergency department\*

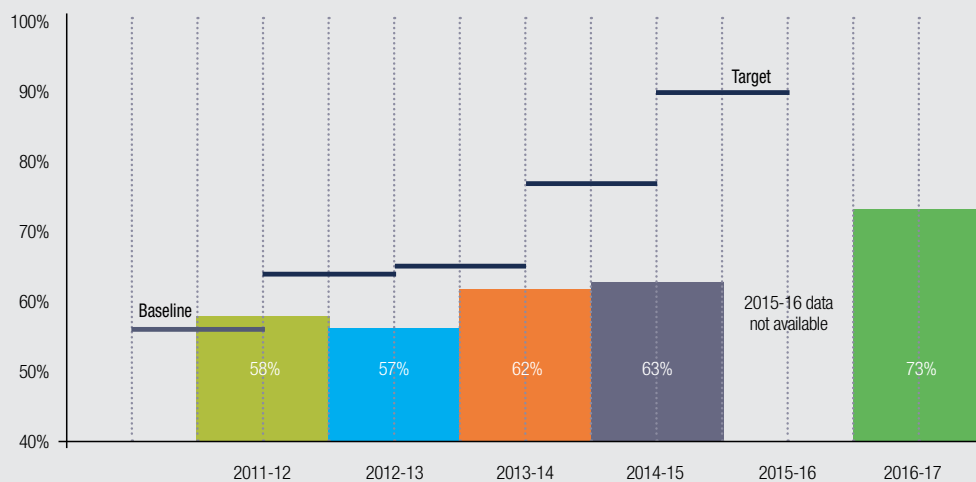
### Waiting times

Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (<30 minutes) – ACT



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: Emergency department care (2010-11 – 2016-17)

### Percentage of emergency department visits completed in four hours or less – ACT

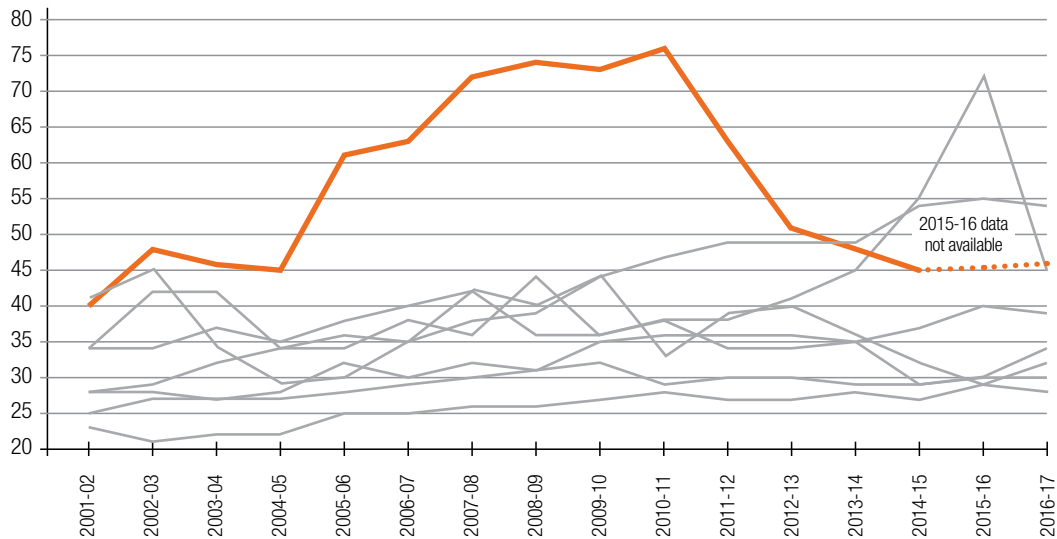


Sources: Australian Hospitals Statistics 2011-12 to 2016-17: emergency department care (AIHW)  
 Note: National Emergency Access Targets were abolished with effect from 1 July 2015

## Elective surgery

### Waiting times

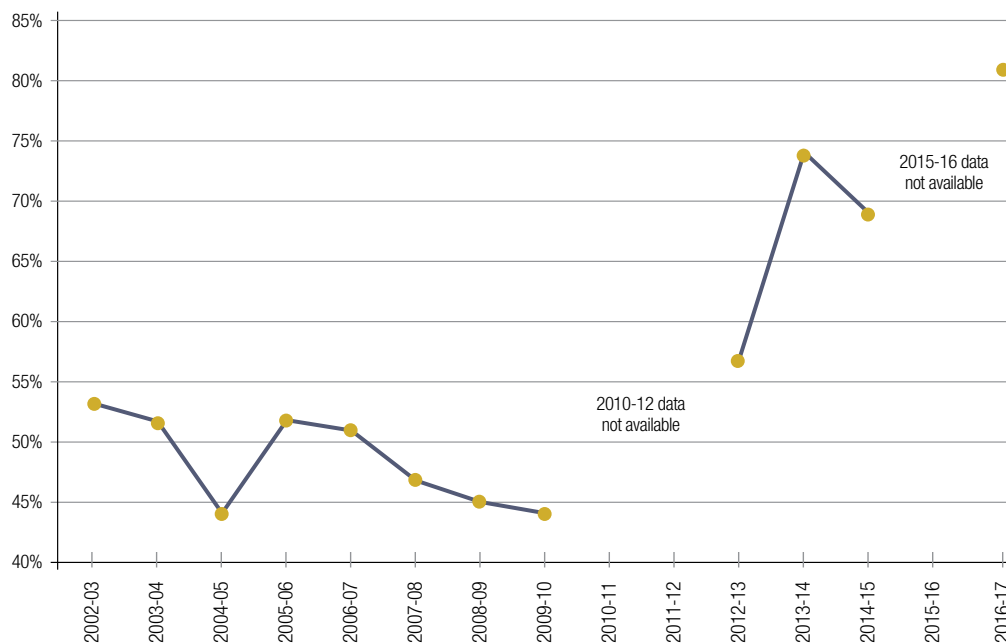
Median waiting time for elective surgery (days) – ACT (compared to other states)



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: elective surgery waiting times (2007-08 to 2016-17)

### Category 2 patients

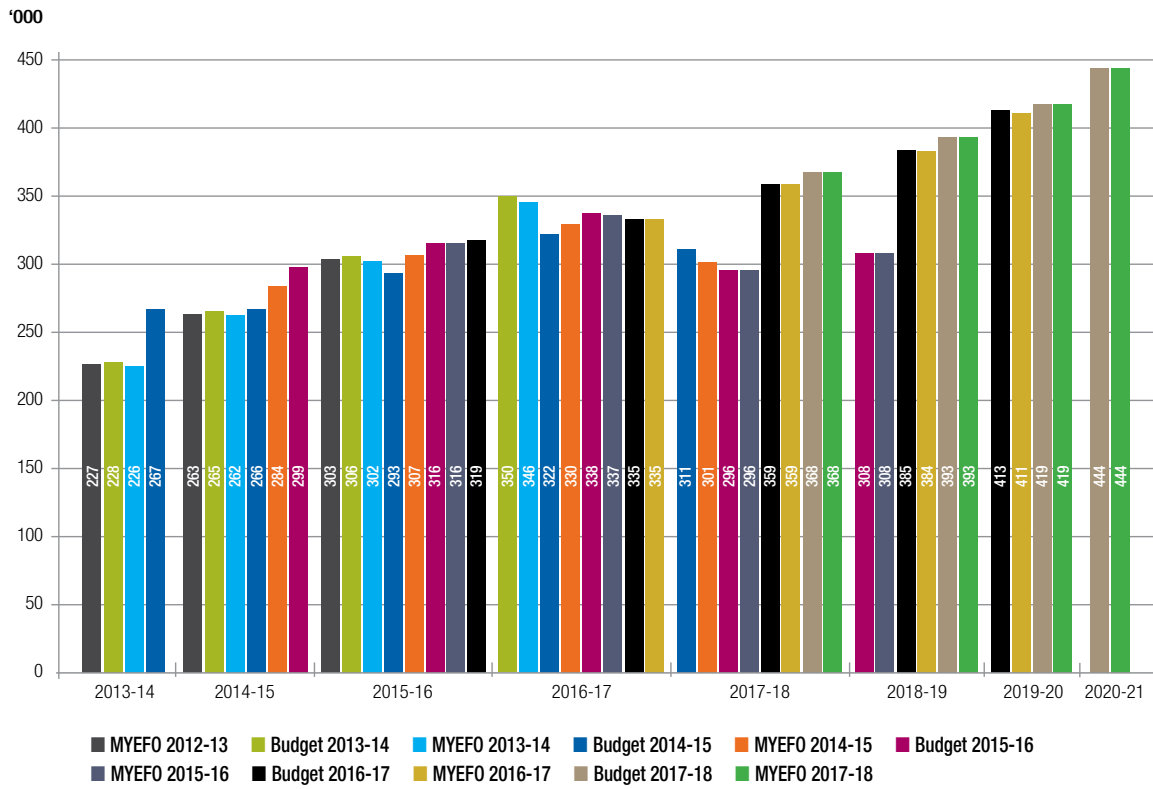
Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – ACT



Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National emergency access and elective surgery targets 2012; AIHW Australian Hospital Statistics 2015-16 – 2016-17: Elective surgery waiting times

## Commonwealth Funding

### Public Hospitals – ACT



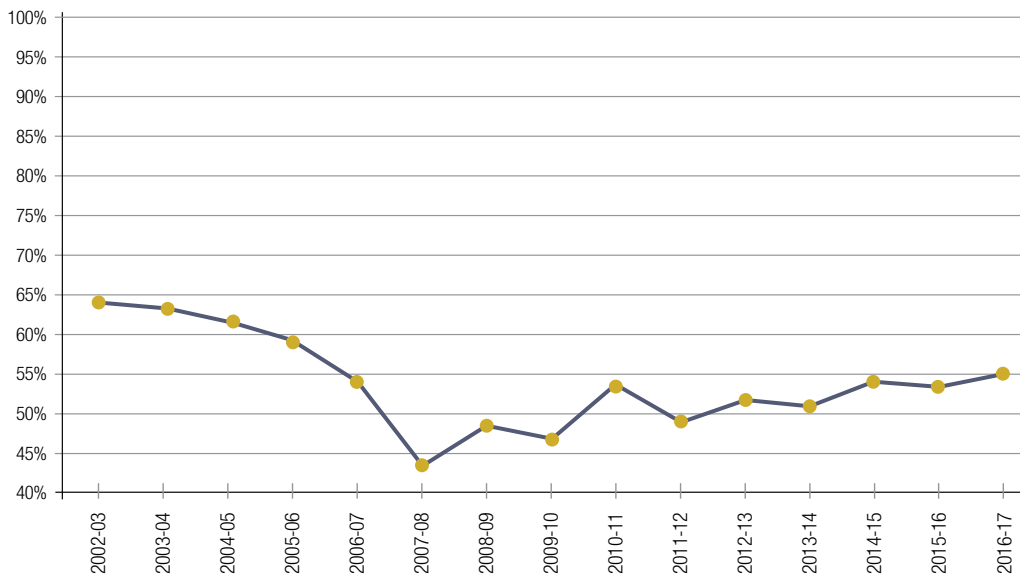
Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

# NORTHERN TERRITORY

## Emergency department

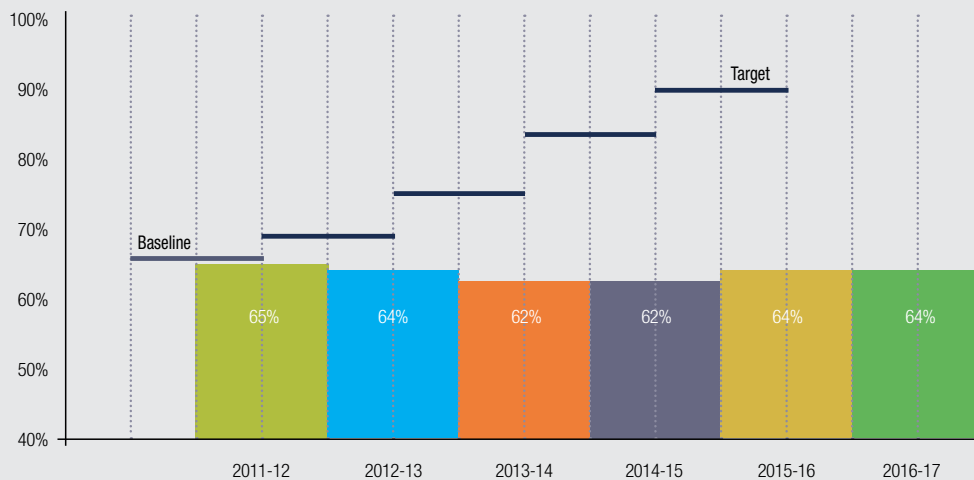
### Waiting times

Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (<30 minutes) – NT



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: Emergency department care (2010-11 – 2016-17)

### Percentage of emergency department visits completed in four hours or less – NT

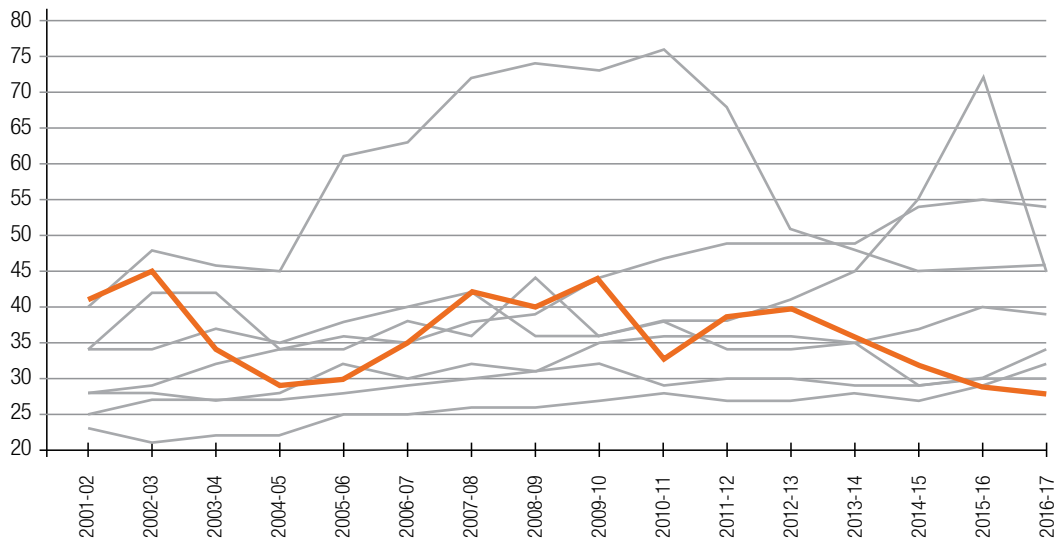


Sources: Australian Hospitals Statistics 2011-12 to 2016-17 emergency department care (AIHW)  
 Note: National Emergency Access Targets were abolished with effect from 1 July 2015

## Elective surgery

### Waiting times

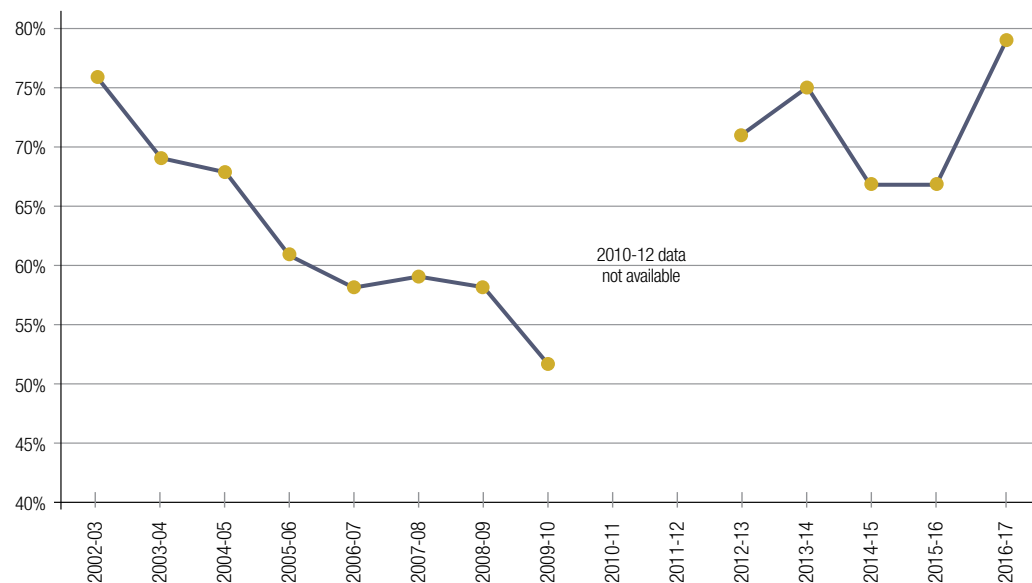
#### Median waiting time for elective surgery (days) – NT (compared to other states)



Sources: AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospitals Statistics: Elective surgery waiting times (2007-08 to 2016-17)

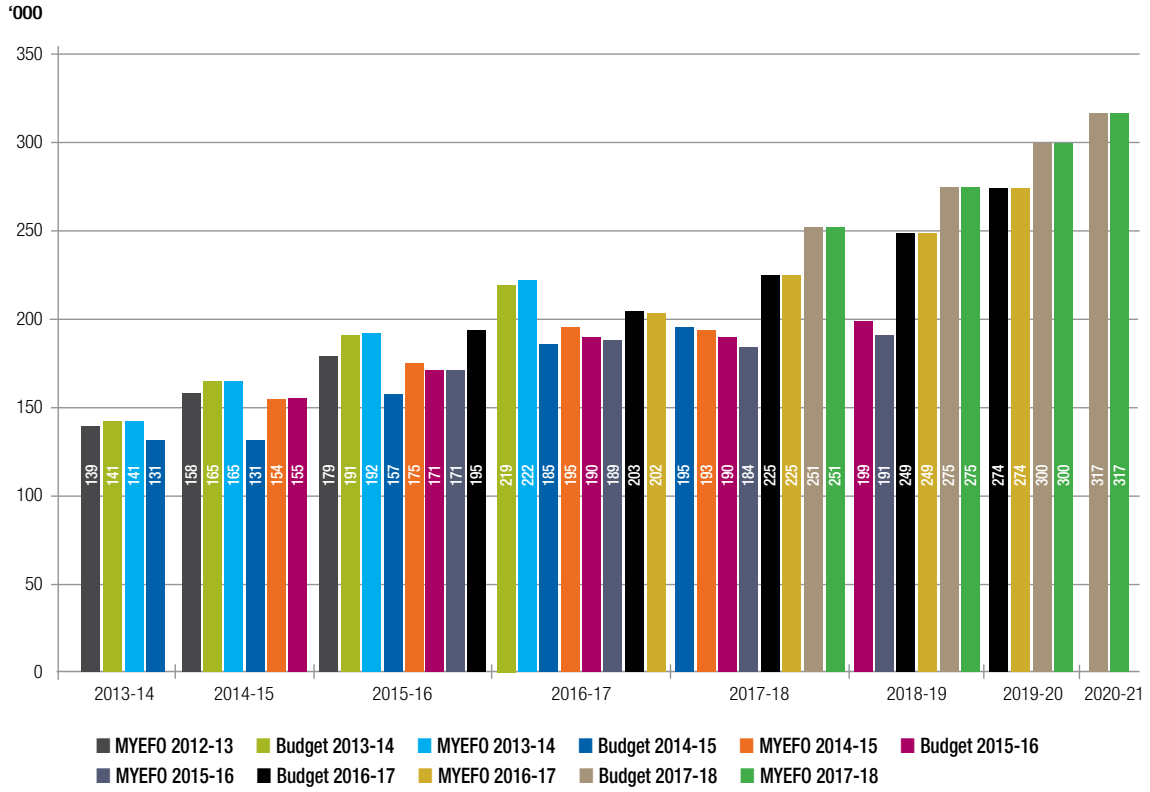
### Category 2 patients

#### Percentage of Category 2 elective surgery patients admitted within the recommended time (90 days) – NT



Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2011-12 estimate based on State and Territory Government published data; State and Territory data for 2012 calendar year published by AIHW in Australian Hospital Statistics: National emergency access and elective surgery targets 2012; AIHW Australian Hospital Statistics 2015-16 – 2016-17: Elective surgery waiting times

## Commonwealth Funding Public Hospitals – NT



Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

## DATA SOURCES

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Australian Institute of Health and Welfare, *Australian Hospital Statistics: Hospital resources 2015-16*

Australian Institute of Health and Welfare, *Australian Hospital Statistics: emergency department care 2015-16, 2016-17*

Australian Institute of Health and Welfare 2017. *Emergency department care 2016–17: Australian hospital statistics*. Health services series no. 80. Cat. no. HSE 194. Canberra: AIHW. 'Table S5.1: Emergency presentation(a) statistics by public hospital peer group and triage category, public hospital emergency departments, states and territories, 2016–17'; data table: Excel spreadsheet, viewed 11 January 2018 <<https://www.aihw.gov.au/getmedia/26f61fe3-8611-4861-8ad2-b32b409b6d95/aihw-hse-194-data-tables.xlsx.aspx>>

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