



## Emergency Department attendance by triage category: what the data suggests.

Mike Moynihan, Research Associate

Acknowledgments: to Bob Birrell and Katharine Betts for advice and assistance with preparation of text.

### Author

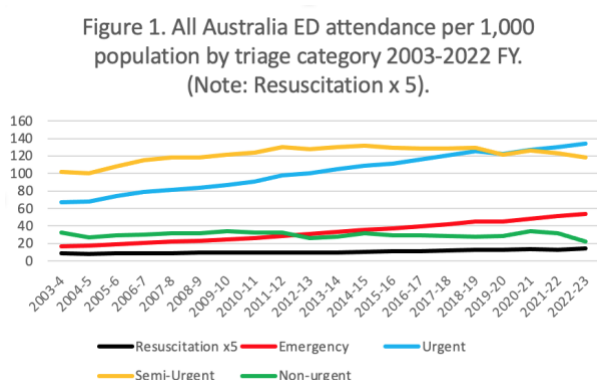
Mike Moynihan is a UK foreign trained doctor and is a retired Australian rural generalist, solo 13 years, and group practice 16 years. He was a representative in the Rural Doctors' Association Victoria and Rural Doctors' Association Australia for 20 years and 9 years respectively, a member of the Joint Consultative Committee for Paediatrics (3 years), worked on GP fellowship curriculum development (both GP Colleges), and was a lecturer in the Swan Hill campus of Monash University Medical School. He was previously Hospital Medical Officer, Provincial Health Officer, and Health Planner in Papua Niugini for 9 years. Contact details: phone 0427 331 370, email moynidoc@gmail.com.

### Abstract

Australian Institute of Health and Welfare (AIHW) Emergency Department (ED) data published since 2003, using National Triage Scale descriptors, allows analysis of ED attendance by category, jurisdiction, age and gender to July 2023.<sup>1</sup> These attendances are matched against population data by AIHW and in this paper. Low acuity (non-urgent and semi-urgent) attendance per 1,000 population has increased by 5% from 2003 but in 2023 is 13% less than it was in 2011. During the same period High Acuity presentations (Resuscitation, Emergency and Urgent) per 1,000 population steadily increased by a total of 125% over the study period, accommodating a 25% increase in the total population. The effect is more marked in the female population of working age. Whilst the Covid-19 pandemic caused fluctuations in attendance, it does not appear to have affected the overall trend. The patterns are seen in all States and Territories. It is suggested that the data provides a useful reflection of the effectiveness of the management of 'ambulant care sensitive conditions' and that this effectiveness may be declining in the community-based medical sector.

### The data

Patients arriving at an Emergency Department (ED) are assessed by a suitably trained nurse and placed in one of five categories of the 'Australian Triage Scale' by the maximum time deemed necessary for the commencement of care. These are: category 1. Immediate, 2. 10



minutes, 3. 30 minutes, 4. 60 minutes and 5. 120 minutes. These correspond to the older descriptions of the 'National Triage Scale', namely 1. Resuscitation, 2. Emergency, 3. Urgent, 4. Semi-urgent and 5. Non-urgent, which terms are used in data reporting by AIHW. The trajectories for each, measured against population, are described in Figure 1.

The first three categories are described as high acuity and the fourth and fifth as low acuity. All high acuity cases have been increasing, and low acuity cases decreasing. Figure 2 illustrates their combined trajectories, with high acuity exceeding low acuity from 2016. Ninety four percent of attendances are in Public Hospital EDs. Data for selected years is detailed in Table 1. Non-urgent attendances plateaued up to around 2011 and then declined, especially during the pandemic after an initial rise. Semi-urgent rose to around 2011 and have declined gently since then except at the onset of the pandemic. High acuity categories have all risen continuously since 2003, increasing from 39% to 58% of the total.

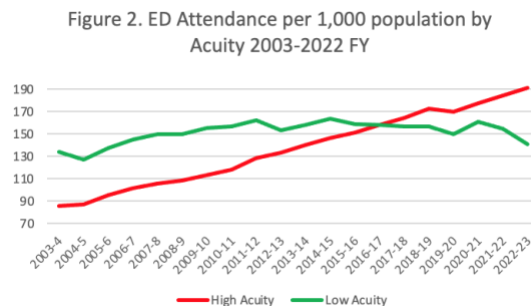


Table 1. Australian ED Cases per 1,000 population by triage category, selected financial years 2003-2022

Fin.Year	Resusc.	Emerg.	Urgent	Semi-Urg.	Non-Urg.	All Triage	% High Acuity.
2003-04	1.7	17	67	102	32	219	39
2011-12	1.9	26	91	124	32	275	43
2018-19	2.6	45	125	129	27	329	53
2022-23	3	54	134	118	23	332	58
Range <sup>1</sup>	2-4	43-61	118-150	93-142	12-35		

Sources: AIHW Emergency Department Care and Hospital statistics annual reports and data tables. Notes: <sup>1</sup>2022 Range per 1,000 population across jurisdictions (States and Territories). Years selected: inception of data, mid-period, pre-covid pandemic, and latest (last year of covid).

Table 2 shows the rise of high acuity ED presentations per 1,000 population in each jurisdiction for the selected years, some growing more than others. It also shows the relative stasis and pandemic related fall of low acuity. These trends are demonstrated for 2003 to 2022 in Figures 3 and 4. A continuous decline of low acuity presentations is visible in Victoria since 2011.

Table 2. High and Low Acuity ED attendance per 1,000 population by jurisdiction. Selected years.

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	All
High Acuity/1,000	2003-04	88	77	85	84	92	77	92	160	85
	2011-12	125	112	147	134	127	112	143	223	129
	2018-19	175	146	196	177	167	147	195	323	173
	2022-23	194	166	215	191	195	179	176	341	191
Low Acuity/1,000	2003-04	125	134	114	133	106	92	119	312	134
	2011-12	182	158	128	173	133	164	176	401	162
	2018-19	189	136	113	189	126	160	160	367	157
	2022-23	177	114	105	157	130	125	137	381	141

Sources: AIHW Financial Year Hospital statistics 2003, and Emergency Department Care, 2011, 2018 and 2022.

Figure 3. Low Acuity ED presentations per 1,000 population by State and Territory 2003-2022 FY (NT/2, 2015 FY no ACT report).

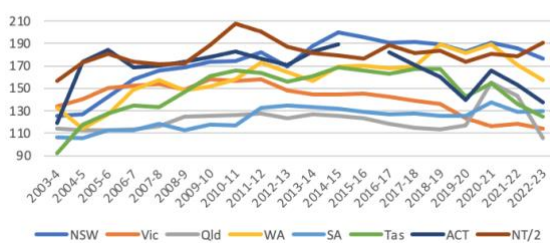
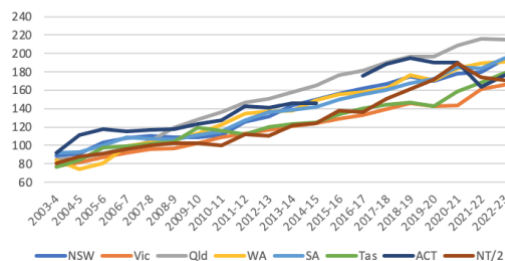
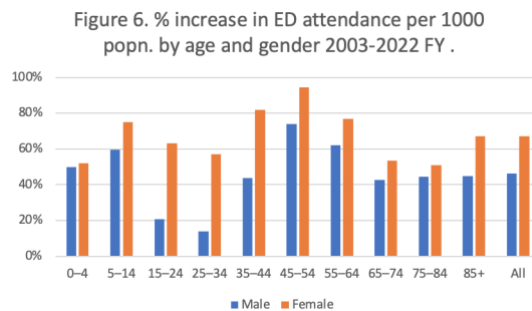
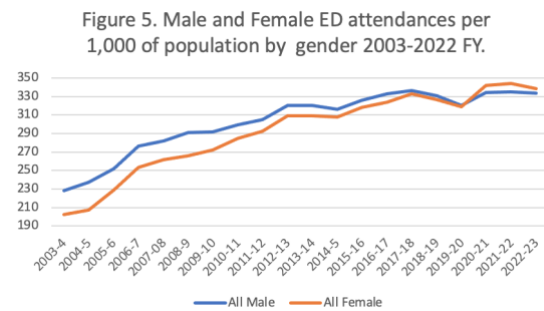


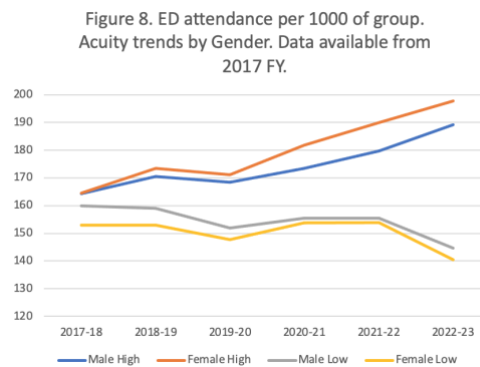
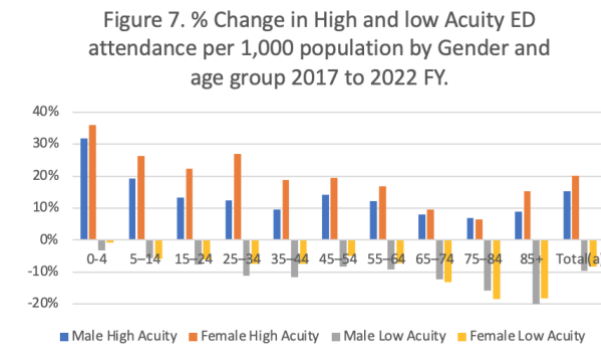
Figure 4. High Acuity ED presentations per 1,000 population by State and Territory 2003-2022 FY (NT/2, 2015 FY no ACT report).



A check on the proportion of male and female attendees reveals that in 2003 females attended considerably less than males. This difference gradually disappeared, with parity reached just as the pandemic period commenced, and then with females attending more during the pandemic (Figure 5). Analysis by age shows that, while higher growth in female attendance occurred in all age groups, it was more pronounced in females of working and reproductive age (Figure 6). As a result females have moved from being the minority in all age groups in 2004 to a majority in 2022 in the 15-44 age range, highest in the 15-24 group. At the same time the proportion of women giving birth before the age of 30 has fallen to 36%.<sup>2</sup>

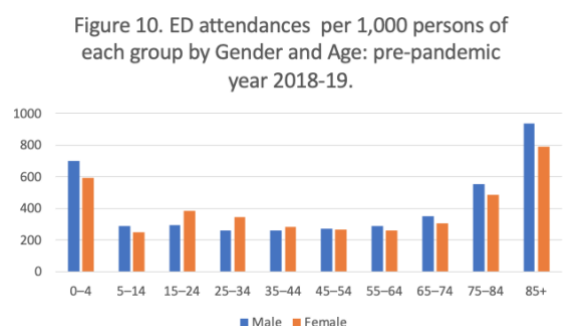
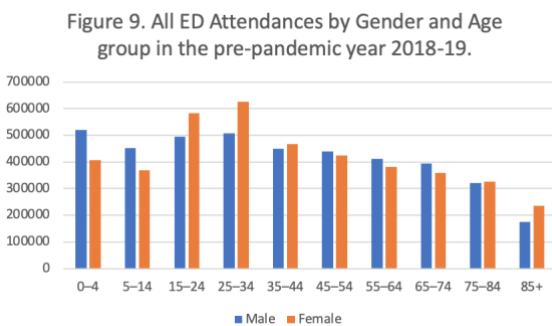


Triage categorisation by age group is available only from 2017. While growth in ED attendance has continued since then, it has been confined to high acuity cases. Low acuity attendances declined in both genders in every age group, particularly in the elderly (Figure 7). High acuity attendances however increased markedly, especially in the very young and all non-geriatric persons, and in females significantly more than males. The increase in female attendances was especially marked in the working age groups. The further differentiation between higher female high acuity, and lower low acuity is illustrated in Figure 8.

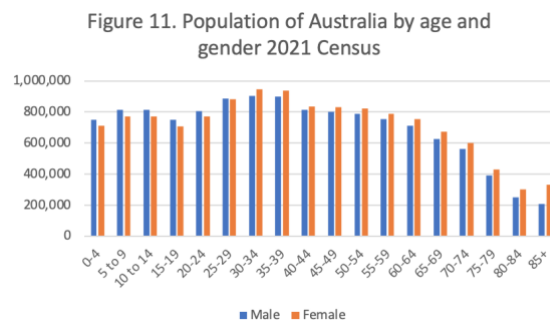


Were these changes solely due to the pandemic? They were in fact just discernible in the year prior. Both male and more so female high acuity triage attendance per capita was rising. This did not follow the pattern of Covid cases per se. Covid cases were low or negligible until the December 2021 omicron spike. Triage placement is determined by the perception of the nursing officer responsible. This can be altered by feelings of urgency in the patient, the patient's family, the views of ambulance officers, and any prevailing sense of emergency in the Emergency Department itself. These factors could all have been amplified in the pandemic atmosphere. A year or two's data will be required to clarify the apparent trend, which has continued despite the attenuation of covid cases in the 2022-23 financial year.

That bulk of ED activity is centred around the working age population is shown for the pre-pandemic year in Figure 9. Against population, attendance is much higher at both ends of the age spectrum (Figure 10). In the very young, parental prudence favours ED as a place of immediate response. In the Elderly, as discussed below, the high use both of ED and General Practice is part of the currently most effective healthcare model worldwide for this age group.



The population distribution by age group to an extent mirrors total ED attendance, except at the extremes of age. The input of migration becomes apparent from the age of five. The gender bias towards male disappears from the age of 30 onwards, with female (permanent) immigrant numbers then causing female predominance. The author's experience is that migrants have heightened medical need in their first year, which might have influenced the data for high acuity attendance. It has to be mentioned that first nations persons comprise 7% of the under 15 age population<sup>3</sup> and 11% of ED attendances in each of the first three 5 year cohorts.<sup>4</sup>



## Discussion

The OECD position is: "Better, more accessible primary health care results in lower rates of hospitalisations and emergency department use".<sup>5</sup> Australia was found to be in the middle rank in the OECD in 2011 for ED attendance with 29.3 attendances per 100 population according to Berchet (2014), reported as 275/1000 population by AIHW 2011, compared to 12.4/100 for the Netherlands, 70.5/100 for Portugal, and 30.8/100 averaged for the 21 countries polled.<sup>6</sup> The OECD does not routinely collect ED data. In Australia and around the OECD it is commonly presumed that rising low acuity presentations, especially of non-urgent cases, are blocking emergency departments. There are multiple initiatives aimed at this contingency.<sup>7,8</sup> In the absence of data initiatives these cannot be said to be evidence based. Research has questioned their usefulness.<sup>9</sup>

Habitual ED attendance is probably not a major issue. In 2019 Lago and co-authors found in the Illawarra region that the large majority of frequent attendances were episodic because of effective community-based case management.<sup>10</sup> Persistent attendance at ED accounts for 7.1% of attendances and was variably associated with psychiatric illness, substance abuse disorder, economic disadvantage, and first nation status.

The two lowest socioeconomic (SES) quintiles are responsible for 45-48% of ED presentations. All quintiles shared the relative rise in high acuity attendance from 2017 to 2022, which

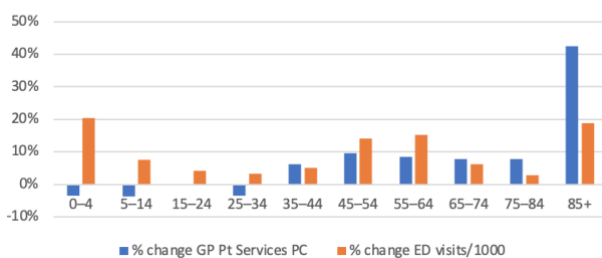
nonetheless was not as pronounced among the higher SES groups (4 and 5 (Figure 11)).<sup>11</sup> Forty seven percent of First Nations persons live in the first (lowest) socio-economic quintile.<sup>12</sup> Their population has risen since 2011 from 2.4% to 3.1% of the total for Australia in 2021. Their individual ED attendance has increased from 5.2% of total to 7.7%, a rise in proportion to their share of the population. Their individual ED attendance is 2.7 times that of the non-ATSI population and peaks at 3.8 times that of the non-ATSI 40-44 age group.<sup>13</sup> Their attendance with doctors accessing non-referred rebates (those in General Practice) however is more or less the same as that of the general population, indicating a preference for ED.<sup>14</sup> As already mentioned, they also comprise 11% of children under 15, but only 7% of ED attendances at this age.

Figure 12. High and Low Acuity ED presentations per 1,000 population by "socioeconomic status of area of usual residence" 2017 and 2022 FY (AIHW ED Care, Table 3.4): 1 (lowest) -5 (Highest). 2022 data "based on 2021 SEFA classification").



The supply of General Practitioners and their availability and effectiveness largely determine the volume of ED attendance. Trust, sentiment and quality of previous experience also matter.<sup>15 16</sup> DoH data by patients' age is available from 2014. There was gentle rise in GP attendance from 2014, which increased much more during the pandemic, before a retraction

Figure 13. % change in GP services of patients per capita and ED attendance per 1,000 popn. by age group 2014 - 2022



in 2022-23. A Comparison with ED attendance data (Figure 12) shows a pronounced swing to ED among children and adolescents, a small swing towards General Practice in the young working age group, a swing towards ED in those of older working age, equivalence in the 65-84 age group, and in the over 85s a large increase in ED attendance and a very large increase in General Practice attendance.

As a proportion of Australia's working doctors, GPs have dropped this century from 46% to 36%.<sup>17</sup> The stasis in low acuity ED presentations occurred simultaneously around 2011 when the 'Full Service Equivalent' (FSE) GP supply had reached 0.87 per 1,000 population in most jurisdictions, having risen by 23% since the 2003 trough of 0.71 per 1,000.<sup>18</sup> When last reported in 2017-18, GP FSE had reached 1.02/1,000, increasing by 17% over 6 years. The new workforce equivalent estimation method of 'GPFTE' (General Practice Fulltime Equivalent) increased from 1.06/1,000 population in 2014-15 only to 1.11 in 2022-23, an increase of just 5% over 8 years, perhaps a more accurate estimation than that provided by the FSE because of a reduction in working hours.<sup>19</sup> The 2022-23 GP workforce of 1.5 head per 1,000 population was 80% comprised of qualified specialist GPs working 37.3 hours weekly,<sup>20</sup> providing 1.12 standard medical workforce FTE (40 weekly hours) per 1,000 population. Between 2017 and 2022 financial years vocationally registered GPs (with specialist or specialist status equivalence) headcount rose from 74% to 80% of total and their proportion of services from 81% to 86%. Their provision of services rose from 81.5% to 85.8% of total. Reliable comparative data are lacking but this is probably a good level of supply in world terms.<sup>21</sup>

Persons appear to be arriving at Australian ED steadily sicker than had previously been the case. It is this that is making EDs busier, though they are acting effectively as a safety net for General Practice. Forty eight percent of patients presenting at ED in Berlin were judged to have 'ambulatory care sensitive conditions' (ACSCs).<sup>22</sup> High acuity ED presentations in Australia were 58% of the total of ED presentations in 2022-23 (Table 1), but only 28% were hospitalised overnight in 2019.<sup>23</sup> Australia's acute overnight hospitalisation rate is relatively static but in 2019 prior to the pandemic had risen to 3<sup>rd</sup> highest in the OECD as other countries had reduced theirs.<sup>24</sup> By themselves pre-Covid, Australian public hospital acute overnight hospitalisations have fallen into the middle range for whole country levels in the OECD. The additional overnight hospitalisations in Australia, around 30% of the total, occur in private hospitals, and are no doubt amplified by the \$6 billion tax rebate for private health insurance.<sup>25</sup>

ED attendance in the elderly is not increasing at the rate commonly presumed, perhaps because of their high levels of GP servicing. This amounted to 18 services per annum per patient over the age of 85 at the height of the pandemic.<sup>26</sup> Also, Australia was ranked 1<sup>st</sup> worldwide in 2019 for Healthcare access and Quality (HAQ) in the elderly aged 65-74.<sup>27</sup> The rank for the 15-64 working age population was further down at 12<sup>th</sup> and for the under 15's even further at 17<sup>th</sup>. This gave Australia the overall rank of 6<sup>th</sup>, unchanged from 1990 but risen from 8<sup>th</sup> in the elderly and decreased from 8<sup>th</sup> in those working and 9<sup>th</sup> for children.

Care of the working age population and their children is limited by lack of after-hours access to GPs as most surgeries close by 6 pm. An informal internet search suggests that Victoria, with greatly declined low acuity at ED and lowest high acuity figures (Figures 3 and 4), has considerably more general practices open after this time than other jurisdictions, commonly to 8pm. The provision of a few urgent care clinics in a number of States (since 2022) does not address this aspect systemically and is not on a scale sufficient to significantly benefit population health. For acute illness there is a clear preference for ED attendance in the under 5 age population. This is not overcome by financial inducement,<sup>28 29</sup> and may relate to a lack of Paediatric capacity in General Practice. HAQ score in the under 15s is not related to Paediatrician supply in OECD countries, and in Australia is unlikely to be improved by the great expansion in paediatrician numbers currently underway.<sup>30</sup> The 1994 recommendation by the Joint Consultative Committee for Paediatrics, that all GPs in training should gain acute paediatric experience has not been fully implemented and could be revisited.

The bulk of the increase in high acuity presentations at ED is occurring in the working age and young population. Overall morbidity has not increased. The burden of disease, Covid apart, has reduced this century, but is greater in males.<sup>31</sup> Delay in management, for example from GP unavailability or ineffective management, allows deterioration of acute medical conditions, and a move into the next triage category up. Are such delays increasing for the working age population, particularly for women? Acute illness demands competent same day management. The Dutch system, (which was industrially negotiated and finalised in the 21.1.19 Woudschoten agreement<sup>32</sup>) compels GPs to staff walk-in primary care physician cooperatives.<sup>33</sup> In practice, Dutch GPs are more solidly supported.<sup>34 35</sup> With fewer GPs per head population, the Netherlands has only 124 ED attendances per 1,000 population,<sup>36</sup>

75/1,000 acute hospitalisations,<sup>37</sup> and 3<sup>rd</sup> position in HAQ ranking in 2019, risen from 9<sup>th</sup> in 1990.

What puts Australian ED attendance at mid-range for ED attendance rather than in the low range say of the Netherlands? Only 51% of Australians have a regular GP,<sup>38</sup> and only 43 % of Australian GPs were found to conduct after-hours care (Britt 2014).<sup>39</sup> The elderly can be accommodated more easily in day-time hours but often not the working population and their families. To be effective, after hours care needs to be provided, on a walk-in basis, in a stand-alone setting with RACGP defined acute care facilities<sup>40</sup> and with access at least to the patient's up to date health summary. The provider needs to be trained as a GP or supervised by one with such training, but not necessarily be the patient's usual GP.<sup>41</sup> These conditions cannot be met in present day Australia and would probably not be met by use of the New Zealand Urgent Care Clinic model. The NZ model is serviced by its own medical specialty, and sees 15% of all primary care doctor presentations.<sup>42</sup> If ED attendance is to be minimised, the aim is for the patient to be seen as soon as possible after the onset of acute illness by a competent General Practitioner with all the tools for initial management of the condition at hand. This would benefit both the patient and the national accounts. The cost to the taxpayer of a GP consultation is around only 10% that of an ED attendance.<sup>43</sup>

Are there structural reasons in the Australian system of Healthcare to account for the rising high acuity ED attendance per 1,000 population? Medical workforce policy has resulted in only 26% of domestic graduates becoming GPs (this author's calculation). As well as double the pay,<sup>44</sup> there are numerous incentives towards specialisation, with large cohorts in training, mostly in hospitals. This has meant an excessive number of public hospital doctors. In 2020-21 there were around only 1 acute overnight hospitalisation *per week* for each full time equivalent public hospital workforce doctor.<sup>45</sup>

Since the 1990s Australian domestic undergraduate training has purposely included a heavy bias towards General Practice, which as a specialty includes skill in the identification of early and indistinct presentations and their physical and mental health components. Early intern rotations have been designed to promote GP capability. Whilst it is hoped that non-GP specialists, (68% of them domestic graduates), benefit from this exposure to GP, this was not the primary intent of the exercise, and this training, en masse, is to a significant extent wasted compared to its potential for population health creation were more domestic graduates to become GPs. The proportion of overseas recruits in General Practice has risen every year this century, from 24% to 42%.

### **Concluding observations.**

Healthcare in Australia is as yet far from achieving its full potential even though Australia is well placed according to broad international indices.<sup>46</sup> This goes beyond the poor status of first nations persons. The age-adjusted death rate was decreasing slightly prior to Covid, although the crude death rate was probably rising. The improvement in longevity could be stalling. The continuing rise in high acuity ED attendance indicates a weakness in General Practice, especially (from HAQ scores) in the care of the young and working-age population. Emergency Departments are accommodating this weakness, but at considerable expense. Seventy four percent or so of domestic medical graduates are progressing to non-GP



specialist practice. The Netherlands experience suggests that properly organised General Practice, not necessarily with huge numbers of GPs, can halve ED attendance and acute hospital admissions.

A focus on acute hospital care has diverted attention from the need for more effective General Practice. Redressing the balance would mean placing limits on specialist training in hospitals and equilibrating the benefits of GP and Non-GP specialisation. To reduce its pull on domestic graduates, the private medical sector needs to be returned to the market by ending the private health insurance tax rebate. Reorganisation of the structural operation of General Practice needs serious consideration. A long term nation-wide structural approach is required. The problem of rural medical workforce supply simultaneously needs attention to further reduce the need for overseas recruitment. These changes are needed to maintain high levels of Healthcare Access and Quality in the long run.

---

<sup>1</sup> AIHW Hospital statistics 2003-2010 financial years, Emergency Department care 2011 to present.

<sup>2</sup> AIHW December 2023. National Perinatal Data Collection preliminary update 2022 — data tables. Table 2.1.

<sup>3</sup> AIHW Estimates of Aboriginal and Torres Strait Islanders. Census based ERP 30.6.21. Age and Sex structure. Australia 2021 Census All persons. Quickstats.

<sup>4</sup> AIHW Emergency Department Care 2021-22, Tables 3.2 and s3.2.

<sup>5</sup> OECD library 2020. Realising the potential of primary care.

<sup>6</sup> Berchet C. OECD health working paper No 83, 2015. 'Emergency care services: trends, drivers, and interventions to manage the demand'. [https://www.oecd-ilibrary.org/social-issues-migration-health/emergency-care-services\\_5jrts344crns-en](https://www.oecd-ilibrary.org/social-issues-migration-health/emergency-care-services_5jrts344crns-en). Fig. 1.

<sup>7</sup> Berchet C. Ibid.

<sup>8</sup> Baier, N et al. Health Policy, V 123, Issue 1 January 2019. 'Emergency and urgent care systems in Australia, Denmark, England, France, Germany and the Netherlands – Analyzing organization, payment and reforms'.

<sup>9</sup> Ismail S A et al. "Reducing inappropriate accident and emergency attendances" BJGP December 2013.

<sup>10</sup> Lago L et al. BMJ Open May 2019. Here one year, gone the next? Investigating the persistence of frequent emergency department attendance: a retrospective study in Australia.

<sup>11</sup> AIHW Emergency Department Care 2017 and 2022 Financial Years, Table 3.4.

<sup>12</sup> ATSI Health Performance Framework, 2.09 index of disadvantage. Australian Government 2023.

<sup>13</sup> AIHW ED Care 2021-2 Tables 3.2 and s3.2.

<sup>14</sup> Ibid. p77 General Practitioner Services and Health Checks.

<sup>15</sup> Schafer et al, 'QUALICOPC, a multi-country study evaluating quality, costs and equity in primary care'. BMC Family Practice 2011 12: 115.

<sup>16</sup> Van Loenen et al. 'Organizational aspects of primary care related to avoidable hospitalization: a systematic review'. Family Practice V31 Issue 5 October 2014.

<sup>17</sup> AIHW Medical Workforce 2000, DoH GP Statistics 2018 and 2023, DoH HWD Datatool 2023.

<sup>18</sup> Department of Health annual GP statistics 2018.

<sup>19</sup> Department of Health annual GP statistics 2023.

<sup>20</sup> Calculated through DoH Health Workforce data datatool.

<sup>21</sup> National summary of Primary Care GP workforce. DoH December 2023.

<sup>22</sup> Frick, J et al. Suitability of current definitions of ambulatory care sensitive conditions for research in emergency department patients: a secondary health data analysis.

<sup>23</sup> AIHW Emergency Department Care 2018-19. Table 4.14.

<sup>24</sup> OECD Statistics. Healthcare Utilisation. Hospital aggregates. Inpatient discharges (all hospitals). Curative Care (acute overnight) discharges.

<sup>25</sup> AIHW Health expenditure Australia 2020-21 Table A6.

<sup>26</sup> Primary Care GP statistics by Financial Year – summary of patients.



- 
- <sup>27</sup> Lozano et al. *Lancet Global Health* 2022; 10 e1715-43. Assessing the performance of the Healthcare Access and Quality Index overall and by select age groups, for 204 countries and territories 2009 – 2019: a systematic analysis from the Global Burden of Disease study 2019. NB Data extracted by this author.
- <sup>28</sup> Walsh et al. 'Did the expansion of free GP care impact demand for Emergency Department attendances?' A difference-in-differences analysis. *Social Science & Medicine*: Volume 222, February 2019,
- <sup>29</sup> Wong C Y and Hall J. 'Does patients' experience of general practice affect the use of emergency departments? Evidence from Australia'. *Health Policy* Volume 122, Issue 2, February 2018.
- <sup>30</sup> OECD data provides number of paediatricians. The Department of Health, Health Workforce Data online 'datatool' provides annual medical workforce and medical training data from 2013.
- <sup>31</sup> <https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2022/contents/summary>
- <sup>32</sup> Van der Horst H E, 'Redefining the core values and tasks of GPs in the Netherlands'. *BJGP* 2020'.
- <sup>33</sup> Baier N et al. *Health Policy* Vol 123 issue 1 January 2019. Germany and the Netherlands – Analysing organization, payment and reforms.
- <sup>34</sup> Van den Berg, Michael and collaborators 'Workload in General Practice'. Netherlands Institute for Health Services Research, Nivel 2010. "Practice assistants have been the GPs' right hand since the 1960s. Over time this function has been strongly professionalised.....over half of the practice assistants independently advise by phone for a number of problems (p34).....there has been a particularly significant increase in the number of technical medical tasks delegated (p35)"
- <sup>35</sup> Why are Dutch GPs so much happier?' *BMJ* 2015; 351 doi: <https://doi.org/10.1136/bmj.h6870> (Published 29 December 2015)Cite this as: *BMJ* 2015;351:h6870.
- <sup>36</sup> Ibid Berchet 2014.
- <sup>37</sup> Ibid OECD statistics.
- <sup>38</sup> Schoen C and Osborn R. 2011 'The Commonwealth Fund 2011 International Health Policy Survey of sicker adults in 11 countries'.
- <sup>39</sup> Britt H et al. GP series 36. U. Sydney Nov. 2014. General Practice Activity in Australia. Bettering the Evaluation and Care of Health (BEACH).
- <sup>40</sup> Royal Australian College of General Practitioners (RACGP) Standards for General Practice 5<sup>th</sup> Edition 2017.
- <sup>41</sup> Van der Horst H E, *BJGP* 2020'. The 21.1.19 Woudschoten agreement 'Redefining the core values and tasks of GPs in the Netherlands'.
- <sup>42</sup> Royal New Zealand College of Urgent Care <https://rnzcuc.org.nz/>.
- <sup>43</sup> The independent Health and Aged Care Pricing Authority (IHACPA) is an independent Government agency originally established as the Independent Hospital Pricing Authority (IHPA) in 2011For admitted patients in 2019 the ED cost was \$1,030 and for non-admitted \$575. The average fee charged for a General Practice service that year was \$55-71 and the average benefit paid by Medicare was \$51-31 (MBS data 2019-20).
- <sup>44</sup> OECD 'Health at a glance' 2023 Figure 8.11.
- <sup>45</sup> In 2020-21 there were 53,948 FTE salaried medical officers reported in Public Hospitals (AIHW Hospital resources 2020-21 , Table 3.2). For 2020 the Health Workforce datatool gives a calculation of 43,993 working 46.6 hours weekly which equates to 51,266 FTE (40 hours per week), including an estimated 1,386 in private hospitals (AIHW Hospital workforce website for 2020-21), giving 52,562 or 49,880 FTE depending on which figure is used.. There were 2,895,679 acute overnight separations in public hospitals in 2020-21 (AIHW Admitted Patient Care 2020-21, table 2.15). This equates to 55 – 58 patients per FTE doctor *per year*, or roughly 1 a week. This does not include the input of visiting (mostly specialist) medical officers, which would reduce the number further. Whilst there are other activities including clinic work and day case admissions, acute overnight admissions are by far the most resource intensive.
- <sup>46</sup> Australia's OECD current 3<sup>rd</sup> ranking for Life Expectancy (LE) of 83.3 results from higher Covid death rates in other countries. In 2016, 18 Australian Electorates had LE 85 to 86.3, at world's highest levels (Life Expectancy in Australia's Commonwealth Electoral Divisions. Roden, M, Statistics and Mapping, Parliamentary Library 2020).