Australian Medical Association

Pre-Budget Submission 2023–24

AMA

BACKGROUND

Australia's health system is one of the best in the world. In 2021, the highly regarded Commonwealth Fund rated Australia as having the third best health system when ranked among eleven similar high-income countries. In its report, Australia was placed number one on both healthcare outcomes and equity.

Australia however performed less well on other key measures, including access to care where we are considered below average when it comes to affordability and timeliness of care. In relation to measures of preventive care, safe care, coordinated care, and engagement and patient preferences, Australia was ranked in the middle. Australia is therefore falling short in a number of areas, and more needs to be done in the areas of access to care, prevention, and coordination.

In 2021, the AMA released its *Vision for Australia's Health*, which proposed sensible and targeted reforms that would help fix our health system, including addressing those issues identified by the Commonwealth Fund. Our reform ideas focus on five pillars: general practice, public hospitals, private health, a health system for all, and a health system for the future. The AMA Pre-Budget Submission 2023–24 draws on the reform ideas outlined across these five pillars, leveraging costed research performed by the AMA.

Note: some of the costings in this budget submission are estimates from 2022–23 to 2025–26 to align with the costings outlined in the related AMA research reports.

CHAPTER 1: GENERAL PRACTICE

Overview

This chapter of the *AMA Pre-Budget Submission 2023–24* draws on *Delivering Better Care for Patients: The AMA 10–Year Framework for Primary Care Reform*, the AMA research report *Putting health care back into aged care*, and the AMA research report *Solutions to the chronic wound problem in Australia* with some of the modelling adapted and extended to give estimates of impact between 2022–23 and 2025–26.

Problem statement

Primary healthcare is the front line of the healthcare system and usually the first level of contact with the national healthcare system. It is scientifically sound, universally accessible and constitutes the basis for a continuing healthcare process — providing the right care, at the right time, at the right place.

General practice is the cornerstone of successful primary healthcare, underpinning population health outcomes and is key to ensuring we have a high-quality, equitable, and sustainable health system. Research in Australia and internationally shows that a well-funded and resourced general practice sector is pivotal for success of primary healthcare, improving the health outcomes of individuals and communities.[1,2] It also shows that it can create significant savings through better care, greater efficiency, and reducing the burden on other more expensive parts of the health system.[3,4,5]

General practice is the most accessed form of healthcare in Australia, with almost 85 per cent of patients seeing a general practitioner (GP) each year,[6] and over 95 per cent of patients attending the same practice.[7] Despite being so heavily accessed and the research supporting a well-funded general practice sector, the total Commonwealth expenditure on GPs in 2020–21 was $11.2 billion,[8] which is equivalent to only $437 per person.[9]

Furthermore, government investment in general practice has not matched the increase in the cost and demand for providing high-quality patient care. General practice is underfunded with the Medicare Benefits Scheme (MBS) systematically devaluing GP services through inadequate indexation and a consultation item structure that fails to keep up with the growing complexity of care and the need for GPs to spend more time with their patients.[10] With a population that is growing, ageing, and increasingly developing more complex health needs, we need a modern Medicare so patients can spend *more time* with their trusted GPs, access *more care* from their general practice, and receive *more health* though comprehensive and evidence-based care.

Policy proposals

Priorities for the Strengthening Medicare Taskforce

The Commonwealth Government has committed to spending $750 million to strengthen Medicare over three years. The AMA's key priorities for the Strengthening Medicare Taskforce include:

- Increasing the cap and indexing the Workforce Incentive Program (WIP), which supports access to multidisciplinary care as part of a GP-led and coordinated team and provides incentives for GPs to work in rural areas. The WIP has improved access to care for patients, although its value has diminished over time as payments under its practice stream have not changed since they were established in 2012 under the former Practice Nurse Incentive Program.

  The AMA proposes that the government increase the cap on the incentive available under the WIP to 7,000 Standardised Whole Patient Equivalent (SWPE) initially, with a view to uncapping it in the future, and commit to annual indexation. This will help embed the medical home model of care in Australia and ensure that general practice continues to evolve into a hub where patients can access care from a range of healthcare providers working in a collaborative model with GPs.

- Improved access to GPs afterhours, by aligning the definition of afterhours with the Approved Medical Deputising Service (AMDS), which is any period outside 8:00am until 6:00pm on weekdays and outside 8:00am until 12:00pm on Saturdays. As the current Medicare arrangements discourage GPs from offering in-clinic services afterhours, patients are often diverted to an AMDS or the emergency department. Aligning the definition to the AMDS will improve patient access to afterhours care through their usual GP or general practice.

- Implementing Voluntary Patient Enrolment (VPE), which is designed to formalise and strengthen the relationship between a patient and their GP to improve continuity of care and patient experience through the provision of non-face-to-face services.[11] VPE will give general practices the ability to define their patient population, better understand and address patient needs and gaps in care, as well as measure care outcomes. VPE should be offered to all Australians, and the process for enrolling patients should be as simple as possible.

  Linking chronic disease management, health assessment, and medication management review MBS items to VPE will support those GPs who are truly the patient's usual GP in providing care that is of value to the patient and appropriate for their care, improving patient experience and health outcomes. It will also generate savings, which can be used to implement other necessary reforms, such as wound care for targeted chronic wounds.

While the Commonwealth Government's $750 million commitment is welcomed, additional long-term investment will be required to fund the priorities identified by the Strengthening Medicare Taskforce, as well as other priorities to ensure people have access to evidence-based primary care and to stem the immediate GP crisis (outlined below).

Wound care for targeted chronic wounds

It is widely acknowledged that chronic wounds represent a significant health and economic burden in Australia. Research suggests that chronic wounds affect approximately 450,000 Australians at any time, costing the health system around $3 billion each year.[12,13,14] The current funding arrangements do not support general practices to deliver evidence-based wound care, as the costs of providing the appropriate consumables results in a net financial loss for many general practices. Many patients are therefore required to purchase consumables from the pharmacy at retail price, or alternatively seek treatment at community healthcare settings that provide free wound care such as hospital outpatient clinics.

The government should establish a funded wound consumables scheme to subsidise the cost of wound dressings and other consumables for patients with specific chronic wounds. This will remove the cost barrier to accessing appropriate and evidence-based wound care products, reducing the financial strain on both patients and general practices. New MBS items should also be established to better support general practices in assessing and managing chronic wounds, and improve the delivery of evidence-based wound care.

Aged care funding model

Healthcare for older people is getting more complex. Increasing life expectancy is resulting in more years of life lived with chronic diseases, and often greater complexity of medical care in old age (such as managing comorbidities). This, combined with our ageing population, means that demand for aged care and healthcare services will only continue to increase in the future.

Positioning GPs at the centre of healthcare provision in aged care is central to improving the health outcomes and quality of life for older people, as well as reducing avoidable hospitalisations.[15] GPs however are not well supported to deliver healthcare in residential aged care facilities (RACFs), with the MBS rebates not adequately compensating for the additional time and complexity involved in delivering care in RACFs compared to their own practices (refer to the AMAs *Putting health care back into aged care report* for further details).

The AMA calls for government to review the incentives for GPs to attend RACFs and establish a new funding model which makes it sustainable for GPs to deliver increased and continuing services in RACFs, including via telehealth with RACF staff in circumstances where patients are unable to effectively communicate due to underlying health conditions. This funding model should support the provision of coordinated, high-quality, person-centred, and longitudinal healthcare, and should compensate for the time and care spent with an older patient in an RACF and the other activities required to support the patient (such as discussing treatment plans with relatives and RACF staff).

New MBS consultation item to support longer consultations

Patients are attending general practice with increasingly complex care needs, yet current Medicare arrangements do not give them adequate support and instead encourage shorter consultations. To enable GPs to spend more time with patients, the AMA is calling for a new attendance item to be introduced for consultations between 15 and 19 minutes. This is consistent with the recommendation in the government's own Medicare Benefits Schedule (MBS) Review that Medicare must support GPs to spend more time with patients. This longer item will encourage prevention, support timely access to early intervention, and enable a more comprehensive approach to care. It will also reward quality and value-based care and ensure that patients can spend the time they need with GPs.

Risks and implementation

Priorities for the Strengthening Medicare Taskforce

Increasing the cap and indexing the WIP

Raising the cap on the incentive available under the WIP to 7,000 SWPE and indexing the program will better support the employment of nurses, pharmacists, and allied health professionals within general practice. It will also better support earlier reforms announced by the Commonwealth Government in the 2018–19 Budget where it expanded the range of health practitioners that could be engaged under the WIP but did not provide any extra funding to support this. Additional funding will offer general practices the flexibility to employ clinical staff that best support GPs to care for their local communities which will be key to the future success of the WIP. Additionally, without appropriate indexation, the objectives of the WIP are undermined as the rising costs of employing staff erodes the value of the incentive.

Improved access to GPs afterhours

Failure to implement this change will support the status quo, which sees patients accessing care through more expensive options including their local emergency department. The new definition will need to be clearly communicated to GPs so that they are encouraged to take up this opportunity. It will also need to be promoted to patients to encourage them to see their general practice as the first point of call for care in after-hours periods.

Implementing VPE

A key enabler of VPE is the embedding of patient-centred medical homes (PCMH), which facilitate a partnership between individual patients, their usual treating GP, and extended healthcare team to provide healthcare that is comprehensive, patient-centred, coordinated, accessible, and focused on quality and safety.[16] While implementing the PCMH model would require a significant investment of time and resources, the 10 building blocks of high-performing primary care — outlined in The AMA 10-Year Framework for Primary Care Reform and originally published in 2014 by Bodenheimer et al. — presents a roadmap to guide transformation of primary healthcare towards the PCMH.[17,18]

Linking chronic disease management, health assessment, and medication management review MBS items to VPE will also be key to successfully implementing VPE, as this will facilitate and reward longitudinal care. GPs will be only able to claim these items for enrolled patients, noting that there would need to be some flexibility for vulnerable and hard-to-reach populations and a sufficient period for transition.

To avoid administration costs associated with implementing VPE it will be essential for the process to be streamlined and incorporated into practice software systems. A clear outline of the patient's role in enrolment should be developed, noting the importance of patient consent. Enrolment also presents challenges for people living in rural and remote areas, mobile populations, and those living with disability and / or transport limitations.[19]

Wound care for targeted chronic wounds

It is recommended that the wound consumables scheme be initially implemented for concession and healthcare card holders, and then subsequently expanded to all patients with chronic wounds. Prioritising concession and healthcare card holders will ensure that those patients who are likely to be greatly impacted by the costs of consumables are prioritised during the implementation of the scheme.

As recommended by the MBS Review Taskforce Wound Management Working Group, it is recommended that new MBS items be established to support general practices deliver evidence-based wound care, including:

- an item for the general practitioner to perform a comprehensive initial assessment of a chronic wound
- an item for the general practitioner to perform regular assessments of the chronic wound
- an item for an appropriately trained practice nurse, Aboriginal and Torres Strait Islander Health Practitioner, or Aboriginal Health Worker to provide short term treatment of a chronic wound.

These new MBS items would facilitate a stepped care model for wound care, and would be linked to regular education and training to encourage upskilling of those involved in managing wounds and evidence-based practice. Additionally, improved coordination education and training requirements as well as reform initiatives would reduce the duplication of effort and silos that currently exist in the sector. As patients with chronic wounds often suffer from other chronic conditions and comorbidities, it is recommended that the proposed new MBS items and funded wound consumables scheme be linked to voluntary patient enrolment to support the delivery of coordinated care.

Aged care funding model

Unless the government funds initiatives to improve access to GPs in aged care facilities, residents will have a lower quality of life and downstream costs will be incurred through costly hospital transfers and unnecessarily long hospital stays.[20]

In implementing additional funding, the AMA supports the adoption of blended funding models. This will address problems identified by the Royal Commission into Aged Care Quality and Safety that relate to patients not being able to access sufficient services or the right mix of services. Future arrangements should encourage both.

New MBS consultation item to support longer consultations

Implementing the proposed longer consultation item for consultations between 15 and 19 minutes would be relatively straightforward as GPs are accustomed to changes to the MBS and would welcome this item as a means of better supporting their patients. Failure to support GPs to spend more time with patients will, as the population ages and care needs become more complex, drive health costs up in the longer term as it will undermine efforts to improve prevention, better manage conditions in primary care, and likely result in more tests and investigations being required.

The risks of not taking action

The Australian population is growing, ageing, and developing more complex health needs as the incidence of chronic disease and mental ill-health continues to increase. GPs are therefore managing more problems in each consultation and are spending more time with patients.[21] Inadequate support for general practices will therefore have a significant impact on the capacity of general practices to continue providing quality care into the future.

Missed opportunities for timely preventive and holistic care increases healthcare expenditure over the longer term and contributes to fragmentation of care, inefficient use of resources, and poorer patient health outcomes. This will result in significant cost increases to the health system,[22] with 6 per cent of all hospitalisations in 2016–2017 due to 22 preventable conditions that could be managed by general practice, accounting for over 2.8 million bed days.[23] It will also result in poorer health outcomes for patients, which in turn is associated with absenteeism, presenteeism, lower productivity, and lower workforce participation.[24,25]

Timeframes and costing over four years

The figures below are in nominal dollars, and are in addition to the government's budgeted funding outlined in the 2022-2023 Budget.

Priorities for the Strengthening Medicare Taskforce

Note: The below priorities have not been costed as the Commonwealth Government has committed to spending $750 million ($250 million per year from 2023–24) to strengthen Medicare over three years. These initiatives however will require long-term funding to ensure their value does not deteriorate over time.

Increasing the cap and indexing the WIP

Raising the cap on the incentive available under the WIP to 7,000 SWPE will cost the government $206.9 million across the forward estimates. When an annual indexation of 80 per cent Wage Price Index (WPI) and 20 per cent Consumer Price Index (CPI) is introduced alongside raising the cap, the net cost to government is $326.1 million. The cost however would be covered by using the $448.5 million previously earmarked for VPE.

The number of GPs currently at or above the SWPE 5,000 cap have been calibrated to match the current program. This calibrates the expenditure on the former PNIP in 2018/19 to the practice stream of the WIP,[26] as well as the current distribution of GPs working in practices of size 1, 2–5, 6–10 and ≥11 in 2019.[27,28,29] There is also an allowance for a greater proportion of part-time workers in larger practices as outlined in the Royal Australian College of General Practitioners *General Practice: Health of the Nation 2020 report*,[38] which lowers the maximum SWPE of larger practices compared with survey results based on head count.

Table 1: Impact of raising the cap on the incentive available under the WIP to 7,000 SWPE and introducing annual indexation

	2022–23	2023–24	2024–25	2025–26	Total
Cost of raising the cap to 7,000 SWPE ($m)	48.1	50.4	52.9	55.5	206.9
Cost of annual indexation ($m)	10.1	22.5	35.8	50.8	119.2
Total cost to government ($m)	58.2	72.9	88.7	106.3	326.1

Improved access to GPs afterhours

Aligning the definition of after-hours for general practices with the AMDS will cost the government $339.7 million across the four-year forward estimates. This assumes that 5 per cent of the additional GP services will replace ADMS services. It also assumes that there is no change in the proportion of Level A, B, C and D services currently delivered under after-hours care. No other price changes are assumed other than standard MBS indexation.

Table 2: Impact of aligning the definition of after-hours for general practices with the AMDS

	2022–23	2023–24	2024–25	2025–26	Total
Total number of GP services delivered 6pm–8pm (million)	6.61	6.77	6.94	7.11	27.43
Proportion of additional GP services delivered 6pm–8pm that would have otherwise not been delivered by any other healthcare provider	*165,277*	*169,301*	*173,434*	*177,680*	*685,693*
Net cost, after allowing for reduction in ADMS ($m)	79.4	83.0	86.7	90.6	$339.7
Total cost to government ($m)	79.4	83.0	86.7	90.6	**339.7**

Implementing VPE

Modelling indicates that linking chronic disease management and health assessment MBS items to VPE will result in a 4 per cent reduction in claiming of these items (as these items will only be able to be claimed for enrolled patients, preventing potential misuse of these items). Linking medication management review MBS items to VPE are expected to reduce claiming by 10 per cent. Over four years, this would translate to government revenue of $224.7 million across between 2022–23 and 2025–26. This assumes that there is a 75 per cent uptake of services through VPE.

As outlined above, this $224.7 million saving could be used in establish a funded wound care scheme and wound care MBS items to improve the delivery of evidence-based wound care in general practices (refer to costing below). The VPE savings would begin from date of first enrolments in January 2022 but would not become fully realised until the financial year 2023–24 when utilisation of these item numbers is exclusive to VPE (from July 1, 2023).

Table 3: Impact of linking chronic disease management, health assessment, and medication management review MBS items to VPE

	2022–23	2023–24	2024–25	2025–26	Total
Cost recovery by linking chronic disease management MBS items to VPE ($m)	22.7	48.2	51.2	54.3	176.5
Cost recovery by linking health assessment MBS items to VPE ($m)	5.1	10.9	11.6	12.3	39.9
Cost recovery by linking medication management review MBS items to VPE ($m)	1.1	2.3	2.4	2.5	8.3
Net revenue to government ($m)	**29.0**	**61.5**	**65.2**	**69.1**	**224.7**

Wound care for targeted chronic wounds

For patients with chronic wounds (note: the AMA's analysis focused on diabetic foot ulcers, arterial leg ulcers, and venous leg ulcers, and does not include pressure wounds or acute wounds), the consumables scheme is estimated to cost the Commonwealth Government $3.7 million in 2022–23 ($16.1 million from 2022–23 to 2025–26) for the estimated 30 per cent of concession and healthcare card holders that would access wound care through a general practice (as opposed to another healthcare setting such as a hospital outpatient clinic). If this program was expanded to all patients (i.e. not just concession and healthcare card holders), this scheme is estimated to cost $5.3 million in 2022–23 ($22.9 million from 2022–23 to 2025–26).

Implementing the new MBS items for the general practitioner and appropriately trained practice nurse, Aboriginal and Torres Strait Islander Health Practitioner, or Aboriginal Health Worker is estimated to cost the government an additional $1.7 million in 2022–23 (7.4 million from 2022–23 to 2025–26). This additional cost is on top of what is already funded for the treatment of wounds through the existing MBS consultation structure and the WIP, and accounts for the proposed changes to the consultation structure.

The total savings for the delivery of evidence-based wound care is estimated to be $47.1 million in 2022–23 ($203.4 million from 2022–23 to 2025–26). Additionally, the implementation of the MBS items for trained practice nurses, Aboriginal and Torres Strait Islander Health Practitioners, or Aboriginal Health Workers is estimated to "free up" around 148,000 general practitioner consultations in the first year, and 162,000 consultations by the fourth year, as under the current consultation structure a general practitioner is required to be present on all occasions to bill the MBS.

Table 4: Summary of the impact of evidence-based wound care[30]

	2022–23	2023–24	2024–25	2025–26	Total
Cases	76,250	78,750	81,000	83,250	319,250
Hospitalisation	27,750	28,750	30,000	31,250	117,750
Investment					
MBS ($m)	1.7	1.8	1.9	2.1	7.4
Consumables ($m)	3.7	3.9	4.1	4.3	16.0
Total cost to government ($m)	**5.3**	**5.7**	**6.0**	**6.4**	**23.4**
Savings					
Savings in-patient hospital ($m)	19.9	20.8	21.6	22.6	84.9
Patient savings ($m)	3.7	3.9	4.1	4.3	16.0
Out-patient savings ($m)	22.0	23.4	24.7	26.1	96.2
Other community savings ($m)	1.4	1.5	1.6	1.7	6.3
Total saved ($m)	**47.1**	**49.6**	**52.1**	**54.7**	**203.4**
Return on investment multiple	8.808	8.72	8.65	8.57	8.68
Total government savings ($m)	16.6	17.4	18.3	19.2	71.6
Net savings to government ($m)	**11.2**	**11.8**	**12.3**	**12.9**	**48.2**

Refer to Appendix B of the AMA's research report *Solutions to the chronic wound problem in Australia* for further details and assumptions on how the cost of a funded wound consumables scheme and MBS items was estimated.

Aged care funding model

These costings represent a much-needed increase in funding to support GPs to deliver health care in aged care settings. Using some of this funding, government should review incentives for GPs to attend RACFs and establish a new long-term funding model which supports the delivery of coordinated, high-quality, person-centred, and longitudinal healthcare which compensates for the additional time and complexity involved in delivering care in RACFs. These costings assume that growth in RACF residents will slow due to the expansion of the Home Care Program, impact of the pandemic incentivising people to remain in their homes longer, with services delivered in RACFs now assumed to grow at 2.0 per cent per annum.

Table 5: Cost of increasing payments to GPs delivering services in RACFs

	2023–24	2024–25	2025–26	2026–27	Total
Cost of increasing payments to GPs delivering services in RACFs ($m)	128.1	133.4	141.6	153.4	556.5
Net cost to government ($m)	**128.1**	**133.4**	**141.6**	**153.4**	**556.5**

New MBS consultation item to support longer consultations

Implementing a new consultation item for consultations between 15 and 19 minutes will require a $1.03 billion investment from government from 2022–23 to 2025–26. The fee is assumed to be $54.66 (100 per cent of proposed MBS fee in 2021–22, where the new consultation item increases by 85 per cent of the mid-point of Level B and C consults). BEACH data on the mode, median and mean length of consult was used to establish the distribution of time for standard Level B attendance item in 1 minute increments. An estimated 25 per cent of all Level B attendances are between 15 and 19 minutes. There is an estimated increase to 31 per cent of items billed for the 15–19 minute consultations using the number of consults that are close to the 15 minute window that might be extended to claim the longer consultation item MBS fee. There is also a conservative assumption that the entire increase in the new MBS item claims comes at the expense of fewer standard Level B attendances. The final cost may be lower if the new MBS item results in a reduced number of Level C attendances.

Table 6: Cost of implementing new MBS consultation item for consultations between 15 and 19 minutes

	2022–23	2023–24	2024–25	2025–26	Total
Cost of implementing a longer attendance item between 15 and 19 minutes ($m)	95.4	198.5	309.8	429.8	1,033.6
Net cost to government ($m)	**95.4**	**198.5**	**309.8**	**429.8**	**1,033.6**

Other policy priorities

Encouraging a career in general practice

Employment reform

The AMA is calling for the introduction of a single employer model for general practitioners in training. Under a single employer model, general practitioner registrars would be able to move between general practices without losing their entitlements. It would also bring remuneration and benefits like accrual of leave (sick/maternity) in line with hospital-based registrars to make entering a general practice training program a more attractive and viable option for registrars.

Exposure to general practice in medical school and prevocational medical training

The AMA is calling for the implementation of initiatives to increase exposure to general practice and primary care in medical school and during prevocational training. This includes:

- embedding exposure to primary care in the medical school curricula and reintroducing the John Flynn Placement Program for medical students (this was discontinued in early 2022)
- establishing a Community Residency Program (or similar) to promote stronger recruitment into general practice, by providing doctors in training with more opportunities to undertake prevocational training in general practice and ensuring more doctors have a fundamental understanding of the functioning of general practice and primary care.

Incentives to encourage rural practice

The AMA is calling for the introduction of incentives to encourage general practitioners (as well as all medical practitioners) to work in rural areas:

- provide rural, emergency/on call and advanced skills loadings and incentives that encourage doctors to work in rural areas and reward long service
- fund the establishment of networks between rural and city general practices to support non-metropolitan general practice e.g. share administration, provision of locum relief
- provide tax free infrastructure grants to rural practices to support investment in new technologies e.g. telehealth, home monitoring
- provide extra funding and resources to rural and regional hospitals to support the provision of adequate facilities, improved staffing levels and flexible work arrangements, e.g., core visiting medical officers, locum relief for GPs and non-GP specialists
- provide family support that includes spousal opportunities/employment, educational opportunities for children, subsidy for housing/relocation and/or tax relief
- improve access to educational support for rural doctors including continuing professional development and mentoring
- provide access to high-speed broadband in rural areas including the rollout of the National Broadband Network.
- implement models to address the market failure of small rural practices e.g. funding for local governments to adopt the AMA easy entry, gracious exit model.

CHAPTER 2: PUBLIC HOSPITALS

Overview

This chapter of the *AMA Pre-Budget Submission 2023–24* draws on the AMA research report *Public hospitals: cycle of crisis* with some of the modelling adapted and extended to give estimates between 2022–23 and 2025–26.

Problem statement

The Australian public hospital system is in crisis, with patients caught in logjam. Chronic underfunding at both state and territory and Commonwealth levels has led to declining performance. In the last few years we have increasingly heard stories of people dying waiting to be seen in public hospitals that are operating at breaking point, patients waiting years for essential surgery, and ambulances ramping outside hospitals because there are not enough beds and staff to cope with demand. Only 63 per cent of patients waiting to receive urgent care in the emergency department will be seen within the clinically recommended 30 minutes, a decrease of four per cent from the previous year.[1] For those patients who require Category 2 essential elective surgery — procedures like heart valve replacements or coronary artery bypass surgery — one in three will wait longer than the clinically indicated 90 days.[2]

Since 2008 we have lost six public hospital beds for every 1000 persons over the age of 65.[3] 30 years ago we had more than 30 beds in our public hospital system per 1000 people over the age of 65, whereas now we now have less than 15.[4] At the same time our population is growing, ageing, and increasingly developing more chronic and complex health needs. We expect that by 2035 more than one million people will be older than 85, almost double what it is today.[5] The cost of health delivering health care is also increasing, with cost growth (inflation) plus demand growth for services likely to start exceeding government funding growth (AMA projection). These problems have existed for years, and COVID-19 has only amplified the problem. Australia urgently needs a recovery plan to address the backlog of elective surgeries, build enough capacity to meet the growing needs of the community, and clear the hospital logjam.

Policy proposals

Urgent reform of public hospital funding is needed. The AMA's vision is for a new funding approach to supplement the current focus on activity-based funding — one that includes funding for positive improvement, increased capacity, and reduced demand, and puts an end to the blame game.

While broader reform is needed in the long term, the AMA is calling for targeted reforms that are needed right now to stem the public hospital crisis. This includes:

Increase funding and the funding cap

The Commonwealth contribution should increase to 50 per cent for activity (as per current COVID-19 partnership agreement), with states and territories to use the 5 per cent of 'freed-up' funds on improvement. The annual growth cap (6.5 per cent) on the Commonwealth's contribution should be removed, allowing funding to meet demand for hospital services.

Address demand

Activity-based funding should still be the funding model for the majority of people, but should be supplemented by an alternative model of care better designed for holistic treatment of patients with chronic and complex disease. Some alternative models of care have been trialled, but time and money are needed to support and scale successful pilot projects to state-wide services, and enable further trials of innovative models of care. The Commonwealth should partner with the states and territories to provide additional up-front funding for this purpose. Return on investment would be realised through reduced public hospital costs, over time. Improved patient outcomes would also be achieved through reduced admissions and re-admissions.

Improve performance

Select pay-for-performance targets should be reintroduced and monitored with the goal of at least reversing the decline in public hospital performance. This Commonwealth funding would be in addition to, and separate from, activity-based funding. In the short term there should be immediate Commonwealth funding targeting ED performance and capacity improvement, noting that some state and territory governments have undertaken reviews into what is required,[6] but there is not a mechanism for large scale/state-wide cost sharing of this work with the Commonwealth, within the parameters of the current hospital funding agreement.

Expand capacity

States and territories should use the 5 per cent of 'freed-up' funds to invest in evaluation and improvement activities to increase their capacity through improved processes. Public hospitals should also be given additional funding to expand their capital infrastructure where needed. The Commonwealth Government should fund this in partnership with the states and territories, in the knowledge that it will improve both hospital efficiency and patient outcomes. This additional money could be allocated on a match funding basis, following proposals from the states and territories.

Risks and implementation

State and territory government expenditure

It is a possibility that the state and territory governments would not choose to spend the 5 per cent of 'freed-up' funds on public hospitals. This is unlikely given the crisis situation that public hospitals are experiencing right now. Additionally, most state and territory governments have committed either publicly or in writing to the AMA that they would reinvest the 5 per cent into improving public hospital performance. This risk could be mitigated by including a requirement to reinvest the additional 5 per cent in a revised funding agreement.

Performance improvements

It is possible that reforms will only result in performance of public hospitals being stabilised (no further decline), rather than improved. This is a risk given the dire situation that public hospitals are facing right now and the fact that funding reform is overdue — additional funding may initially be absorbed into stabilising the current crisis. This risk is inversely proportional to the scale of reform and new investment; if funding reform lacks ambition the risk of minimal impact will be greater.

The risks of not taking action

The AMA has modelled what public hospital performance will look like in the future under a 'do nothing' scenario, and the risks of not taking action are significant:

- Bed numbers will continue to decline relative to the population. Without an increase in the rate of additional beds (currently 1 per cent per year), the number of beds per 1,000 people aged 65 and over can be expected to fall from 14.9 in 2019–20 to 12.7 by 2030–31.
- Growing hospital admissions and ED demand will put even more pressure on public hospitals. There is sustained growth in ED presentations and also in the share of those presentations which are then admitted to hospital. The combined effect of strong growth across both measures begins to paint a disturbing picture. When growth is projected out to 2030–31, it shows admissions from ED will grow to over 5 million per year in 2030–31 from only 2 million in 2012–13.
- Beds will increasingly be taken up by emergency admissions. Average daily admissions from the ED are already exceeding 10 per cent of total public hospital bed capacity. Due to the projected increase in admissions from ED, without an increase in the rate of new beds being added, this will reach 20 per cent by 2030–31.
- Waiting lists for elective surgery will increase. When a stretched hospital needs to accommodate ever increasing admissions from ED, those beds, doctors and nurses become unavailable for any other form of admission. The resulting impact will be that other admissions will be increasingly deprioritised, leading to even longer waiting lists for elective surgery and non-emergency medical treatments.
- There will be significant unmet demand for non-emergency public hospital services. When faced with beds which are increasingly occupied by admissions from the ED, hospitals do their best to accommodate all other admissions. This capacity constraint combined with the 6.5 per cent funding cap will lead to fewer admissions than there otherwise would be. By 2030–31 unmet demand will rise to approximately 14 per cent of all hospital activity or around 1.4 million admissions. For comparison, this is larger than the current size of all elective surgery. This is a significant amount of unmet demand for hospital treatment that can be expected within ten years if no action is taken.

Timeframes and costing over four years

The figures below are in nominal dollars, and are in addition to the government's budgeted funding outlined in the 2021-2022 Budget.

Table 7: Impact of select funding reform measures on Commonwealth budget

	2022–23	2023–24	2024–25	2025–26	Total
Additional hospital activity (remove 6.5% cap) ($b)	1.5	1.8	2.1	2.5	7.8
Increase Commonwealth share of hospital funding to 50% ($b)	2.8	3.1	3.3	3.5	12.7
Net cost to government ($b)	**4.3**	**4.8**	**5.4**	**6.0**	**20.5**

Costings for performance improvement, capacity increases and avoidable admissions and re-admissions are not provided at this stage, as each state and territory would remain responsible for identifying current and future capacity needs, models of alternative care and areas for improvement, before the Commonwealth would be required to provide partnership/matched funding under these funding streams.

It is envisaged that each state and territories' mix of requirements would differ, as would the timelines for development, implementation and therefore expenditure. In considering future outlays, it should be recognised the potential savings that will accrue over a longer period of time to the health system from more effective management of chronic disease, and therefore lower levels of hospital admissions and re-admissions than would otherwise be the case. Performance and infrastructure improvements will no doubt require additional expenditure, and likely increase volumes of patient throughput, but will also generate some benefits for the individual and the economy from improved health outcomes, less unmet demand, and fewer delayed hospital presentations from the community.

CHAPTER 3: PRIVATE HEALTH

Overview

This chapter of the *AMA Pre-Budget Submission 2023–24* draws on the AMA research report *Prescription for private health insurance*, and the AMA's discussion paper with some of the modelling adapted and extended to give estimates between 2022–23 and 2025–26.

Problem statement

The private health system is an essential component of Australia's healthcare system, offering patients access to a wider range of services and reducing demand on the public sector. One of the unique strengths of the Australian healthcare system is the equilibrium that exists between the public and private sectors, which work in partnership to provide high-quality healthcare to Australians. The equilibrium relies on a strong private healthcare sector which complements the public sector to:

- reduce demand on the public health system, with 66 per cent of all elective surgeries conducted in the private system[1]
- enable consumers to have more control over their healthcare, including selecting their preferred practitioner, accessing care more quickly (through reduced wait times for elective treatment), and having access to a wider range of services outside of the public sector
- encourage innovation and quality improvement in healthcare services.

Australia's unique private health insurance system offers 'community rating' (two people on the same product pay the same premium, regardless of differences in expected claim cost/risk), which allows all Australians to 'buy into' the high-quality private system, regardless of their age or pre-existing health conditions.

The last couple of years have shown how quickly a sector can come under financial pressure. In the lead up to the COVID-19 pandemic, insurers were increasingly under fiscal threat as participation rates had dropped for 20 successive quarters and their outlays were continuously increasing. Through the pandemic participation rates have now climbed for 8 successive quarters and outlays have decreased due to the impact of lockdowns and workforce shortages. Private hospitals have now faced 3 years of decreased activity which has significantly impacted on their ability to generate income

Notwithstanding the recent increase in insurance uptake, those over 60 years of age are set to become the largest insured population in the foreseeable future, with younger and healthier Australians no longer seeing the value in insurance. This decline in membership is due to several factors, including:

- The private health insurance rebate has eroded over time, as rebate was effectively frozen when government indexed it by the Consumer Price Index rather than premium growth since April 2014.[2] The value of the average rebate has therefore fallen from 30 per cent in April 2013 to 24.61 per cent in April 2021.[3]
- Many consumers no longer see the value for money of private health insurance. In a survey, 76 per cent of people identified as not having private health insurance but being able to afford it, gave "premiums too expensive/out of pocket costs too high" as the main reason for not having private health insurance.[4] Payout ratios (amount paid in premium relative to amount received through benefit claims) among for-profit providers (83 per cent) are also lower than not-for-profit providers (90 per cent), with 66 per cent of all those insured with for-profit funds.
- Premium growth (61 per cent) has outstripped income growth (29 per cent) over the past decade. Additionally, income growth among younger people is even slower. Among 21-34 year olds, it is only a quarter for 'Professionals' and 62 per cent for 'Technicians and trades workers' of what it is for all ages.[5]
- Private health insurance is one of many costs facing younger people as they struggle to repay education debts, contribute to superannuation, save for a house deposit, and pay high rent, and there is a lack of incentives to engage young members.

These factors are resulting in a shift in demographic composition of the insured pool, placing insurers and the private health system more broadly under increased financial pressure.

Policy proposals

Establish a Private Health System Authority

The current regulatory arrangements were designed at a time when private health insurance was in a relatively healthy position with strong membership, when most insurers operated on a not-for-profit basis, and when private hospitals had a greater profit margin. While the arrangements are effective at protecting the interests of consumers by maintaining insurer solvency, managing consumer complaints, and ensuring the safe delivery of healthcare, there are limited mechanisms in place that ensure the private health system is changing in a lasting way as government policy intends. There are also limited whole-of-system mechanisms to ensure the needs of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers and doctors are considered and balanced.

The AMA is calling for the establishment of an independent and well-resourced Private Health System Authority (the authority) to fill the gaps in the current regulatory environment and oversee the private healthcare system. This 'independent umpire' would have the capacity, objectivity, and expertise to ensure the system evolves as government policy intends, balancing the interests of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors. It would also create a platform for all the players in the sector to come together and agree on the necessary once-in-a-generation reforms which are required to ensure the future viability of private healthcare in Australia. Refer to the AMA's discussion paper *A whole of system approach to reforming private healthcare* for more information.

Recalibrate the private health insurance policy levers

To stem the exodus of private health insurance policy holders, we need to increase the value and decrease the pressure on premiums, at the same time. Careful reform will be required both in the short and long term. In the short term, all the policy levers operated by government will need to be recalibrated.

Since the *AMA's Prescription for private health insurance* was published, work to review some of these policy levers is now underway. A slightly revised policy proposal is outlined below to recognise that some work has begun and the reform that is still required.

Restore the private health insurance premium rebate

Restore the private health insurance rebate to 30 per cent for targeted groups to make private health insurance affordable for younger Australians and those in the workplace on lower incomes.

Increase the Medicare Levy Surcharge

Reconsider the Medicare Levy Surcharge levels and thresholds, in order to determine what settings are required to deliver on the policy intent. A government review is now underway. For the purposes of the costing, the AMA has set a threshold of a 2 per cent Medicare Levy Surcharge for those earning over $105,000 per year.

Mandate a minimum payout ratio

To improve the value proposition of private health insurance, mandate a minimum return amount (e.g. 90 per cent) to the health consumer for every premium dollar paid. There needs to be a standardised return that is higher than the current private health insurance industry average.

Lifetime Health Cover loading

Review the Lifetime Health Cover loading and penalties to make it an easy choice for Australians to stay in private health insurance for life. A government review is now underway. This should ensure that Lifetime Health Cover loading can fulfil its original intent to act as an incentive for early purchase rather than a barrier, such as by raising the age at which it first applies.

Youth Discounts

Better promote existing government youth discounts on private health insurance, and extend the age of eligibility to align with reformed Lifetime Health Cover loading that stems from the review presently underway.

Risks and implementation

Establish a Private Health System Authority

An independent authority would consolidate regulatory functions previously carried out by other parts of government/agencies so that they operate in a more cohesive and effective way (including relieving the Department of Health of its conflicted role as regulator and policy maker). It would also incorporate new functions and skills to fill the gaps in the current regulatory environment, as well as supporting the regulatory and advisory functions currently performed by other agencies. Cost transfer for existing functions carried out by other agencies as well as additional costs would be required. Sufficient transition time and resource should be allocated to make sure this is done effectively, however overall costs are not anticipated to be high.

Recalibrate the private health insurance policy levers

Impact of premium rebate

It is possible that extra expenditure on the premium rebate will only result in a moderate uplift in private health insurance membership. This is a risk given the current public perception around private health insurance, particularly that younger people perceive it as a low value proposition. This risk could be minimised with better promotion of youth discounts and reformed incentives for younger people to join. The risk is also inversely proportional to the scale of reform and new investment, as a lack of ambition in funding reform will increase the risk of suboptimal impact.

Public and stakeholder opinion

Among the suite of reforms that are required to steer private health insurance out of crisis are a range of policies that may disproportionally impact different populations. For example, older people will not be eligible for youth discounts and incentives, higher wage earners could pay more Medicare Levy Surcharge than previously, and private health insurance companies may resist greater transparency, a mandated minimum payout, and/or a new Private Health System Authority. The risks to each of these groups (as well as the general population) of taking no action however are too high, and therefore careful stakeholder management should be undertaken and involve communication of these risks. The medical profession supports a move to greater transparency, provided all players partake.

The risks of not taking action

The risks of not taking action are significant and would overall make the private health sector unsustainable. This would impact the delicate balance that exists between the public and private sectors, and would result in increased burden on our already struggling public hospital system. Without intervention, the value proposition for younger people will not improve and the downwards trend in their membership numbers will continue. This will result in rising premiums, which in turn will result in more people dropping their insurance cover. If this is not addressed now, more radical reform may be required in the future, such as abandoning community rating to bring younger and healthier people back into private health insurance, while making premiums unaffordable for older and sicker people. This in turn would put pressure on the public system and result in longer waiting times for care emergency and non-emergency treatment, and result in significant unmet demand for health services which will ultimately impact population health, productivity, and the economy. It would also contradict the principles of fairness and access that are the hallmark of the Australian health system.

Timeframes and costing over four years

Establish a Private Health System Authority

The direct cost of an independent authority which currently doesn't exist is difficult to estimate. At present, the Australian Prudential Regulation Authority (APRA) provides prudential regulation of private health insurers. APRA reports that its total operating expenditure for the 12 months to 30 June 2020 was $196.2 million.[9] Using the number of private health insurers it prudentially regulates (37 during 2019–20) and comparing that to the total number of entities it regulates (2,273), we could apportion the cost to a sensible approximation of $3.2 million per year.

This role currently performed by APRA is only one of an expanded set of roles envisioned for the proposed authority; additional funds would be required to fulfil these extra functions. The total annual cost of the proposed authority is estimated in the table below, which includes the $3.2 million cost reallocated from assuming responsibilities from APRA.

The government could choose to recover the ongoing cost of the authority through charges to insurers. This would represent approximately 0.1 per cent of revenue taken by private health insurers ($25m per year in 2019–20).[10] This would likely see the cost passed on to consumers through higher premiums in the order of 0.1 per cent.

An additional $10 million is estimated to be required to establish the new authority and consult with stakeholders regarding its ongoing roles and responsibilities. If cost recovery was undertaken, this $10 million would be the only net cost to government between 2022–23 and 2025–26.

Table 8: Cost of a Private Health System Authority

	2022–23	2023–24	2024–25	2025–26	Total
Establishment cost ($m)	10	-	-	-	10
Ongoing cost ($m)	28	29	30	32	119
Cost recovery through charges to insurers ($m)	28	29	30	32	119
Net cost to government ($m)	10	-	-	-	**10**

Recalibrate the private health insurance policy levers

Explanatory note

In the costings, the 'premium' refers to the 'average base premium' that insurers set. The 'price' refers to the retail price that consumers pay for that premium after any applicable rebate. Some policies will affect the base premium, which is then assumed to also be passed onto consumers through the price. Policies involving the rebate will have a direct effect on the price but may also have an indirect effect on the premium through change in the underlying private health insurance membership.

In the costings it is assumed that the 'additional private health insurance policies' claims experience, which arise in response to incentives to either retain or join private health insurance, will be at a reduced average rate to existing members (60 per cent of the average rate).[6] This is based on most of the incentives targeting people aged 65 and under, who have a much lower average claim profile.

There are also additional benefits to individuals and government which are not costed directly. The claims which are made against the additional private health insurance policies, even if at a reduced rate, still offer direct benefit to the individual claiming. Those benefits paid also offer care which otherwise would have to be carried out in the public hospital system. The benefits are most likely to accrue to reduced wait times for public hospital patients given the capped public hospital funding model.

Restore the private health insurance premium rebate

The costings for restoring the private health insurance rebate to its previous levels are only for people aged under 65 (30 per cent for those earning $90,000 or less, 20 per cent for those earning between $90,001 and $105,000, and 10 per cent for those earning between $105,001 and $140,000). For family policies the rebate levels used are the same as for singles, however the equivalent household income thresholds for couples are double those of singles. The income thresholds for singles and couples match the existing Medicare Levy Surcharge thresholds.

The price elasticity of demand for the impact of the change in the rebate was estimated at -0.5 ceteris paribus (with no other simultaneous changes a 1 per cent decline in price increases policies by 0.5 per cent), specifically among those under the age of 65.[7,8] The total cost to government between 2022–23 and 2025–26 is calculated as $5.31 billion. The number of additional private health insurance policies are measured as the difference between the baseline and the policy scenario at each year.

Table 9: Impact of an increase to the private health insurance rebate (to restore to previous levels) for people under 65

	2022–23	2023–24	2024–25	2025–26	Total
Additional private health insurance policies (above baseline)	340,709	348,224	360,322	371,606	371,606
Rebate for additional private health insurance policies ($m)	343	360	383	407	1,494
Additional rebate for existing private health insurance policies ($m)	982	1,050	1,136	1,222	4,390
Change in Medicare Levy Surcharge revenue ($m)	-7	-8	-8	-9	-32
Reduction in average premiums because of new members (%)	1.82	1.92	2.04	2.16	2.16
Clawback rebate from lower premiums ($m)	138	146	155	164	603
Reduction in the price of private health insurance policies for members with $90,000 or lower income (including rebate and lower premiums) (%)	9.07	9.42	9.78	10.15	10.15
Net cost to government ($m)	1,194	1,272	1,373	1,474	**5,312**

Increase the Medicare Levy Surcharge

Costing is provided below for increasing the Medicare Levy Surcharge to 2 per cent for those earning $105,001 or greater. If applied without matching incentives to Lifetime Health Cover, the effect will be to raise more revenue but reduce the number of additional private health insurance policies. The total cost to government between 2022 – 23 and 2025 – 26 is an estimated $1.01 billion. This policy cost estimate does not include the simultaneous increase in the private health insurance rebate.

Table 10: Impact of increasing Medicare Levy Surcharge to 2 per cent for people earning $105,001 or greater (without Lifetime Health Cover change)

	2022–23	2023–24	2024–25	2025–26	Total
Additional private health insurance policies	138,270	169,373	183,397	189,313	189,313
Rebate for additional private health insurance policies ($m)	38	52	59	58	206
Change in Medicare Levy Surcharge revenue ($m)	-163	-201	-216	-227	-808
Reduction in average premium (%)	0.7	0.9	1.0	1.1	1.1
Net cost to government ($m)	200	253	275	285	**1,014**

Mandate a minimum payout ratio

The direct cost to government of an increase in the minimum payout ratio is zero. There would however be indirect costs — the main one being that additional private health insurance policies would cost the government additional private health insurance rebate. A behaviour shift towards more private health insurance policies would mainly be seen among those currently not subject to tax penalties or incentives — those earning $90,000 or less.

With more people taking out private health insurance policies, there would be 'second round effects' of lower premiums further boosting the number of people taking out policies, including those earning over $90,000. These second-round effects are not estimated or included in the costs.

The policy itself would not encourage as many people over the age of 65 and those subject to Medicare Levy Surcharge to take out private health insurance as these people already receive a larger benefit on average (through greater use) or a much larger price incentive through existing policies. The impact of a 90 per cent minimum payout ratio is costed below, at $560 million between 2022–23 and 2025–26.

Table 11: Impact of implementing a 90 per cent minimum payout ratio

	2022–23	2023–24	2024–25	2025–26	Total
Direct change in premium (%)	-3.8	-3.8	-3.8	-3.8	-3.8
Additional private health insurance policies	173,171	170,641	170,498	170,117	170,117
Rebate for additional private health insurance policies ($m)	138	138	141	143	560
Net cost to government ($m)	138	138	141	143	**560**

Increase the Medicare Levy Surcharge alongside changes to Lifetime Health Cover

As Lifetime Health Cover is currently under review with many different options being considered to encourage private health insurance membership, it is not possible to provide a detailed costing for as yet unknown changes. Instead, the AMA has provided costing for the higher Medicare Levy Surcharge rate of 2 per cent for people earning $105,001 or greater, if introduced alongside a change in Lifetime Health Cover.

If implemented alongside improvements to Lifetime Health Cover, the change in the Medicare Levy Surcharge rate would drive more people who are over the $90,001 income threshold but under the $105,001 income threshold to take up a private health insurance policy.

The changes to Lifetime Health Cover itself are not included in cost estimate below because this won't cost the government directly (same as for changes to youth discounts). Rather, improvements to Lifetime Health Cover will cause indirect costs to government from:

- an increase in the cost of the private health insurance rebate due to more people taking out private health insurance policies
- a decrease in Medicare Levy Surcharge revenue due to more people taking out private health insurance policies.

These indirect costs are included in the estimate below. When the Medicare Levy Surcharge policy change (increase to 2 per cent for people earning $105,001 or greater) is introduced alongside improvements to Lifetime Health Cover, the cost to government rises to $1.42 billion between 2022–23 and 2025–26.

Table 12: Impact of increasing Medicare Levy Surcharge to 2 per cent for people earning $105,001 or greater (with Lifetime Health Cover change)

	2022–23	2023–24	2024–25	2025–26	Total
Additional private health insurance policies	197,910	229,014	247,495	262,169	262,169
Rebate for additional private health insurance policies ($m)	70	85	96	101	352
Change in Medicare Levy Surcharge revenue ($m)	-223	-261	-281	-301	-1,066
Reduction in price of private health insurance policies (%)	1.1	1.3	1.4	1.5	1.5
Net cost to government ($m)	293	346	377	402	**1,418**

CHAPTER 4: A HEALTH SYSTEM FOR ALL

Overview

This chapter of the *AMA Pre-Budget Submission 2023–24* draws on the AMA research report *A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue* with some of the modelling adapted and extended to give estimates between 2022–23 and 2025–26.

Problem statement

There is an obesity crisis in Australia which is getting worse. In Australia, 31 per cent of adults and 8 per cent of children are obese. When including those who are overweight this increases to 67 per cent of adults and 25 per cent of children.[1] The prevalence of obesity in Australia is expected to continue to increase, with a third (33 per cent) of the projected adult population will be obese by 2025.[2] Obesity is a major risk factor for chronic and preventable conditions including type 2 diabetes, heart disease, hypertension, stroke, gall bladder disease, osteoarthritis, sleep apnoea and respiratory problems, mental health disorders and some cancers.

Sugar-sweetened beverages (SSBs) are a major contributor to the obesity crisis and provide almost no nutritional benefit. SSBs are drinks containing large amounts of 'free sugars' such as sucrose, high-fructose corn syrup or fruit juice. They deliver a high number of liquid calories but provide almost no nutritional benefit, with 8–12 teaspoons (33–50 grams) of sugar in the average 375 millilitre can of soft drink.[3] Despite the high sugar content, Australians are consuming SSBs in huge volumes.[4] In 2019–20, Australians consumed on average 70 grams of free sugar a day, with more than a quarter (18g) of this coming from sugary drinks.[4] The AMA estimates that Australians drink 2.4 billion litres of SSBs per year.[5]

Policy proposals

The AMA recommends implementing an excise tax based on sugar content on selected SSBs, at a rate of around $0.40/100g sugar, to reduce consumption, improve health outcomes, and lower the financial burden on the healthcare system. SSBs are a logical target for a public health intervention, given the high level of consumption of these products, which provide almost no nutritional benefit but make a major contribution to the obesity crisis, and to poor dental health, through high levels of free sugar.

A tax can deliver both a clear message for consumers that the product is unhealthy, and a tangible deterrent in the form of higher prices. An appropriately designed tax can also incentivise manufacturers to reduce the sugar content in their products. SSBs are also a practical target for a tax, as they are a discreet category that is easily identifiable.

SSBs subject to tax

This category of beverage typically includes carbonated and non-carbonated fruit, dairy/milk, sport, energy and cordial drinks containing free sugars, and excludes alcoholic and artificially-sweetened (diet) drinks. The AMA's proposal is to tax a subset of SSBs — all non-alcoholic drinks containing free sugars, excluding 100 per cent fruit juice, milk-based and cordial drinks. The focus is on drinks that provide no nutritional benefit.

Design of tax

The AMA recommends a sugar content tax, which is a sliding scale where the tax increases as the sugar content increases. A sugar content tax is the most logical option, given that harm is caused proportionate to the sugar content, not the value or the liquid volume. It is the only option that creates an incentive for manufacturers to lower the sugar content of their products, and therefore is the option most targeted at reducing sugar consumption.

Target of tax

The AMA recommends the tax be applied to domestic and international manufacturers of SSBs. The tax should be targeted at the manufacturer in order to incentivise reformulation. An excise (and customs) tax is the most logical option to do this.

Scale of tax

The AMA recommends a tax rate of $0.40/100g sugar. The World Health Organization's recommendation is that a tax on SSBs would need to raise the retail price by at least 20 per cent in order to have a meaningful health effect.[6] The proposed rate would have the effect of increasing the price of the average supermarket SSB by at least 20 per cent. SSB tax rates vary around the world. Several comparable countries to Australia have implemented sugar content taxes, some of which are set at a similar rate to that which is proposed. The tax would raise the price of a 375ml can of coke (which contains 40g sugar) by $0.16 (see Table 1 in the research report).[7]

Risks and implementation

Public support

Australian surveys have consistently shown majority support for a tax on SSBs.[8] Public support is even higher if tax revenue is hypothecated to fund initiatives to tackle obesity.[9] A nationally representative survey undertaken in 2017 found 60 per cent of Australians support a tax on sugary drinks. This increased to 77 per cent support if the proceeds were used to fund obesity prevention.[10]

International success

SSB taxes in other countries have been successful in reducing consumption and incentivising reformulation of SSBs. Almost 60 jurisdictions across the world have implemented SSB taxes.[11,12] There has been confirmed success already in a number of countries, including the United Kingdom (2018), Mexico (2014), France (2012), Chile (2014), Catalonia, Spain (2016) and in some US jurisdictions (Portland 1991; Cleveland 2003; Berkeley 2015), where robust evaluations have shown a drop in consumption following the tax.[13]

Pass-through of tax

There is no guarantee that an excise tax will be fully passed on to the consumer, as the retailer, wholesaler or manufacturer may choose to absorb it in part or in full. However, the international experience is that the SSB tax pass-through is sufficient to have an impact on consumption.[14] The government also has a range of options to influence tax pass-through such as raising the tax over time.

Impact on obesity and healthcare expenditure

Reduced sugar consumption and improved diet would likely lead to a reduction in the prevalence of obesity and substantial healthcare savings. According to previous Australian modelling, an SSB tax that increases the retail price by 20 per cent would lead to a reduction in the prevalence of obesity of around 2 per cent, and healthcare expenditure savings of $609 million to $1.73 billion (over the lifetime of the population modelled).[15]

Impact on vulnerable groups

A flat tax will inevitably have a greater impact on lower income consumers of the taxed product, as a proportion of their expenditure/income. This regressive effect is reduced if there is an untaxed substitute that consumers can easily switch to.[16] In the case of SSBs, healthy substitutes such as water are readily available and affordable to most people, and consumers can avoid the tax, as well as improving their health, by making this change.

When viewed holistically, an SSB tax could be considered a progressive measure, as lower socioeconomic groups, who are more likely to have poorer diets and be overweight and obese,[17] would theoretically experience a disproportionate health benefit in response to the tax. There is also potential to use the revenue from the tax to implement initiatives that would produce a benefit for lower socioeconomic groups, such as targeted subsidies on healthy foods.

It must be recognised that price signals do not have the same relevance in remote communities where the water supply is unsafe and/or unstable, as there is no safe and affordable source of hydration to switch to. The impact of price rises in these areas must therefore be considered to avoid creating further disadvantage, with particular attention paid to the safety and availability of drinking water, and the price of bottled water. The AMA recommends implementing the tax alongside measures to ensure reliable, safe access to water and affordable hydration beyond SSBs.

Impact on sugar industry

There would be minimal impact on Australia's sugar industry as around 80 per cent of Australia's domestic sugar production is exported (averaged over the past decade),[18] and only 5.3 per cent of total domestic production goes towards domestic SSB manufacture.[19] The estimated change in SSB consumption due to the proposed tax is 12 to 18 per cent (scenario 1 in the research paper), which translates to a 0.64 to 1.01 per cent drop in demand for domestic sugar production. The domestic sugar market has a much greater level of volatility than this change.[20] The impact on the sugar industry is therefore anticipated to be minimal and does not appear to warrant a government assistance package. Government may wish to consider whether there are any specific small farmers that mainly supply the domestic market, who may warrant an assistance package (which could be funded from the tax revenue).

The risks of not taking action

There is a strong association between SSB consumption and increased energy intake, weight gain and obesity.[21] Conversely, reduced consumption of SSBs is significantly associated with weight loss.[22] People living with obesity have healthcare costs that are approximately 30 per cent greater than their healthy weight peers.[23] Many of these healthcare costs are borne by the government, with the AMA estimating that if no action is taken to stem the obesity crisis, by 2025 governments will have footed a further $29.5 billion for the direct healthcare costs of obesity (over four years to 2024–25).[24]

Timeframes and costing over four years

Original modelling by the AMA indicates a tax on select SSBs would reduce sugar consumption by 21 per cent in 2022–23 to 31 per cent by 2025–26. It would raise annual government revenue of $740 million in 2022–23, falling to $678 million in 2025–26.

Over four years, this would translate to government revenue of $2,839 million between 2022–23 and 2025–26. More importantly, it would result in the reduction of 3.15 kilograms of sugar per person per year consumed through SSBs.

The rate of tax per 100g of sugar is indexed at an assumed 2 per cent between 2022–23 and 2025–26.

Table 13: Impact of implementing an excise tax on select SSBs

	2021–22 (baseline)	2022–23	2023–24	2024–25	2025–26	Total
Sugar per person from SSBs (kg/person)	8.90	6.91	6.54	6.10	5.75	-
Excise rate per 100g sugar ($)	0	0.40	0.41	0.42	0.42	-
SSB revenue ($m)	0	740	724	697	678	2,839
Estimated cost of administration to Australian Taxation Office ($m)	-	2	0.5	0.5	0.5	3.5
Net revenue to government ($m)	**-**	**738**	**723.5**	**696.5**	**677.5**	**2,835.5**

Revenue estimates have been derived using the more conservative price elasticity (in revenue terms) from the paper, derived from real-world impact evaluations of SSB taxes around the world (-1.00).[25]

Consumption of SSBs would drop the most when the tax is first introduced. An assumption in this modelling is that manufacturers would reformulate their products to reduce the impact of the tax and to align with an accelerated consumer preference for healthier beverages. These two factors cause the revenue raised from the tax to fall over time. The rate of reformulation has been assumed to match a similar reduction in sugar per beverage (34 per cent) to what was seen in the UK following introduction of a similar tax, but across a longer timeframe of 5 years, whereas this occurred in the UK within 3 years.

In this modelling, the impact of the tax is compared to and built upon a 'no tax' scenario. In the no tax scenario, there is assumed to be growth in underlying beverage consumption due to Australian population growth, in line with flat consumption per person. There is also assumed to be a gradual move toward no and low sugar beverages at the rate of a 1 per cent increase in market share of those products each year, in line with the aggregate industry trend.[26]

It is anticipated the government would use the existing ATO policies and processes responsible for excise and excise equivalent goods to administer the new SSB tax. It is assumed there would be an initial cost to set up new internal processes — an indicative estimate is given of $2 million set-up cost and $0.5 million per year thereafter for the ATO's ongoing compliance duties.

Other policy priorities

Preventive health

Investing in preventive health helps mitigate the onset of chronic illness, affords people longer and healthier lives, and reduces pressure on the health system. Prevention must become a foundation of healthcare planning and design. The AMA is calling for implementation of the National Preventive Health Strategy 2021–2030, including the commitment to allocate five per cent of health expenditure to prevention activities in the life of the strategy.

Aboriginal and Torres Strait Islander health

The AMA supports the National Agreement on Closing the Gap. This partnership gives Aboriginal and Torres Strait Islander leaders an equal seat at the table with all governments, and is designed to ensure Indigenous voices are prioritised in policy, budget and direction setting for policy across a broad range of areas.

Even so — the health gap remains persistent, and more effort is needed to ensure equity of access to culturally safe, response, affordable and accessible healthcare for Aboriginal and Torres Strait Islander peoples including:

- funding for Aboriginal and Torres Strait Islander health services is allocated according to need and under the advice of Aboriginal and Torres Strait Islander expertise
- expanding and investing in successful community-controlled health service delivery models, to allow Aboriginal and Torres Strait Islander organisations to deliver culturally safe and appropriate health services to their own communities
- investing in evidence-based strategies to grow the Aboriginal and Torres Strait Islander medical workforce
- ensuring cultural safety training is embedded across the medical profession.

Mental health

Three years into the pandemic, we have seen an increase in prevalence of mental ill-health to now impact almost one in four Australians at some point in their lifetime. We have also seen an increase in mental ill-health amongst young people who have been isolated from the normal freedoms and opportunities that define this significant time in life.

A comprehensive government response is needed over the long term to rebuild and reshape the Australian mental health system, and respond to a growing demand for services in the years to come, including:

- investment in mental health services delivered through general practice, offering comprehensive care to patients, and reducing fragmentation of care. This includes mental health nurses, social workers and other support services embedded within general practices to provide responsive mental healthcare
- increased MBS rebates for GPs providing mental healthcare to have parity with other chronic illness consultations
- expanding community mental health services to take pressure off other parts of the health system including emergency departments

Climate change

The health sector makes a significant contribution to Australia's carbon emissions — around 7 per cent each year. The AMA is committed to a net zero target for the healthcare sector by 2040, with an interim target of 80 per cent by 2030.

The AMA welcomes the Commonwealth governments $3.4 million commitment to establishing a National Health Sustainability and Climate Unit, and looks forward to working with government to ensure that the unit is an enduring long-term function that:

- enables all health departments across Australia to work together to reduce emissions and elevate sustainable practices in health car
- implements a national strategy
- incorporates waste reduction strategies as a requirement in hospital accreditation.

Child health

Climate change, poverty, a poor diet, and unstable housing can have a huge impact on a child's health. Social determinants have a direct impact on health and wellbeing, and the AMA believes that a commitment to equity must underpin fiscal, social, and economic policy. The AMA, along with other expert peak organisations, are calling for the establishment of a child health taskforce.

Other policy priorities

Matching the medical workforce to community needs

To avoiding the boom-bust cycle that has characterised medical workforce planning, we must ensure that medical school intakes are linked to workforce planning and community need. While we have seen an explosion in medical student numbers in Australia since 2004, this has not solved problems of maldistribution and specialty shortages.

The growth in full fee-paying student places encourages medical graduates to pursue specialty areas that are better remunerated, and these are typically areas of subspecialist practice located in large metropolitan centres.

We need to see a better system where there is regulation of all medical school places, including domestic and overseas full fee-paying places, so that medical school intakes are matched to community need, with clear limits on the number of full fee-paying students.

Investing in the rural medical training pipeline

To improve access to medical care for regional/rural areas and disadvantaged communities, we need to develop clear training pathways and solutions to rural medical workforce needs and distribution. This requires an increased focus on generalism within the specialist workforce, improved access to specialist services in rural Australia, and development of a rural training pipeline which takes students all the way through to the completion of specialist fellowship training. The achieve this we need to see:

- the expansion of the Commonwealth Government's Specialist Training Program (STP) to 1700 places over the next term, giving priority to rural areas, generalist training and specialties that are under-supplied
- investment in regional teaching hospitals to ensure they have sufficient capacity to host STP-funded non-GP specialist registrars
- implement the National Rural Generalist Pathway nationally, and a commitment to ongoing funding
- encouragement of end-to-end rural medical training programs, with a view to ensuring they provide positive rural exposure and lead to retention of rural medical practitioners
- expansion of capacity for remote learning (training and educational opportunities, especially for trainees in regional/rural sites, and potential remote supervision)
- promotion of regional training and research teaching hospital hubs to grow non-GP specialist capacity outside metropolitan areas.

CHAPTER 5: A HEALTH SYSTEM FOR THE FUTURE

Problem statement

Indexation of MBS rebates has been a source of controversy for many years, as government indexation of Medicare rebates has never kept pace with the rising costs of running a medical practice. As with all businesses, the costs of providing medical care go up each year, with increases in wages for staff, rent, medical equipment, cleaning, electricity, technology and insurance. All these costs are met by the fees the doctor charges for patient care. After years of frozen and low indexation, there is now a substantial disconnect between the MBS and the realistic cost of providing health services.

Over almost three decades, from 1995 to 2022, the MBS has had an annual average indexation rate of 1.1 per cent[1], whereas the average annual changes to the Consumer Price Index (CPI) and Average Weekly Earnings (AWE) — which are indicative of the increase in costs of running a medical practice — are 2.4[2] and 3.5[3] per cent respectively. Although the MBS received a boost in indexation of 2.5 per cent in 2006, this was followed by several years of low or no indexation. Since indexation was recommenced in 2017, it has only averaged at 1.3 per cent annually.[4] From 1 July 2022, Medicare items were indexed by 1.6 per cent,[5] and last year the indexation rate was 0.9 per cent, however it is predicted that inflation will reach 7.75 per cent in the year to December 2022.[6]

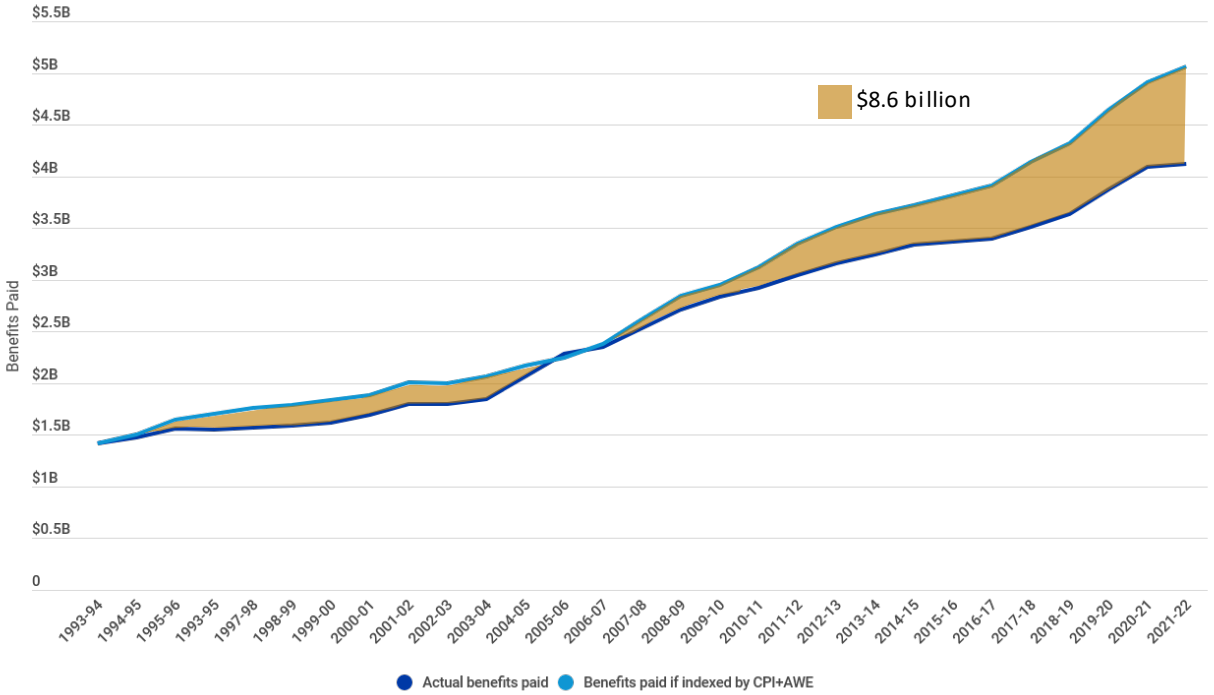
Medicare is designed to subsidise the cost of health services, as opposed to covering the full cost of providing the service, with most patients expected to pay some form of out-of-pocket cost for the majority of health services.[7] When a patient is bulk-billed for a service (for example, when a patient cannot afford to pay an out-of-pocket cost), the difference in cost for providing the service is cross-subsidised from the out-of-pocket costs from other patients, as well as other funding sources (for example, government grants or block funding).

Years of inadequate indexation however has meant that the patient rebate provided by Medicare no longer bears any relationship to the actual cost of providing high-quality services to patients, and the cross-subsidisation is not sufficient enough to make up the difference. The medical practice therefore has to either absorb these costs and risk becoming unviable, or pass more of the cost onto patients (with either higher out-of-pocket costs, reduced time spent with patients, or reduced bulk-billing of patients). This inadequate indexation has effectively resulted in a cost shift from the government to healthcare providers and patients.

To illustrate this issue of inadequate indexation, an analysis of the indexation of the Level B consultation item (the most commonly used item by general practitioners, used for consultations lasting less than 20 minutes) was performed, using CPI/AWE (70 per cent weight based on the AWE and 30 per cent weight based on the CPI) as an indicator for the increase in costs of running a medical practice. Depicted in Figure 1, this inadequate indexation has saved the government around $8.6 billion over the lifetime of the Level B consultation item, with this cost shifting to Australian general practices and patients by way of out-of-pocket costs and shorter consultations for patients, and revenue loss for practices.

Interestingly, the Level B rebate was increased in 2004–05, and then again in 2005–06, when the government of the day (the Howard government) increased the Medicare rebate from 85 per cent to 100 per cent of the schedule fee for all GP visits[8] and introduced bulk-billing incentives.[9] This was in response to a significant fall in bulk-billing rates amongst GPs, which was highlighted in the Senate Select Committee on Medicare report[10] published in 2003: *"real incomes for GPs who exclusively bulk-bill, relative to average weekly ordinary time earnings, have fallen in the past ten years, and that an increase in net earnings of about 10.6 per cent would be required to retain relative parity"* and that "*this decline in remuneration in real terms for GPs who bulk-bill around 80 per cent of their patients is of serious concern, and the Committee concludes that the relative under-remuneration is a primary factor, along with practitioner shortage, in the falling rates of bulk-billing in Australia."* Since then however, the rebate for the Level B consultation item has significantly diminished over time. For example, the rebate was $37.05 in 2017–18[11] and $39.75 for 2022–23[12], which represents a 7.3 per cent increase over the five years, despite CPI and AWE increasing by 13.9 per cent[13] and 14.7 per cent[14] respectively over the same time period.

Figure 2: Medicare rebate for the Level B consultation item, 1993–94 to 2021–22[15]



The analysis of the Level B consultation item is a clear example of how years of frozen and low indexation of Medicare rebates has stripped healthcare funding away from medical practices and the Australian population. To offset this, medical practitioners have to either increase out-of-pocket costs for patients or reduce the time they spend with patients to remain viable. In many cases, the patients that most frequently go to the doctor because of age, chronic conditions, and comorbidities are the ones that are least able to pay the out-of-pocket costs. As the population continues to age and the disease burden grows, the share of patients seen by general practices will increasingly be from this vulnerable cohort, and there will not be enough cross subsidisation from those patients who can afford the high out-of-pocket costs without additional funding from other sources. Ultimately, the current reliance on a few patients to help fund those vulnerable patients is a short-term and unsustainable solution that will ultimately lead to patient and community health needs not being met.

Policy proposals

The AMA is calling for the government to implement a revised indexation tool to ensure rebates better reflect the rising costs of providing high-quality medical care and running a medical practice. This will reduce patient out-of-pocket costs, encourage greater access to medical services, and build an important foundation for delivering sustainable, high-quality and value-based health services into the future. It would help improve the value proposition of private health insurance (outlined in Chapter 3).

Risks and implementation

Implementation of the revised indexation tool should prioritise those services where there has been a decline in bulk-billing and minutes per consultation, and an increase in patient out-of-pocket costs, as these may be the areas where the rebate does not sufficiently support the delivery of high-quality and holistic services. Ultimately, these rebates should be indexed to enable medical practices to meet the health needs of their patients and community.

The risks of not taking action

Medical practices, in particular those practices who bulk-bill the majority of their patients such as general practices, are increasingly struggling to remain viable. This year there have been many reports of bulk-billing GP clinics in financial stress and forced to close their doors. There has also been a decrease in bulk-billing of patients, particularly by general practices, which signals that practices are struggling to remain viable and are therefore needing to charge patients an out-of-pocket medical gap in order to pay for the increasing costs of running a medical practice. If the gap between the Medicare rebate and cost of providing medical care continues to increase, practices will increasingly be unable to absorb the costs associated with providing high-quality healthcare. This will result in more bulk-billing practices closing their doors and out-of-pocket costs for patients, which will ultimately impact patient access to timely and affordable care.

Timeframes and costing over four years

A simple indexation costed projection has been performed as an indicative example, to demonstrate the potential cost to government if the indexation of MBS items was improved to better reflect the rising costs of high-quality medical care and running a medical practice.

The overall MBS indexation rate as at July 2022 (1.6 per cent) was used for the analysis. Projecting forward MBS utilisation by Broad Type of Service (BTOS), a baseline cost for expenditure by broad MBS category can be established. Below, the AMA has costed lifting this rate to match a simple index of 70 per cent weight based on the AWE (assumed 3.5 per cent) and 30 per cent weight based on the CPI, which has been projected to return to the centre of the Reserve Bank of Australia (RBA) band of 2.5 per cent. The difference between the current rate of indexation and this simple metric was applied across all BTOS categories. The gap between the projected index and 1.6 per cent was applied to 'Pathology' as several pathology items have not been indexed.

In performing the review of indexation, government should consider the amount of capital and labour that reflect the cost of providing services within each BTOS, and whether indexation rates should therefore be different for each BTOS to account for the differences in healthcare settings, services provided, technology requirements etc.

Table 14: Cost of lifting MBS indexation for each Broad Type of Service category.

	2023–24	2024–25	2025–26	2026–27	Total
GP (all items) ($m)	153	324	514	725	1,717
Specialist Attendances ($m)	52	111	178	253	594
Obstetrics ($m)	4	8	12	17	41
Anaesthetics ($m)	10	21	33	46	109
Pathology ($m)	62	132	209	295	699
Diagnostic Imaging ($m)	88	191	310	447	1,037
Operations ($m)	42	89	140	197	467
Assistance at Operations ($m)	2	3	5	8	18
Optometry ($m)	9	20	32	44	105
Radiotherapy and Therapeutic Nuclear Medicine ($m)	15	34	58	87	195
Net cost to government ($m)	**438**	**933**	**1,492**	**2,120**	**4,983**

Other policy priorities

Building a health system that incorporates new technologies

The pandemic response saw years of healthcare reforms enacted in days. Telehealth and e-prescribing will remain, yet there are other advances we should still make. For example, there needs to be funding for innovations in rural health and technological infrastructure to ensure doctors are more accessible to patients.

The benefits of telehealth need to be expanded beyond the simple doctor-patient dynamic, with options for telehealth between clinicians to improve the outcome of a patient consultation, funded through Medicare.

Remote monitoring technology can facilitate equitable healthcare, in particular for private medical practices in rural and remote areas, yet there are no appropriate funding mechanisms that exist to encourage this. Medical practices can invest in these technologies, however practices struggle to justify this without a means of funding, despite the benefit to the patient.

Genuinely interoperable health systems

Right now, clinical software in a hospital and in a general practice or RACF do not communicate properly. This is inefficient and can lead to duplication and errors. Building interoperability into clinical software will ensure that each person involved in care has current information about the patient to enable provision of the best possible quality care.

We need a national focussed attempt to improve digital maturity through workforce training initiatives, eliminating fax use, and promoting secure messaging uptake through directed improvement payments or grants.

We need to continue to pursue better interoperability of clinical software so that all healthcare providers can easily and securely share data where necessary.

Empowering patients to track their health data

My Health Record is a valuable but underused resource. We need to encourage widespread use and adoption, with a specific focus beyond general practices. Patients should be supported with education for, and access to, digital health and assistive technologies to receive high-quality care where they need it.

Coordinated approaches to disease control

Infectious diseases are a serious global health issue. Australia must play a global role in the prevention of epidemics, pandemics and other health threats. The AMA welcomes the Commonwealth's initial $3.2million investment to establish an Australian Centre for Disease Control (CDC), and looks forward to working with government to ensure it is fit-for-purpose. Further outlined in the AMA's submission, the CDC needs to be adequately funded and resourced over the long-term to undertake its multitude of functions, including rapid risk assessment, scientific briefings, public education, and disease prevention.

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