AMA

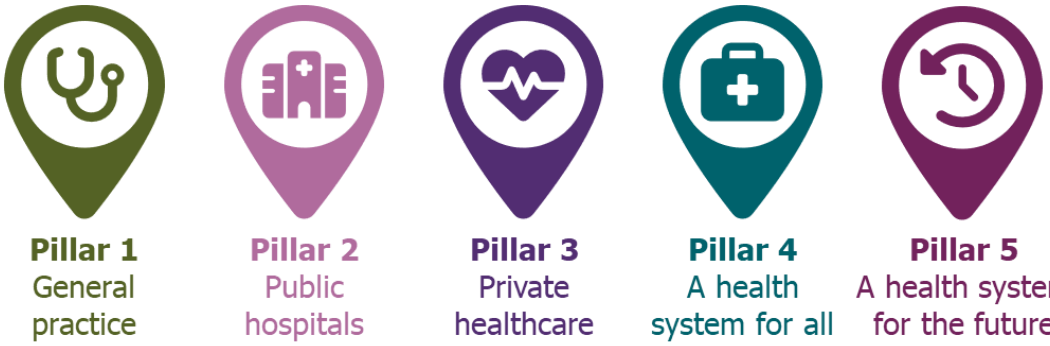
Federal election platform 2025

Detailed policy costings

EXECUTIVE SUMMARY

This year, the highly regarded Commonwealth Fund rated Australia as having the 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.

There are however issues in our health system that require genuine reform, including long waits for public hospital treatment, general practice funding not keeping up with community demand for services, a private health system that is in need of reform, and a lack of investment in preventive health. In 2024, the AMA released its updated *Vision for Australia's Health*, which proposed sensible and targeted reforms that would help address these issues in our health system. 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 *Federal election platform 2025 — detailed policy costings* outlines detailed, costed, targeted, and implementable initiatives across these five pillars that represent an investment in the health of Australians.



Summary of policy proposals

Policy proposal	Cost/revenue to government over the forward estimates ($m)
Pillar 1: General practice	
Reforming funding arrangements to basic GP item numbers	4,500
Improving access to general practice by encouraging more doctors to become general practitioners — equalise salary and leave conditions for GPs in training	185.2
Improving access to general practice by encouraging more doctors to become general practitioners — more GP training places and more GP prevocational rotations	150.1
Improving access to team care in general practice by increasing the maximum number of allied health professionals covered under the WIP	401.4
Funding for better general practice information collection and research	17.5
Pillar 2: Public hospitals	
Fund public hospitals to improve their performance and increase capacity	
Cost for federal government	12,500
Cost for state and territory governments	15,300
Pillar 3: Private healthcare	
Establish a private health system authority	146.9
Mandate a minimum payout	- 448
Increase the Medicare Levy Surcharge	1,191
Pillar 4: A health system for all	
A tax on sugar-sweetened beverages (Negative cost to government is revenue raised)	- 3,638
Pillar 5: A health system for the future	
Establish and fund an independent national health workforce planning agency	182.6

Note: The analysis and costings outlined in this submission are current as of November 2024. The analysis and costings was undertaken in time for the Treasurer's budget consultation process in early 2025. Therefore, the analysis and costings does not take account of recent Budget announcements.

CHAPTER 1: GENERAL PRACTICE

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, in 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. National and international research shows a well-funded and resourced general practice sector is pivotal for the 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]

Several years of the undersubscription of general practitioner training places in the Australian General Practice Training (AGPT) program, combined with growing community demand, has left Australia with a shortage of GPs that is projected to get even worse over time. The shortfall projected varies between an estimate of 5,560 FTE by 2033 by the Department of Health and Aged Care, reinforcing the independent modelling by the AMA which projected a range of 3,600 up to a shocking 10,600 (FTE) by 2031 (see the AMA report, *The general practitioner workforce: why the neglect must end*).[6] General practice is no longer seen as a financially attractive career for many doctors, in part because there is disparity in remuneration and workplace entitlements between general practitioner registrars and their hospital-based counterparts.[7]

Despite investments in the 2023–2024 Budget, access to general practice remains a key issue, and many general practices are struggling to remain viable.[8,9]

The AMA has been advocating for increased Medicare funding, as the MBS no longer bears any relationship to the actual cost of providing services to patients (see the AMA report, *Why Medicare indexation matters,* and the *AMA analysis of Medicare indexation freeze*).[10]

To address the need to Modernise Medicare to support general practice in the face of Australia's health needs, the AMA has undertaken a project to redesign the standard general practice consultation items, as the current consultation item structure is no longer fit-for-purpose. This proposal, along with the others outlined in this chapter, aims to improve access to general practice by supporting patients to spend more time with their GP; encouraging more doctors to become general practitioners; better supporting our existing general practitioners; improving the collection of data to inform research and policy making in the future; and improving our workforce planning for future generations.

Previous AMA budget submissions have given support to the implementation of voluntary patient enrolment, which the government has adopted and called MyMedicare. MyMedicare recognises the central role of general practice in the health system and can support the delivery of better healthcare outcomes by strengthening the linkage between patients and their GP and providing a strong foundation to improve access to care through the better use of teams within a well co-ordinated GP-led model. The AMA will continue to work with the government to develop MyMedicare as part of Australia's Primary Health Care 10 Year Plan 2022–2032.

Policy proposals

Reforming funding arrangements to basic GP item numbers

Until recently, the current basic GP item structure — Levels A, B, C, and D — had barely changed since the advent of Medicare. The only minor change was the recent addition of Level E for consultations more than 60 minutes in length.

A modern Medicare needs to recognise the changing nature of general practice, evolving from frequent acute individual presentations to more complex conditions with patients increasingly suffering from mental health concerns and chronic illness. Patients need to spend more time with their GP, yet the structure of Medicare does not adequately support this care.

Clearly, our existing Medicare structure does not reflect modern health issues faced by patients and their treating GPs, and as consultations get longer, inadequate Medicare rebates are forcing more GPs to pass on the costs to patients through an increase in out-of-pocket costs. The measures proposed here are part of the investment needed, but clearly more will be needed in future years as demand continues to grow for services.

A modernised Medicare that supports longer consultations will also better support Australia's female GPs. BEACH data has shown female GPs often spend longer in consults with patients, despite the current Medicare system effectively providing a disincentive to do so.[11]

We also need to attract more GPs. In particular, the reforms must attract new GPs and continue to support them to treat people with mental health, co-morbid and chronic conditions. We know these conditions can take more time, but if treated effectively at the primary care level, lead to a reduction in avoidable hospital admissions. Medicare funding must increase to reflect the growing cost of providing the care patients need, and support GPs in undertaking this critical work.

Risks and implementation

This reform requires a new standard consultation item structure for general practice that can support GPs in adapting to a changing healthcare environment. Medicare must be reformed so it supports patients with acute presentations as well as those with more complex needs.

The AMA has undertaken extensive consultation with a broad range of GPs across the AMA. These GPs reflect a wide range of practices across diverse patient cohorts. The data was examined to find the best time lengths to include in a new rebate structure, reflect the existing patient demand and how it is spread over time different periods, and account for the need to encourage longer consults to allow better treatment of complex and chronic conditions.

Importantly, the AMA invested the time to examine behavioural change for GPs to embrace the new funding structure and incorporated these changes into the base costing. The micro-level analysis of individual GP behaviour to the proposed new patient rebate levels (Level 2 to Level 5) underpins this change, recognising the government's previously stated intention to deliver more support for GPs to care for patients.

The proposed reformed rebate structure has seven tiers, ranging from Level 1 (0–5 minutes), Level 2 (6–15 minutes), Level 3 (16–25 minutes), Level 4 (26–35 minutes), Level 5 (36–45 minutes), Level 6 (46–59 minutes), Level 7 (60 and over minutes). The proposed rebates are Level 1 — $19.60, Level 2 — $45.00, Level 3 — $78.25, Level 4 — $111.75, Level 5 — $149.00, Level 6 — $186.30, and Level 7 — $260.80 (Levels 6 and 7 are stepped rebate levels based on consistent time intervals with the micro-level analysis of Level 2–5 GP behaviour). This reformed rebate structure provides a modest lift for shorter consultations — $2.15 in additional funding for a 10–12-minute patient consultation. However, it simultaneously recognises that the patients who need to see their GP for an extra 5–10 minutes will receive an additional $35.40 in the patient rebate to allow this to occur. This will enable the patient to pay less out of pocket, with more GPs able to provide the longer care, while limiting the out-of-pocket impact.

Risks of not taking action

Failure to act now to reform Medicare to equip general practice to face the future health demands of the nation will have significant impacts on both patients and the health system.

Firstly, those with chronic conditions, mental health concerns and complex care requirements will continue to be underserviced, resulting in higher costs as they rely on the hospital system once their conditions worsen. Secondly, Australia will fail to attract sufficient doctors to general practice, further worsening the current workforce shortage. Without better funding and sustainability, it is also likely GPs will seek to retire earlier than planned and this will mean patient access to care will deteriorate further. The failure to invest properly in general practice is already seeing band-aid solutions being implemented, including by state and territory governments. These fragment care by increasing the scope of practice for the non-medical workforce outside of a GP-led model, which undermines the very system that has served Australia so well. It is not the optimum model of care and detracts funding from the system.

Timeframe and costing

The AMA has estimated the cost of reforming basic consultation item structure over the forward estimates, allowing for additional supply from GPs, growing by more than 5 per cent.

Table 1: Estimated cost of reforming basic consultation items from four to seven tiers

	2025–26	2026–27	2027–28	2028–29	Total
Reform to basic consultation items ($b)	1.01	1.08	1.15	1.23	4.5
Total cost to government ($b)	**1.01**	**1.08**	**1.15**	**1.23**	**4.5**

Policy proposals

Improving access to general practice by encouraging more doctors to become general practitioners — equalise salary and leave conditions for GPs in training

After years of AMA advocacy, the federal government has recognised the need to address the inferior pay and conditions of GP trainees, investing in single-employer model trials, with an additional $4.5 million for 10 trials and evaluation announced in the 2023–24 federal budget, and continued in the subsequent budget.[12]

While the announcement of these recent models was welcomed, the current workforce shortages and access issues are critical and must be addressed, and therefore reforms to general practitioner trainee employment conditions must be sector-wide. This will act as a lever to encourage more doctors to choose a career in general practice, as they will no longer need to face the prospect of a large reduction in pay and conditions when leaving the hospital system, and reduced access to entitlements during their training.

Beyond this proposal, we will need a comprehensive plan for workforce that considers public and private hospitals, primary care, aged care and NDIS, not to mention rural and regional medical workforce needs, based on local conditions and patient demand.

Risks and implementation

Reforms must not be done in a piecemeal way, however the current approach with state/territory and federal initiatives is uncoordinated. A comprehensive solution is required that deals with pay as well as the continuity of leave entitlements. Critical to the success of any scheme is the need to ensure that support and funding for training practices and general practitioner supervisors is not diminished in any way and, indeed, strengthened over time. We also need support for GP supervisors and training practices as a priority.

Risks of not taking action

The accessibility of general practice should be one of the key priorities for governments, as general practitioners play an integral role in preventing, diagnosing, and managing diverse medical conditions. The predicted shortages of general practitioners is a significant issue that will take years to address if nothing is done now to stem the crisis. If nothing is done now, patients will increasingly find it challenging to access care through their general practice, which will have an impact on health outcomes and increase the burden on emergency departments which are more expensive and are already operating at capacity.

Timeframe and costing

The AMA has estimated the cost of reforming employment conditions for general practitioner trainees to match their hospital-based counterparts. This costing covers rates of pay as well as parental, long-service leave, and study/examination leave entitlements. Additionally, this costing is based on the number of Australian General Practice Training (AGPT) program trainees as an indicative estimate, noting there are other pathways to fellowship, and trainees on these pathways would also benefit from such reforms.

Table 2: Estimated cost of reforming employment conditions for general practitioner trainees

		2024–25	2025–26	2026–27	2027–28	Total
Salary boost ($m)		14.4	22.3	31.3	39.1	107.2
Parental, long-service leave, study/examination leave ($m)		18.6	19.2	19.8	20.4	78.0
Total cost to governments ($m)		**33.0**	**41.5**	**51.1**	**59.5**	**185.2**

Policy proposals

Improving access to general practice by encouraging more doctors to become general practitioners — more GP training places and more GP rotations

There has been greater focus by all levels of government on the need to recruit more GPs. To achieve this, we need to boost the number of GP trainees to enable the GP workforce to grow, otherwise there will be a shortfall as the population grows and our GP workforce ages. The range of shortfall projected varies between an estimate of 5,560 FTE by 2033 by the Department of Health and Aged Care, and the independent modelling by the AMA, which projected a range of 3,600 up to a shocking 10,600 by 2031. To address this in the first instance, the AMA proposes an expansion into more areas of workforce shortage of the John Flynn Placement Program and the addition of 500 more training rotations, along with a phased progression of a further 500 funded AGPT places.

Risks and implementation

Additional training places must start soon and build to the level required to meet demand for GPs in the longer term. This must include addressing capacity constraints and ensure a consistent and well-developed pipeline of trainees into general practice.

The increase in the number of graduates from medical school willing to undertake GP training must be aligned with those medical interns and registrars that have exposure to GP practices and the number of GP places available from GPs able to deliver Australian General Practice Training (AGPT) places.

Work must be done to improve the attractiveness of general practice to improve the flow of medical graduates into GP training places.

Risks of not taking action

This chart shows the implications of the department's own labour modelling of GP supply shortfall. Even under the department's conservative assumptions, the demand-supply gap will continue to widen into the future. The AMA's proposal of an additional 500 rotations will not close the supply gap, but it will slow the growth, and hopefully stabilise it until further investment and action can be taken.

Figure 1.1: GP full time equivalent 'shortfall' and additional GP places (number)

Timeframe and costing

The AMA has estimated the cost of increasing the number of AGPT training places by 500 trainees as well as increasing the number of 500, phased in over the four years. This costing covers rates of pay as well as parental, long-service leave, and study/examination leave entitlements. Additionally, this costing is based on the number of AGPT program trainees as an indicative estimate, noting there are other pathways to fellowship, and trainees on these pathways would also benefit from such reforms. The benefit for patients would be immediate, with the additional trainees working in general practice providing increased capacity and supporting improved access to care within a well-supervised environment.

Table 3: Estimated cost of increasing places for general practitioner trainees

	2025–26	2026–27	2027–28	2028–29	Total
Additional rotations	160	300	500	500	
Additional AGPT places	150	300	500	500	
John Flynn ($m)	1.6	3.2	5.4	5.5	15.7
AGPT Training Places ($m)	12.6	26.8	46.5	48.4	134.4
Total cost to government ($m)	**14.5**	**29.9**	**51.8**	**53.9**	**150.1**

Policy proposals

Improving access to care in general practice by supporting more nurses and allied health professionals to work in general practice

After years of AMA advocacy, the federal government agreed to index the amount of the benefit paid under the Workforce Incentive Program (WIP) for nurses and allied health professionals (AHPs), effectively lifting the maximum amount available under the program from $25,000 per subsidy to a maximum of $32,500 in the first year. This recognised the significant contributions being made by registered nurses and other allied health professionals within practices as well as the reality of the significant cost of their salaries.

Nurses' salaries are some of the fastest growing costs faced by a general practice and this increase in funding made some contribution to keeping these vital workers part of the practice. Unfortunately, funding arrangements continue to constrain the number of nurses and AHPs are supported to engage.

Risks and implementation

This past reform, while an increase, needs further investment to recognise how modern GP practices operate. Many more practices today are much larger, with many containing 10 or more GPs. Removing the cap on WIP payments for nurses or AHPs will increase the capacity of practices to modernise to reflect the growing number of patients with chronic conditions.

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.[13] 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,[14] with 5.7 per cent or 660,000, of all hospitalisations in 2021–22 due to 22 preventable conditions that could be managed by general practice. It will also result in poorer health outcomes for patients, which in turn is associated with absenteeism, presenteeism, lower productivity, and lower workforce participation. [15,16]

Timeframe and costing

The AMA has estimated the cost of reforming with WIP for General Practices, based on the assumption that practices uptake will increase to the equivalent of 7000 SWPE compared to the current 4000 SWPE limit.

This costing assumes the base rate remains the same and continues to be indexed.

Table 4: Estimated cost of increasing the WIP payment to support more nurses or AHPs in general practice

	2025–26	2026–27	2027–28	2028–29	Total
Remove limits on WIP ($m)	93.1	97.8	102.7	107.8	401.4
Total cost to government ($m)	**93.1**	**97.8**	**102.7**	**107.8**	**401.4**

Policy proposals

Funding for better general practice information collection and research

High-quality general practice data plays a pivotal role in advancing both clinical care and service delivery, while also serving as a critical foundation for shaping primary care policy. Accurate and comprehensive general practice data assists in making informed decisions about patient treatment, diagnosis, and preventative care, particularly with the establishment of MyMedicare. It can also inform operational processes, enhance resource allocation, optimise appointment scheduling, and allow policymakers to identify trends, allocate resources effectively, and design evidence-based strategies for healthcare.

The Bettering the Evaluation and Care of Health (BEACH) dataset analysed general practitioner and patient interactions and patient management. It supported numerous academic publications, grant applications, provided data to various sectors, including industry, government, and non-profit organisations. It aided health system planning, policy development, educational material creation, and pricing decisions.[17]

Despite its effectiveness, the federal government ceased funding for BEACH in 2016, and the commitment to "develop a more contemporary means of accessing general practice and primary health care research and data, to guide decision making and policy development", never materialised.[18] To this day, any serious policy proposal in general practice still uses BEACH data. The pressing need for more contemporaneous data is becoming dire as reforms are desperately needed.

Risks and implementation

Financial and structural support will need to be provided to general practices and general practitioners to support the translation of data into improved service delivery. Data collection must leverage existing clinical management systems to ensure general practitioners involved in the project are not burdened with additional administration. Additionally, analysis of the strengths and weaknesses of the BEACH data project should be performed so learnings can be applied to this new research and data project. There should also be adequate and long-term funding and resource allocation, along with a strong commitment to data privacy and ethics.

Risks of not taking action

The BEACH dataset is outdated. However, many studies still rely on this dataset as there is no alternative. The Department of Health and Aged Care's Supply and Demand Study of General Practitioners in Australia, released in August 2024, stated there are still 'gaps' in the data available.[19] Researchers, policymakers, and industry stakeholders are therefore lacking contemporary insights into general practice, patient-based risk factors, and the effects of health service activity. This has a significant impact on policy development, program design, and ultimately the delivery of evidence-based healthcare services.

Timeframe and costing

The BEACH total budget was reported to be $1.3 million in 2007, of which 23 per cent was funded by the federal government. Additionally, the original BEACH dataset was on a sample of 1,000 general practitioners, about 3.5 per cent of general practitioners in 2007.[20] Using this as a baseline, the AMA estimates that establishing a similar research and data collection project today would cost $17.5 million over the forward estimates. It should be noted BEACH was able to secure funding from other sources, a model that could again be replicated, potentially bringing down the federal government's contribution.

Table 5: Estimated cost of funding for general practice research and data

	2025–26	2026–27	2027–28	2028–29	Total
Total GPs	42,100	43,000	43,800	44,600	
Sample size	1,750	1,750	1,750	1,750	
Total cost ($m)	4.2	4.3	4.4	4.6	17.5
Total cost to government ($m)	**4.2**	**4.3**	**4.4**	**4.6**	**17.5**

CHAPTER 2: PUBLIC HOSPITALS

Problem statement

The Australian public hospital system is in crisis. Chronic underfunding at federal, state, and territory levels has led to declining performance. In the last few years, we have increasingly heard stories of people dying while 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 61 per cent of patients waiting to receive urgent care in emergency departments were seen within the clinically recommended 30 minutes, and approximately four in 10 patients stayed longer than four hours in emergency departments.[1] Beyond treatment in emergency departments, planned surgery waitlists continue to blow out, with only 71 per cent of patients referred for semi-urgent, Category 2 planned surgery treated within the recommended 90 days. That is approximately one in three patients waiting longer than the clinically indicated time for essential surgeries like heart valve replacements or coronary artery bypass surgery.[2] The national proportion of individuals receiving Category 2 planned surgery on time has fallen 18 per cent in just six years. While the number of public hospital beds in Australia has slowly been increasing over time, our population has been growing much faster. In total, 1,932 new public hospital beds became available between 2017–18 and 2022–23 (from 63,119 to 65,051), yet our population grew by more than a million people over the same period. Unfortunately, this means we have only installed 16 new beds for every 10,000 new Australians since 2018–19, far below our capacity of 25.3 beds for every 10,000 Australians in 2017–18.[3] As demonstrated by the AMA Public Hospital Report Card, these problems have existed for years, and the new funding agreement in 2025 offers the opportunity to address it.

Policy proposals

Fund public hospitals to improve their performance and increase capacity

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. This section draws on the original AMA report, *Public hospitals: cycle of crisis*,[4] with updated modelling adapted and extended to give estimates between 2024–25 and 2027–28.

Since that report was released, the federal government has agreed to increase their share of future funding to 45 per cent of activity, as well as lifting the cap on their contribution towards public hospitals in the next funding agreement. This is in line with previous AMA calls for an increase in federal funding.

As outlined in the AMA report, *What happens when we fund hospitals to perform*,[5] the introduction of activity-based funding (ABF) has resulted in improved efficiency, but it has also come at a cost to quality improvement and innovation, particularly with the removal of performance funding. The new funding agreement will need additional dedicated funding streams for performance improvement. It should be reintroduced with continuous monitoring of progress against appropriate performance targets, with the goal of at least reversing the decline in public hospital performance.

Unfortunately, despite this change in the funding split between the federal government and the states and territories, there has been no budgeted increase in overall funds, from the previous AMA predictions in 2021 (see chart below).

That is, the total funding envelope has remained consistent with projections under the AMA's earlier 'do nothing' scenario. The result of not increasing funding to match the call from the AMA has meant that hospital activity has been significantly falling behind community demand (see chart below).

This is because while the cap for the federal government has been increased, it appears to be coming from a lower base today than it should have been, if funding in past years had increased in line with AMA projections. The other issue that is clear is that unless states and territories commit additional funding, hospitals will not have the capacity to fully utilise the increase in the federal cap in funding. Finally, as a result of the increase in health inflation, a reasonable amount of the funding increase to the cap will be used to cover the increasing costs of services, rather than just increase the number of services provided.

Hospitals running near or at capacity have less scope to improve efficiencies. Without spare capacity (beds and staff), they can't plan blocks of surgical time dedicated to alleviating waiting lists efficiently. This is removing the effectiveness of the efficiencies that ABF funding has been able to deliver up to 2021–22. This further limits the amount of activity afforded with the same funding.

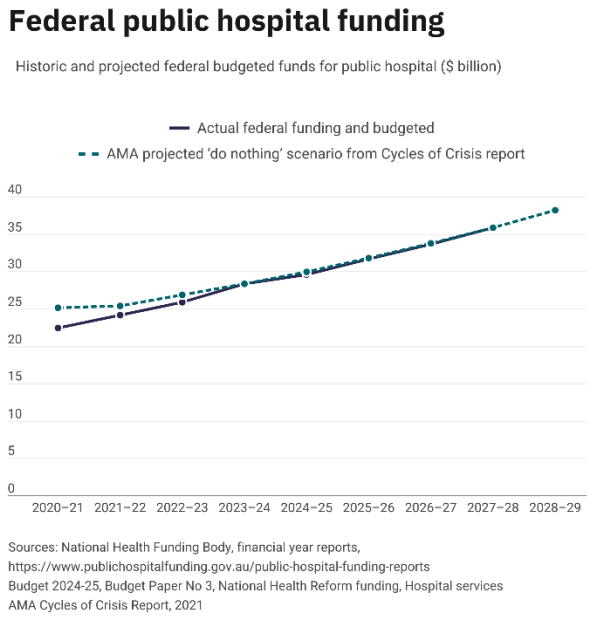


Figure 2.1: Historic and projected activity for public hospitals versus the AMA projected 'do nothing' scenario. Note: This graph was produced in time for a Budget submission and therefore pre-dates the $1.8 billion additional funding in the Budget for the single year of 2025–26.

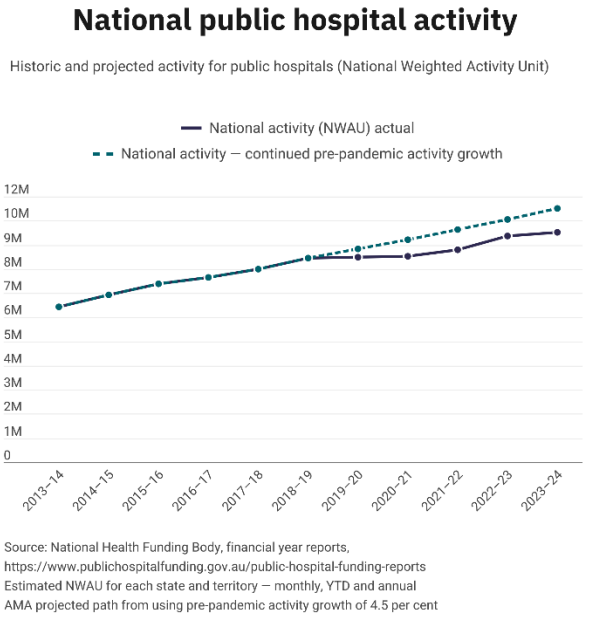


Figure 2.2: Actual activity for public hospitals vs trend

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.
- Hospital admissions and emergency department demand will continue to grow and put more pressure on public hospitals. There is sustained growth in emergency department presentations and 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 EDs will grow to more than 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 emergency departments are already exceeding 10 per cent of total public hospital bed capacity.
- Those emergency admissions will continue to struggle to find a bed to admit in a timely manner, leading to even more significant ambulance ramping than we have now.
- Waiting lists for elective surgery will continue to increase, as surgeries are cancelled to accommodate urgent admissions.
- Appropriate staffing levels will be harder to maintain the longer funding remains inadequate.

Risks and implementation

State and territory government expenditure

Given the nature of state and territory government finances across Australia, budgets are under increasing pressure. The states may need to look for additional permanent revenue sources to sustain larger hospital expenditure.

Urgently increase funding to meet community need

While the federal government has agreed to increase its share of future funding to 45 per cent of all activity, as well as lifting the cap on their contribution towards public hospitals in the next funding agreement, states and territories will need to increase their capacity, and their funding/funding caps, to fully utilise this opportunity. Furthermore, the agreement should recognise and allow for periods where some of the additional funding cap is used up in the increasing costs of delivery of services, and accounts for this.

Expand capacity

State and territory governments should use additional 'freed-up' funds resulting from greater federal funding to invest in evaluation and improvement activities to increase their capacity through improved processes. In addition, public hospitals should also be given separate funding to expand their capital infrastructure and staffing where needed. The additional funds must lift planned capacity and not simply fund outsourced surgeries. The federal 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. The risk is that without this, states and territories may not be in a position to utilise the additional funding on offer.

Funding to address demand

Activity-based funding should still be the funding model for the majority of people, but it 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 federal government should partner with state and territory governments to provide additional up-front funding for this purpose. Return on investment would be realised through reduced public hospital costs, reduced admissions and re-admissions, and improved patient outcomes.

Performance improvements

It is possible that reforms will only stabilise performance (i.e. no further decline), as opposed to improve performance. This is a risk given the dire situation public hospitals are facing right now and the fact funding reform is overdue. Funding for performance improvement should be in addition to, and separate from, activity-based funding. In the short term there should be immediate federal government funding targeting emergency department performance and capacity improvement, noting 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 federal government — within the parameters of the current hospital funding agreement.

Timeframe and costing

The AMA is calling for funding in addition to the latest federal announcement. The federal government made a commitment of $13 billion as part of National Cabinet process to lift the federal government's proportion of hospital expenditure to 45 per cent. A further commitment is needed by the states and territories. Extra funding for hospitals is needed to lift activity to make use of this pool of 'matched funding' under the new NHRA to ensure these budgeted funds flow through to hospital bottom lines. In doing so, there would be additional funding required by the federal government to match this.

The funding commitment by the federal government is forecast to increase the growth of overall activity (separations) from where we are now. This does not back date the growth in funding to account for the unfunded growth in activity across 2019–20 to 2024–25. Underlying/pre-capped activity continued to grow at around 4–4.5 per cent over this period. This underlying activity growth reflects strong recent population growth (1.5–2 per cent), ageing of baby boomers into age cohorts of higher demand (~1 per cent) and greater co-morbidities, complexity and technology improvement (1–1.5 per cent). This created a gap in activity from where we are to the level needed to address underlying demand.

In addition, hospitals have experienced a period of strong cost growth against a capped total funding envelope. Unfortunately, this has meant some of the additional funds put on the table by the federal government have been absorbed by cost increases in the sector along with a failure by states to increase funding.

Following recommendation from the response to the COVID-19 inquiry,[7] the federal government committed to:

> *Immediate actions – Do in the next 12–18 months:*
>
> *Health Ministers should coordinate a 'COVID Catch-up' strategy in response to a decline in the delivery of elective surgery and cancer screenings, including:*
> - *a national plan to reduce the elective surgery backlog, in consultation with the private and public hospital sectors*
> - *additional funding and an implementation strategy to re-engage regional, rural and remote and other high-risk populations in preventive care to help address undiagnosed cases of cancer, diabetes and other illnesses.*

The figures below incorporate the additional funding necessary to lift activity to 'catch-up' to underlying demand which is in addition to further performance improvement — therefore, much of this ask is in addition to the $13 billion the federal government has already committed for the future five-year period. Going forward, a greater commitment will be necessary from the federal, state and territory governments, recognising the share of federal funds are now 45 per cent.

Costings for performance improvement, increasing capacity, and addressing avoidable admissions and re-admissions are not provided at this stage in this submission, 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 federal government would be required to provide partnership/matched funding under these funding streams.

It is envisaged that the requirements for each state and territory will be different, as would the timelines for development, implementation and therefore expenditure. In considering future outlays, the potential savings that will accrue over a longer period of time to the health system from more effective management of chronic disease should be acknowledged. Performance and infrastructure improvements will no doubt require additional expenditure — and likely increase volumes of patient throughput — however, they will also generate benefits for the individual and the economy through improved health outcomes, less unmet demand, and fewer delayed hospital presentations from the community.

The figures below are in nominal dollars and are in addition to the government's budgeted funding outlined in the 2025–2026 federal budget.

Table 6: Impact of select hospital funding reform measures on federal, state and territory budgets

	2025–26	2026–27	2027–28	2028–29	Total
Federal budget, additional	2.70	3.0	3.3	3.6	12.5
State/territory governments, additional	3.30	3.6	4.0	4.4	15.3
Total cost to governments ($b)	**6.0**	**6.6**	**7.3**	**7.9**	**27.8**

CHAPTER 3: PRIVATE HEALTH

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 approximately 70 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' (where 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 past 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 several successive quarters and outlays have decreased due to the impact of lockdowns and workforce shortages.

As costs increase across the sector, patients are looking for more affordable treatment options. This means more patients are downgrading to lower levels of cover. This feeds through to slower total premium growth than headline premium increases suggest as nationwide coverage levels are 'hollowed out'.

Over time this has eroded, as the 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 2024.[3]

The 'PHI rebate adjustment factor' is a very important factor which effectively determines what proportion of the PHI premium is paid by the government for those with lower incomes below $97,000 (Tier 0). The calculation of the factor is hidden from the public and is only alluded to by the ATO:

*"The rebate adjustment factor is a percentage of the **increase in the consumer price index** (CPI) and the average **annual premium price increase**. It is calculated by the Department of Health."*[4]

In the past two years, where the CPI has been higher than premium growth, the rebate factor should have increased. The final rebate factor has instead remained constant at 24.61 per cent.[3] This has been a silent reduction in rebate when compared to what should have been expected.

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 many younger and healthier Australians increasingly opting for reduced cover. This is due to several factors, including:

- Further reductions in the private health insurance rebate.
- 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.[5] Payout ratios (amount paid in premium relative to amount received through benefit claims) among for-profit providers (average of 82 per cent of hospital premiums returned as hospital benefits) are also lower than not-for-profit providers (average of 90 per cent of premiums returned as benefits), 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. Income growth for younger people remains below that of older people though it has improved compared with the past decade. Across the latest five years, among 21–34-year-olds, wage growth is about 90 per cent of that of overall wage growth.
- 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.

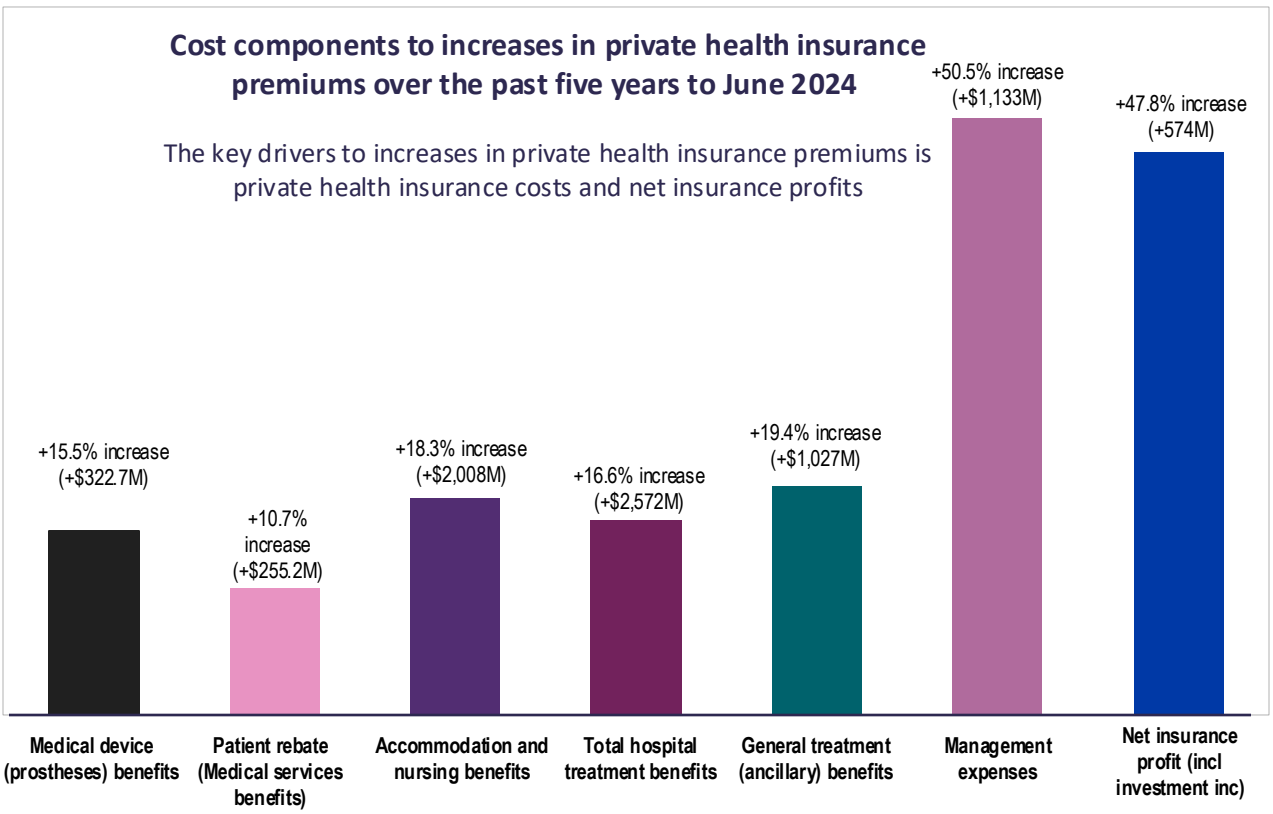


Figure 3.1: Cost growth by category of expenditure within private health insurance

Figure 3.1, above, demonstrates the key drivers to increases in private health insurance premiums are private health insurance costs, in particular management expenses, and net insurance profits. It is important to note all insurers, including not-for-profits, must retain a small amount of profit to stay viable.

In addition to the affordability of private health insurance, there are now substantial questions about the sustainability of the private health system. In the wake of a spate of closures to private hospitals, particularly maternity service closures, the federal government undertook a review into the financial viability concerns of the private hospital system. The AMA has welcomed the review (and the subsequent announcement of a CEO's forum), noting the closure of services has left patients without access to private health services, which does little to encourage continuing insurance uptake. It also puts further pressure on public services to 'pick up the slack' of these closures and further exacerbates the already extensive public waiting lists for essential surgery and a logjammed public hospital system.

Policy proposals

Establish a private health system authority

This section draws on the AMA research report, *A whole of system approach to reforming private healthcare*, with some of the modelling adapted and extended to give estimates between 2024–25 and 2027–28.

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 still 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.

Risks and implementation

An independent authority would consolidate regulatory functions previously carried out by other parts of government/agencies so they operate in a more cohesive and effective way (including relieving the Department of Health and Aged Care 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. There would be some costs transferred from other agencies for existing functions carried out, as well as additional costs for new functions that 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.

Risks of not taking action

The current private health regulatory and legislative framework is complex and is limiting innovation and reform. Additionally, the mechanisms in place that ensure the private health system is changing in a lasting way as government policy intends are limited and ad hoc. 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 private health system is already lagging when it comes to reform — for example, reform to out-of-hospital models of care as outlined in the AMA's research report, *Out-of-hospital models of care in the private health system* — and this will only continue if the regulatory and legislative frameworks remain not fit-for-purpose. Additionally, the gaps in regulation impact patients through unexpected out-of-pocket costs, restricted choice, and additional complexity.

Timeframe and costing

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 2024 was $237.0 million.[6] APRA also collected $240 million in levies to recover costs, $10.4 million was directly attributed to revenue levied against private health insurers. Using the number of private health insurers it prudentially regulates (30 during 2023–2024).[6]

This role currently performed by APRA is only one of an expanded set of roles envisioned for the proposed authority, and therefore 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 $10.4 million cost re-allocated from assuming responsibilities from APRA.[6]

An additional $11 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 $11 million would be the only net cost to government between 2025–26 and 2028–29.

Table 7: Cost of a private health system authority

	2025–26	2026–27	2027–28	2028–29	Total
Establishment cost ($m)	11				11
Ongoing cost ($m)	31.7	33.2	34.7	36.4	135.9
Total cost to government ($m)	**42.7**	**33.2**	**34.7**	**36.4**	**146.9**

Policy proposals

Mandate a minimum payout

This section draws on the AMA report, *The repeat prescription for private health insurance*, with some of the modelling adapted and extended to give estimates between 2025–26 and 2028–29.

Private health insurers will generally aim to set premium levels to cover the expected costs of benefits (that is, coverage paid for members' medical treatment), plus the fund's management costs. As a result, if management expenses as a proportion of payments are higher, a smaller proportion of premiums is being spent on treatment. Naturally, such calculations are complex, but it is likely that a greater proportion of premiums being paid towards benefits is one indicator of value and return on investment.

Management expenses comprise the amount of premiums per policy that are used to manage the business of the fund. All funds have management expenses and depending on their position in the market and whether they are for-profit, they can have varying marketing costs, salaries, overheads and profit margins that need to be built into these expenses.

Currently there is no policy regarding the proportion of premiums (consumer and federal government investment combined to purchase a policy) that should be returned in the form of health services, and there is considerable variability in funds returned as benefits between insurers.[7] To improve the value proposition of private health insurance, there should be a mandated 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.

Risks and implementation

The federal government increasingly has a role in promoting private health insurance, particularly in light of its involvement in recent reforms to private health insurance, as well as its contributions to support access to private health insurance (such as the private health insurance rebate). As the Department of Health and Aged Care is both the policymaker and regulator, there is the possibility that this conflict of interest may impact reforms (such as a minimum payout) if issues arise throughout implementation. The establishment of an independent private health system authority could potentially mitigate this risk. Additionally, it is likely that some private health insurers may resist a mandated minimum payout as it could impact viability, and a private health system authority would be well placed to identify an appropriate minimum payout that ensures insurers remain viable.

Risks of not taking action

Negative media coverage about the lack of value in private health insurance, coupled with a focus on the profit margins of the for-profit providers erodes the perceived value of private health insurance in the eyes of the community. Additionally, many private hospitals are struggling to remain viable. This is something that needs to be urgently addressed, especially if the federal government is called upon to invest additional taxpayer funds in the private health system. Australians therefore need assurances that their investment in private health insurance is going to be returned in the form of appropriate coverage for services, when it is needed.

Unbelievably, since the AMA first called for this reform, the payout ratio has dropped a further 2 per cent of the base hospital premium paid as hospital benefits. The latest APRA quarterly private health insurance performance statistics has hospital treatment benefits paid of $18.3 billion, while premium revenue is $21.7 billion, summed across the past four quarters, meaning the payout ratio is now 84 per cent. In addition, funds can now return a much higher investment income from premiums than the recent past, further enhancing their profitability.

Timeframes and costings over four years

The direct cost to government of an increase in the minimum payout ratio is zero. There would however be indirect costs — the first being that additional private health insurance policies would cost the government for additional private health insurance rebate outlays. The second component would be lower rebate outlays via a reduction in the base premium. 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 $97,000 or less — but also towards those that are less likely to claim given people with high expected claims would likely already have a policy.

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 more than $97,000. 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 the 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. As a result of the continued decline in the baseline of the proportion of premiums paid out in benefits, this policy has switched from a previously estimated cost to the government of $589 million in the last Budget submission to now a net save for the government of $448 million over the four years 2025–26 and 2028–29.

Table 8: Impact of implementing a 90 per cent minimum payout ratio

	2025–26	2026–27	2027–28	2028–29	Total
Direct change in premium (%)	-6.62	-6.62	-6.62	-6.62	
Additional private health insurance policies	296,230	294,259	290,456	288,549	
Additional rebate for additional policies ($m)	166	163	159	156	643
Reduction in rebate from lower premiums ($m)	-275	-274	-271	-271	-1,091
Total cost to government ($m)	**-109**	**-111**	**-113**	**-115**	**-448**

Policy proposals

Increase the Medicare levy surcharge

This section draws on the AMA report, *The repeat prescription for private health insurance*, with some rework of the modelling adapted and extended to give estimates between 2025–26 and 2028–29.

Originally introduced in July 1997 for income earners over $50,000, the 1 per cent Medicare levy surcharge (MLS) aimed to encourage those that could afford it, to take up private health insurance. At the time, an income of $50,000 was the threshold for the highest income bracket of taxation, a marginal rate of 47 per cent. The comparable threshold is now $190,000 where marginal tax is paid at 47 per cent (45 per cent marginal tax rate and 2 per cent Medicare levy). The additional MLS rate is now levied at the rates of 1 per cent, 1.25 per cent or 1.5 per cent depending on taxable income.[8] The key policy principle behind the MLS was that higher income earners who did not have private health insurance were penalised with a higher surcharge. This position has been eroded by the federal government which has frozen and applied low indexation to the threshold over many years. This was only recently unfrozen in 2023–24. Until recently, we have seen the growth in premiums outstripping low wage growth, which has compounded the impact. For some cohorts, there is a perverse outcome of the MLS being applied to people at a lower income than originally intended. However, the amount levied is less than the rate likely to be paid for a reasonable private health insurance product, due to increased premiums. The AMA is calling for the MLS levels and thresholds to be reconsidered, to determine what settings are required to deliver on the policy intent. It should be noted the Department of Health and Aged Care has undertaken a significant amount of work on the private health insurance policy levers (including the MLS), and further details of the AMA's response can be found in the *AMA submission to Department of Health and Aged Care consultation on PHI Incentives and Hospital Default Benefits Studies*.

Risks and implementation

In implementing changes to the MLS, the federal government must consider what other policy levers (specifically lifetime health cover (LHC) and the private health insurance premium rebate) must also be adjusted to ensure the change to the MLS has the desired impact. For example, if the proposed changes are applied to the MLS without matching incentives to LHC, the effect will be to raise more revenue but reduce the number of additional private health insurance policies.

It is critical that any changes to policy levers are carefully calibrated given that settings for each of the policy levers have a powerful impact on the equity, efficiency, and effectiveness of the others. They also have a powerful impact on the viability of other foundational policy settings that are out of scope for this consultation, including community rating, a mixed public/private system, and the clinical autonomy of medical practitioners. It is also critical that any changes made improve the value proposition of private health for patients.

To achieve this, the policy levers must be reviewed regularly, and an evidence-base generated to support decision-making. As outlined in the AMA's discussion paper, *A whole of system approach to reforming private healthcare*, this is one of the key roles suggested for a private health system authority.

Risks of not taking action

For Australians to take out private hospital insurance and maintain that coverage through their lives, they must see value in the product they are purchasing. Private health insurance products must not only deliver value to consumers for the amount they pay but also be easy for consumers to understand. If changes to the MLS are not made, there is a risk that the effectiveness of the MLS will decline.

Timeframes and costings over four years

For the purpose of this costing, the AMA has demonstrated the impact of increasing the MLS to 2 per cent for those earning $116,001 or greater. The total cost to government across the forward estimates is an estimated cost of $1.19 billion. This policy cost estimate does not include any increase in the private health insurance rebate.

Table 9: Impact of increasing Medicare levy surcharge to 2 per cent for people earning $116,001 or greater

	2025–26	2026–27	2027–28	2028–29	Total
Additional private health insurance policies	555,867	594,562	634,542	690,642	
Rebate for additional private health insurance policies ($m)	73	78	83	89	323
Reduction in Medicare levy surcharge revenue ($m)	302	335	370	426	1,433
Reduction in average premium (%)	3.0	3.3	3.5	3.9	
Save (clawback of rebate) from lower premium ($m)	-124.8	-135.1	-145.2	-160.2	-565
Total cost to government ($m)	**250**	**278**	**308**	**355**	**1,191**

CHAPTER 4: A HEALTH SYSTEM FOR ALL

Problem statement

While governments recognise the importance of good health, investment in preventive health is often looked at as a cost rather than an investment. Spending on preventive health in Australia remains low by Organisation for Economic Co-operation and Development (OECD) standards — about two per cent of health expenditure outside of the pandemic.[1] There are several reasons for this, including:

- investment in prevention often does not show immediate returns
- short-term political cycles incentivise initiatives that will deliver demonstrable short-term rewards, as opposed to long-term benefits
- there are challenges in collating the evidence to determine what preventive measures have the greatest efficacy
- there are several piecemeal sources of funding for preventive health across the various levels of government, reducing the ability to determine the return on investment
- the loss of the Australian National Preventive Health Agency — an independent agency focused on providing evidence-based advice to federal, state and territory governments on preventive health and the effectiveness of interventions — in 2014[2]
- healthcare needs and outcomes are not uniform across the Australian population
- the complexity of social determinants of health
- preventive health programs often consist of a variety of different initiatives, leading to challenges in identifying those which are most successful.[3]

Public health encompasses a broad range of measures that aim to prevent disease, promote health, and prolong life. Investing in public health measures such as disease surveillance, vaccination programs, and health promotion, can have a significant impact on reducing healthcare costs and improving health outcomes. Public health initiatives also aim to address health and social inequalities and ensure everyone has access to healthcare and social determinants of health, regardless of their socioeconomic status, Indigenous status, or geographic location. For public health measures to be successful, they must encourage the population to take preventive actions to improve their own health outcomes.

Alarmingly, the prevalence of obesity in Australia is expected to increase, with projections suggesting a third of the adult population will be obese by 2025. Recent evidence from the Australian Institute of Health and Welfare shows being overweight and obese has overtaken tobacco as the major cause of preventable death in Australia.[5]

The scale of the obesity crisis is not surprising given the significant consumption of unhealthy foods and drinks in Australia due to their wide availability and affordability. This is confounded by low levels of physical activity and limited population understanding of what is in food and drink products and what constitutes a healthy diet.[6]

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 (including endometrial, prostate, breast and colon).[7] This not only diminishes the health and wellbeing of Australians but places a huge financial burden on our health system, in particular our public hospitals. In 2021, the AMA estimated that if no action is taken to stem the obesity crisis, by 2025 taxpayers will have paid a further $29.5 billion (over four years) for the direct healthcare costs of obesity and the associated chronic diseases.[8] From a health perspective, it is far better to prevent obesity in the first place than try to manage it once established.

Policy proposals

A tax on sugar-sweetened beverages

This section 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 2025–26 and 2028–29.

Sugar-sweetened beverages are a major contributor to the obesity crisis, with studies showing a strong association between consumption of these drinks and obesity.[9] Additionally, sugar-sweetened beverages have a significant impact on oral health, as regular consumption is associated with dental caries/cavities (tooth decay) and erosion.[10]

Sugar-sweetened beverages contain 8–12 teaspoons (33–50 grams) of sugar in the average 375 millilitre can of soft drink.[11] Despite the high sugar content and the health risks, Australians are consuming sugar-sweetened beverages in huge volumes. 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.[12] The AMA estimates that Australians drink 2.2 billion litres of sugar-sweetened beverages per year.[13] In June of 2024, the House of Representatives through the Standing Committee on Health, Aged Care and Sport released a report on the State of Diabetes Mellitus in Australia in 2024. The report included Recommendation 4 for a proposal for a sugar tax:

"... the Australian Government implements a levy on sugar-sweetened beverages, such that the price is modelled on international best practice and the anticipated improvement of health outcomes. The levy should be graduated according to the sugar content." [14]

Despite this recommendation, no legislation has been passed by the parliament.

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. In 2024, the Grattan Institute also joined the AMA's calls for a sugar tax, advocating for the introduction of a tax on sugary drinks,[15] joining a growing list of leading public health groups.

Risks and implementation

Tax design

The AMA recommends that the tax be on sugar content, 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.

Sugar-sweetened beverages subject to the tax

The AMA is calling for a tax on selected sugar-sweetened beverages — all non-alcoholic drinks containing free sugars, excluding 100 per cent fruit juice, milk-based, and cordial drinks (i.e. those that provide no nutritional benefit).

Target of tax

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

Scale of tax

It is recommended that the tax be set at $0.50/100g sugar, to reduce consumption, improve health outcomes, and lower the financial burden on the healthcare system. This aligns with the World Health Organization's recommendation that a tax on sugar-sweetened beverages would need to raise the retail price by at least 20 per cent to have a meaningful health effect.[16] Several comparable countries to Australia have implemented sugar content taxes, some of which are set at a similar rate to that which is proposed.[17] The tax would raise the price of a 375ml can of Coke (which contains 40g sugar) by $0.20.

Risks and implementation

Australian surveys have consistently shown majority support for a tax on sugar-sweetened beverages.[18] Public support is even higher if tax revenue is hypothecated to fund initiatives to tackle obesity.[19] 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.[20]

Risks around the introduction of a sugar-sweetened beverage tax are also limited, as a number of other countries have successfully introduced such a tax and been successful in reducing consumption and incentivising reformulation of sugar sweetened beverages.

As of July 2022, at least 108 countries have applied national-level excise taxes on at least one type of sugar sweetened beverage (SSB), and many jurisdictions, including eight in the United States (Albany, California; Berkeley, California; Oakland, California; San Francisco, California; Seattle, Washington; Boulder, Colorado; Philadelphia, Pennsylvania, Washington; District of Columbia); two in Canada, two in Europe, and four in the Pacific Islands.

Despite several countries implementing SSB taxes for revenue raising reasons, more than 108 countries have implemented a sugar-sweetened beverage tax.[21]

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 United States jurisdictions (Portland 1991; Cleveland 2003; Berkeley 2015 and 2024), where robust evaluations have shown a drop in consumption following the tax. Furthermore, in the United Kingdom, modelling has shown that the amount of sugar consumed by children has decreased to almost one teaspoon per day within a year of the sugar levy being introduced in 2018.[22]

This trend is also reflected in adults, whereby their sugar intake fell by the equivalent of more than two teaspoons per day.[23] Further, between 2015 and 2019, the percentage of drinks in supermarkets with sugar content of more than 5 g per 100 mL fell from 49 per cent to 15 per cent of available drinks.[23] Moreover, Hungary showed a significant reduction in the rate of change of overweight prevalence following the implementation of the sugar tax, and a slowing trend has been observed in Paraguay. Obesity rates have declined in Brazil, Hungary, and Panama, and slowing trends have been observed in El Salvador, Honduras, and France. Furthermore, a significant reduction in obesity levels has been observed in Panama and Paraguay following the implementation of SSB taxation.[24]

As such, Australia has multiple examples of successful international examples from which to draw when implementing such a tax.

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, a sugar-sweetened beverage 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).[25]

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.[25] In the case of sugar-sweetened beverages, 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.

Impact on sugar industry

There would be minimal impact on Australia's sugar industry as about 80 per cent of Australia's domestic sugar production is exported (averaged over the past decade),[27] and only 5.3 per cent of total domestic production goes towards domestic SSB manufacture.[28] The estimated change in sugar-sweetened beverage consumption due to the proposed tax is 14 to 25 per cent, which translates to a 0.72 to 1.2 per cent drop in demand for domestic sugar production. The domestic sugar market has a much greater level of volatility than this change.[28] 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 sugar industry is in a better position now than it has been in some time. The global benchmark sugar price is approximately $USD 0.22 per pound, where it often went as low as $USD 0.10 per pound across the past decade and as recently as 2020.[29]

The risks of not taking action

There is a strong association between consumption of sugar-sweetened beverages and increased energy intake, weight gain, and obesity.[30] Conversely, reduced consumption of sugar-sweetened beverages is significantly associated with weight loss.[31] People living with obesity have healthcare costs that are about 30 per cent greater than their healthy weight peers.[32] 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 $38 billion for the direct healthcare costs of obesity (over four years to 2028–29).[32]

Consumers have been gradually switching to artificially sweetened soft drinks, a continuation of a trend in place for some years, reducing sales of sugar-sweetened soft drinks. In addition, total sales of soft drinks fell, mostly as a result of higher prices and the impact of cost of living for family budgets. This is welcome, however there has still been strong sales growth in energy drinks and sports drinks of more than 11 per cent per year in the four years to 2022–23. This suggests younger consumers' preferences are adapting to new markets but not away from sugar.

Timeframe and costing

Original modelling by the AMA indicates a tax on select sugar-sweetened beverages would reduce sugar consumption by 14 per cent in 2025–26, to 25 per cent by 2028–29, and raise annual government revenue of $937 million in 2025–26, falling to $884 million in 2028–29. Over four years (2025–26 and 2028–29), this would translate to government revenue of $3,642 million. More importantly, it would result in the reduction of 2 kilograms of sugar per person per year consumed through sugar-sweetened beverages. The rate of tax per 100g of sugar is indexed at an assumed 2.5 per cent between 2025–26 and 2028–29.

Consumption of sugar-sweetened beverages 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 United Kingdom following introduction of a similar tax, but across a longer timeframe of five years, whereas this occurred in the United Kingdom within three years.

In this modelling, the impact of the tax is compared to and built upon a 'no tax' scenario. In the no tax scenario, growth in sugar-sweetened beverage consumption is estimated by modelling industry volume from IBISWorld[34] industry projections, and inflation data[35] and forecasts.[36] Inflation outside the forecast period is assumed to average 2.5 per cent. There is also assumed to be a gradual move toward no and low sugar beverages at the rate of a one per cent increase in market share of those products each year, in line with the aggregate industry trend.[34]

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

Table 10: Impact of implementing an excise tax on select sugar-sweetened beverages

	2025–26	2026–27	2027–28	2028–29	Total
Sugar per person from SSBs (kg/person)	6.8	6.4	6.1	5.8	
Excise rate per 100g sugar ($)	0.50	0.51	0.52	0.53	
SSB revenue ($m)	937	919	902	884	3642
Estimated cost of administration to the Australian Taxation Office ($m)	2.00	0.50	0.50	0.50	3.50
Total revenue to government ($m)	**935**	**918**	**901**	**883**	**3,638**

CHAPTER 5: A HEALTH SYSTEM FOR THE FUTURE

Problem statement

Creating a healthcare system that is ready for the future is contingent on building a sustainable healthcare workforce. The effectiveness and efficiency of healthcare services are intrinsically linked to the availability of a workforce that can meet the evolving needs of communities. In Australia, there are many regions where access to the appropriate healthcare professionals remains a challenge due to the maldistribution of healthcare professionals.[1,2] The consequences of this maldistributed or insufficient workforce include prolonged wait times for appointments, delayed diagnosis, and a backlog in care, which ultimately impacts patient health outcomes.

Policy proposals

Establish and fund an independent national health workforce planning agency

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

While health workforce data is being collected, it isn't being used effectively to inform resource allocation, strategic planning, and to ensure healthcare services are distributed efficiently to meet the evolving needs of the population. The Department of Health and Aged Care has many competing priorities and to date has been unable to deliver the workforce modelling output that is required.

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

Risks and implementation

An analysis of the strengths and weaknesses of Health Workforce Australia (HWA) — which was abolished in 2014 — should be performed so learnings can be applied to the new agency. In-scope and out-of-scope functions from the initial consultation phase in 2022 should be further developed and delineated in conjunction with key stakeholders and clearly defined in legislation establishing the independent agency to ensure accountability for decision-making, using the data and advice produced through the agency to ensure it is transparent and verifiable.

The following key principles should underpin the agency:

Autonomy and independence

The agency must have a high degree of autonomy to function effectively. It should be insulated from political influence to make unbiased decisions based on data and healthcare needs.

Data collection and analysis

A crucial aspect of the agency's work is collecting and analysing data on healthcare trends, workforce supply, and demand. This requires a sophisticated data infrastructure and expertise in healthcare analytics.

Stakeholder engagement

Collaboration with various stakeholders, including healthcare providers, educational institutions, and government bodies, is essential. Engaging these stakeholders ensures that the agency's planning aligns with the real-world needs of the healthcare system.

Funding

Adequate funding is crucial for the agency to carry out its tasks effectively, including up-front investment to support establishment.

Transparency and accountability

The agency should maintain transparency in its operations and be accountable to the public and policymakers. Regular reporting on workforce planning and progress is essential to building trust.

Jurisdictional support

Current health workforce planning is fragmented and there is a notable lack of collaboration and co-operation among jurisdictions, who fund and provide the vast majority of training places. The new agency will need to ensure strong jurisdictional support for its operations, without compromising its independence.

Risks of not taking action

Australia, like many countries, is grappling with health workforce shortages and maldistribution.[3] These challenges significantly impact healthcare delivery across the nation. Shortages of healthcare professionals in certain regions and oversaturation in others can result in unequal access to care, prolonged wait times, and decreased healthcare quality. Additionally, the inefficient allocation of resources can drive up healthcare costs, straining both individuals and the government. Moreover, during healthcare crises, the absence of a centralised agency for workforce planning can hinder the country's ability to respond effectively, exacerbating the challenges posed by such emergencies.

Timeframe and costing

The AMA has used the last budget allocation for Health Workforce Australia in 2012–13 — which was abolished in 2014 — to estimate the cost of an independent national health workforce planning agency.

Previously, Health Workforce Australia had a large component of funding which was directed to grants to undertake innovative programs. The budget for grants was $773.6 million over four years (2012–13 to 2015–16).[4]

The AMA has excluded this pool of grant funding from the estimate of the cost of the new agency, at $182.6 million over the forward estimates. This assumes a cost increase in line with WPI (Wage Price Index) between the last budgeted figure in 2015–16 and 2025–26, which was an average of 2.5 per cent each year. In addition, a $5 million allocation for the first year to support establishment has been added. It is worth noting that since the abolition of Health Workforce Australia in 2014, technological advancements and improved data analytics capabilities have likely resulted in more efficient data gathering and analysis methods.

Excluded from these costs are any offsetting savings from duplication of functions from within the Department of Health and Aged Care (where staff will initially come from). There are also likely to be savings between jurisdictions as this agency will offer a co-ordination role with state governments which is missing at present. Any savings can be put toward further innovative functions to improve the efficiency of the health labour force.

Table 11: Cost of establishing and funding an independent national health workforce planning agency

	2024–25	2025–26	2026–27	2027–28	Total
Annual cost of the agency ($m)	42.4	43.7	45.0	46.4	177.6
Establishment cost ($m)	5				5
Total cost to government ($m)	**47.5**	**43.7**	**45.0**	**46.4**	**182.6**

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