AMA

2026–2027 Pre-Budget Submission

Chapter 1: General practice

Problem statement

Primary healthcare is the frontline of Australia's health system — the first and most frequent point of contact for patients. It is designed to be scientifically sound, universally accessible, and continuous, ensuring people receive the right care, at the right time, in the right place.

At the heart of primary healthcare is general practice, which plays a critical role in improving individual and community health outcomes. A strong general practice sector is essential for a high-quality, equitable, and sustainable health system. Both national and international evidence shows that when general practice is well-funded and well-supported, it leads to better health outcomes, more efficient care, and reduced pressure on the hospital system. This extends to further investment in a digitally enabled health system to support secure, real-time data sharing to reduce duplication and support continuity of care.

Despite its critical role, general practice is under increasing pressure. While recent Federal Budgets have included welcome investments, affordability and access to general practice remains a key issue for patients. General consultation items in the Medicare Benefits Schedule (MBS) require urgent reform so they meet the needs of patients, particularly those with complex and chronic disease.

To address this, the AMA is calling for:

- the Modernisation of Medicare, including the redesign of general practice consultation items to better reflect contemporary models of care
- increased funding to improve access to GP-led, team-based care in general practice
- changes to Medicare to make it easier for patients to access GP care outside of normal hours
- improved data collection to support evidence-based policy and workforce planning.

These reforms are essential to ensure general practice remains a viable, attractive, and effective part of Australia's health system.

Policy proposals

Reforming GP consultation items and rebates to better support patient care

For more than 40 years, the Medicare Benefits Schedule (MBS) structure for GP consultations has remained largely unchanged. Yet the needs of patients have evolved dramatically. Today, Australians are living longer, often with multiple chronic conditions, complex mental health needs, and a greater reliance on their GP for ongoing, coordinated care. The current MBS structure does not reflect this reality and is failing to provide patients with adequate support.

The AMA is proposing a reformed seven-tier GP consultation item structure that puts patients at the centre of care. This model ensures patients — particularly those with complex or chronic conditions — can spend the time they need with their GP without facing higher out-of-pocket costs. It removes the systemic disincentive for longer consultations and supports GPs to deliver the kind of care that leads to better health outcomes.

The AMA's proposed model represents a $4.9 billion investment over four years — an investment in the health of all Australians. It aligns with the Australian Government's 10-year primary healthcare plan and its commitment to funding models that encourage high-quality outcomes for patients. The seven-tier structure (ranging from 0–5

minutes to 60+ minutes) is based on real-world GP consultation data and extensive engagement with GPs across Australia.

Risks and implementation

Under the current system, the MBS framework for GP consultations does not provide enough support for patients with complex conditions who need to spend more time with a GP. The AMA's proposed structure provides extra support for longer, better-funded consultations, allowing patients to discuss all their concerns in one visit. The new structure increases rebates for longer consultations, reducing the financial burden on patients who need more time and making it more affordable to access the care they need.

The Organisation for Economic Co-operation and Development's (OECD) Patient-Reported Indicator Surveys (PaRIS) confirms patients with an ongoing relationship with their GP experience better care coordination, higher trust, and improved health outcomes.[1] This proposed reform supports continuity by enabling patients to spend more time with their GP. It ensures they are not disadvantaged by a funding model that rewards short consultations and will ease pressure on our stretched public hospital system by improving access to care through general practice. The proposed rebate structure has seven tiers is outlined below:

What patients can expect:

Level	Consultation length	Proposed rebate (2025 baseline)
Level 1	0-5 minutes	No change
Level 2	6-15 minutes	$46.15
Level 3	16-25 minutes	$80.10
Level 4	26-35 minutes	$114.50
Level 5	36-45 minutes	$152.65
Level 6	46-59 minutes	$190.85
Level 7	60+ minutes	$267.05

Investing in multidisciplinary general practice teams to improve patient care

In 2023, the federal government agreed to index the Workforce Incentive Program (WIP) for nurses and allied health professionals (AHPs), and to lift the maximum subsidy from $25,000 to $32,500.[2] While this reform was a welcome increase, further investment is needed to reflect how modern GP practices operate. Current funding arrangements continue to constrain the number of nurses and AHPs that practices can employ, limiting the potential for multidisciplinary care within general practice that would improve patient access. To meet the needs of patients, policy must support general practice in expanding access to integrated teams of GPs, nurses, pharmacists, and allied health professionals — all within the general practice setting. This is not only convenient for patients but also ensures access to comprehensive and coordinated care as part of a patient centred approach to healthcare delivery.

The AMA proposes removing the current cap in the Workforce Incentive Program, which unnecessarily limits the amount of support general practices can access to employ nursing and allied health staff in their practices.

Risks and implementation

The current cap on WIP payments is limiting practices' ability to scale up multidisciplinary care. Many practices now have 10 or more GPs and serve large, diverse patient populations, yet the cap restricts their capacity to build teams that meet community needs.

Removing the cap will help practices retain and grow multidisciplinary teams tailored to local health priorities and patient complexity. When patients can access high-quality, team-based care through their regular general practice, they benefit from continuity, familiarity, and care that is personalised to their health needs. This is a practical, cost-effective way to strengthen primary care and reduce pressure on the broader health system. Without adequate funding, practices will struggle to attract and retain nurses and allied health professionals. This leads to missed opportunities for preventive and holistic care, contributing to fragmented services, inefficient use of resources, and poorer patient outcomes. In 2023–24, 778,000 hospitalisations — or 6.2 per cent of all admissions — were classified as potentially preventable.[3] This is an increase from 660,000 (5.7 per cent) in 2021–22. Almost half (48

per cent) were due to acute conditions, 44 per cent were linked to chronic conditions, with a further 9.4 per cent due to vaccine-preventable conditions. These hospitalisations represent conditions that could have been managed through timely primary care.

Improving access to general practice after-hours care

Current Medicare arrangements create barriers to after-hours general practice care, limiting patient access to timely, continuous, and trusted general practice services. By defining "after-hours" too narrowly and creating financial barriers for practices to open beyond 8pm, patients are pushed into more expensive and less appropriate care settings, driving preventable complications and fragmenting care when timely access is most needed.

The AMA recommends aligning the definition of after-hours care with that used for Approved Medical Deputising Services (AMDS): weekdays after 6pm, Saturdays after 12pm, and all day on Sundays and public holidays. This alignment would enable more patients to access care from their usual GP or practice team who understands the patient's history, medications, and preferences. This is where preventable complications are most often avoided and continuity of care delivers the greatest value, reducing unnecessary hospital presentations, thereby improving patient safety.

Properly structured after-hours arrangements would encourage practices to operate for extended hours, improving patient access. Enabling more GPs to work after-hours in their usual practice settings reduces unnecessary presentations to emergency departments and urgent care clinics, where continuity of care is often lost.

The AMA urges equal after-hours recognition for Telehealth. The absence of dedicated after-hours Telehealth items is an avoidable barrier that limits timely access and weakens a core part of Australia's primary care system.

Risks and implementation

Patients who need care after 6pm on weekdays or after midday on Saturdays often find their only options are emergency departments, urgent care clinics (UCC), or deputising services — where they may be seen by a clinician unfamiliar with their medical history. This disrupts continuity of care and increases the risk of fragmented or inappropriate treatment.

The current definition of "after-hours" under Medicare is inconsistent and outdated. It discourages GPs from offering in-clinic services outside of standard hours by failing to adequately compensate for the higher costs and unsociable nature of this work. Even when GPs are willing to offer extended hours, the financial disincentive means many practices cannot sustain it — leaving patients without access to trusted, local care when they need it most.

Patients in lower-income areas or those without transport may be disproportionately affected by limited after-hours GP availability. They are more likely to rely on emergency departments or go without care altogether. This deepens health inequities and places additional pressure on hospital systems, which are not designed to provide ongoing, community-based care.

Risks of not taking action

Failure to reform GP Medicare consultation items now will leave patients — particularly those with chronic conditions, mental health concerns, and complex care needs — facing higher out-of-pocket costs, more frequent visits to their doctor, and potentially poorer health outcomes, placing them at greater risk of avoidable hospitalisation. In 2023–24, 778,000 hospitalisations were due to preventable conditions that could have been managed in general practice. Similarly, without reform to after-hours funding, many Australians will remain unable to access GP care outside standard hours, forcing them into emergency departments or deputising services, where continuity of care is lost.

Without increased investment through the WIP, practices will struggle to continue their transformation into medical homes for patients, resulting in poorer access to care and greater fragmentation of services.

Timeframe and costing

Reforming funding arrangements to basic GP item numbers

The AMA has estimated the cost of reforming the basic consultation item structure over the forward estimates, accounting for increased GP supply and demand growth of more than 5 per cent. This investment will future-proof general practice and ensure Australians continue to benefit from high-quality, equitable care.

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

	2026–27	2027–28	2028–29	2029–30	Total
Reform to basic consultation items ($ billion)	$1.11	$1.18	$1.25	$1.34	$4.88
Total cost to government ($ billion)	**$1.11**	**$1.18**	**$1.25**	**$1.34**	**$4.88**

Multidisciplinary care teams in general practice

The AMA has estimated the cost of reforming the WIP for general practices by removing the current cap on subsidy payments. This estimate is based on the modelling assumption that practice uptake will increase to the equivalent of 7,000 Standardised Whole Patient Equivalent (SWPE) compared with the current 4,000 SWPE limit. It also assumes the base rate remains unchanged and continues to be indexed.

Table 2: Estimated costs of increasing the WIP payment to support more nurses and allied health professionals in general practice

	2026–27	2027–28	2028–29	2029–30	Total
Remove limits on WIP ($ million)	$99.3	$103.9	$108.7	$113.7	$425.5
Total cost to government ($ million)	**$99.3**	**$103.9**	**$108.7**	**$113.7**	**$425.5**

GP after-hours care

Aligning the definition of after-hours for general practices with AMDS arrangements will cost the government $410.7 million over the four-year forward estimates. This estimate assumes 5 per cent of the additional GP services will replace AMDS. It also assumes 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 apart from standard MBS indexation.

Table 3: Impact of aligning the definition of after-hours for general practices with the AMDS

	2026–27	2027–28	2028–29	2029–30	Total
Total number of GP services delivered 6pm–8pm (million)	$7.2	$7.4	$7.7	$7.9	$30.2
Net additional services because of better access to care	193,300	201,200	209,400	217,900	821,800
Net cost after allowing for reduction in ADMS, UCCs ($ million)	$93.4	$99.3	$105.6	$112.3	$410.7
Total cost to government ($ million)	**$93.4**	**$99.3**	**$105.6**	**$112.3**	**$410.7**

Chapter 2: Public hospitals

Problem statement

The Australian public hospital system is in crisis. Chronic underfunding by both federal and state and territory governments has led to declining performance. In the past few years, public hospitals have been operating at breaking point, with patients waiting years for essential surgery and ambulances ramping outside hospitals because there are not enough beds and staff to cope with demand.

Australia's public hospitals are funded through a combination of federal and state and territory government contributions, as defined by the National Health Reform Agreement (NHRA). While state and territory governments manage and set their own budgets, the federal government provides some funding to them through activity-based funding — paid to hospitals according to the volume of services delivered — and through block grants. Prior to 2011, all federal funding to the states and territories was provided through block grants, but the introduction of the NHRA established an activity-based model aimed at improving efficiency and transparency. Block funding continues to support services not considered suitable for activity-based funding, such as teaching, training, research, and certain public health programs. It also supports smaller rural and regional hospitals where activity-based funding may be impractical due to lower patient volumes.

This year, we saw emergency departments face their toughest year since the AMA began tracking performance. In 2023–24:

- 61 per cent of patients waiting for urgent care in the emergency department were seen within the clinically recommended 30 minutes[4]
- 45 per cent of patients spent longer than four hours in the emergency department[5]
- 1.6 million patients — or 4,370 a day —, presented to the emergency department with either an immediate or imminently life-threatening condition (Category 1 and Category 2) that must be treated within 10 minutes. This is almost double the 832,500 in 2013–14.

Beyond treatment in the emergency department, planned surgeries continue to blow out. In 2023–24, only 65 per cent of patients referred for semi-urgent Category 2 planned surgery were treated within the recommended 90 days.[6] That means more than one in three patients waited longer than the clinically indicated time for essential surgeries such as heart valve replacements or coronary artery bypass surgery.

Apart from the pressures on resources, health professionals working in public hospitals are increasingly subject to harassment while performing their duties — with verbal and physical violence against staff becoming alarmingly common. Safe Work Australia identifies healthcare as an industry with an elevated risk of workplace violence. Some estimates suggest up to 95 per cent of Australian healthcare professionals have experienced physical and verbal abuse.[7] The medical workforce is therefore at serious risk of burnout and attrition, and the AMA continues to call on all governments to fund and implement the Hospital Registrar and Career Medical Officer (CMO) Framework, developed through the Medical Workforce Reform and Advisory Committee.[8]

Policy proposals

Clear the logjam

This section draws in part on the AMA report Hospital exit block: a symptom of a sick system from 2023, updating the relevant data points.

A lack of government funding has left public hospitals in logjam — with ambulances ramping, emergency departments at capacity, and long waits for essential surgery. Bed capacity (the number of beds available to treat the population) is not keeping pace with population growth, and the beds Australia does have are increasingly occupied by patients well enough to be discharged but with nowhere to go.

While the number of public hospital beds in Australia has slowly increased over time, population growth has outpaced it. Between 2018–19 and 2022–23, 1,932 new public hospital beds became available (rising from 63,119 to 65,051).[9] Yet the Australian population grew by more than a million over the same period.[10] As a result, the rate of hospital beds fell to 2.5 beds per 1,000 population in 2022–23, down from 2.53 per 1,000 only five years earlier.[11] Since 2018–19, the number of beds per 1,000 population in public hospitals has declined by an average of 0.3 per cent each year.[12]

Public hospitals are also experiencing exit block — a situation where patients who are well enough to be discharged but have no safe destination are kept in hospital due to a lack of better options. The most common reason for this occurs when a person's care needs change during their hospital admission, and they must then wait for appropriate care to become available, such as:

- appropriate aged care, like placement in a residential aged care facility or access to a home care package at the right level
- disability care (often linked to National Disability Insurance Scheme (NDIS) funding).

Exit block is a symptom of a healthcare system struggling to meet community demand for health and social services. However, it has a significant impact on hospital capacity. Exit block reduces the number of beds available for inpatient services, which ultimately leads to increased waiting times for ambulance, emergency department services, and essential planned surgeries.

Currently, there is no regular publicly available reporting of the number of NDIS-eligible patients waiting for disability services through the NDIS. Nonetheless, data sourced from the NDIS indicates the operational plan has generally improved discharge planning for NDIS-eligible patients.

Risk and implementation

Our hospitals no longer have capacity to surge and meet increased demand — meaning exhausted hospital staff must work harder, and patients experience delays in care, sometimes for many months. Australians can no longer wait. Urgent action is needed to establish a long-term, sustainable funding plan.

Our health system must be funded for the future to resolve current logjams.

AMA analysis shows targeted programs addressing hospital exit block could save Australian governments an estimated $811.6 million to $2.17 billion each year.

Risk of not taking action

In 2022–23 (the most recent data available), 26,758 hospitalisations were attributed to patients waiting for residential aged care nationally (either a place in a residential aged care facility or an appropriate home care service).[13] Of these patients, more than 15 per cent waited more than 35 days.[14]

The number of hospitalisations attributed to patients waiting for residential aged care — and therefore the number of patients waiting for aged care services — has been trending upwards since 2012–13, when it was just above 12,000.[15] It has more than doubled in a decade.

Before the operational plan was implemented in June 2022, there were 1,433 NDIS-eligible patients in public hospitals waiting to be discharged. On average, patients waited about 160 days — more than five months — for appropriate supports to be put in place through the NDIS so they could leave hospital. Of these 1,433 patients, 44 per cent had a discharge plan in place.

Public hospitals cannot afford to keep operating with this level of exit block, particularly as they already have limited capacity and are struggling to meet demand. The federal, state, and territory governments need to work together to refine the current arrangements for transitioning people out of inpatient wards into appropriate care.

Timeframe and costing

The AMA plan to deal with our struggling, logjammed hospitals is:

- **Expand capacity:** Provide public hospitals with additional funding for extra beds (along with the necessary staff) and support them to expand capacity to meet community demand, respond to surges when required, improve treatment times, and end ambulance ramping.

- **Addressing demand for out-of-hospital alternatives**: Fund alternatives to hospital care so patients whose needs can be better met in the community are treated outside hospital. Programs that work with GPs to reduce avoidable admissions and readmissions should be prioritised.
- **Increase funding and remove the funding cap:** Increase the federal government's financial contribution to hospital activity, allowing states and territories to reinvest the freed-up funds to improve performance, capacity, and innovation. Remove the artificial cap on funding growth shared between states and territories so funding can meet community health needs based on real demand.

If the latest National Efficient Price (NEP) Determination indexation rate of 5.6 per cent is maintained throughout the five-year agreement to 2030-31, the extra funding required is as follows:

Table 4: Impact of selected hospital funding reform measures on federal, state, and territory budgets (no efficiency)

	2026–27	2027–28	2028–29	2029–30	2030–31	Total
Australian Government ($billion)	$1.6	$4.3	$7.5	$11.2	$15.6	$40.2
State and territory governments ($billion)	$4.0	$5.5	$7.1	$9.0	$11.1	$36.7
Australian Government ($billion) Legacy price adjustment for 2021–22, 2022–23 indexation	$1.7	$1.8	$1.9	$2.0	$2.2	$9.6

Alternatively, if we are able to 'clear the logjam' and hospital price indexation can be contained through efficiency at 2.5 per cent per annum, the impact is as follows:

Table 5: Impact of selected hospital funding reform measures on federal, state, and territory budgets, better efficiency

	2026–27	2027–28	2028–29	2029–30	2030–31	Total
Australian Government ($billion)	$1.6	$3.1	$4.8	$6.7	$8.9	$25.1
State and territory governments ($billion)	$4.0	$3.8	$3.6	$3.3	$2.9	$17.6
Australian Government ($billion) Legacy price adjustment for 2021–22, 2022–23 indexation	$1.7	$1.8	$1.9	$2.0	$2.2	$9.6

The AMA is calling for an increase in the Australian Government's share to **45 per cent by 2030–31**, which is reflected in the above estimates. This is faster than the government proposal. The costing tables includes five years of estimates instead of four, to align with the term of the NHRA.

In both presented scenarios, additional funding excludes the historic cost increases already announced in the 2025–26 NEP, which are not reflected in the current Budget. The impact of the NEP increase is about $9.6 billion across all five years.

The results in the two tables make the stakes very clear. If we cannot clear the logjam, cost escalation will continue, and the impact on all government budgets will be significantly higher. While cost escalation as measured by the Independent Health and Aged Care Pricing Authority (IHACPA) in past years (2021–22 and 2022–23) is now locked in, the forecast IHACPA rate is still being determined by the efficiencies hospitals are able to achieve. Hospitals that are given the resources to effectively plan and deliver should be able to rein in costs to a reasonable level of 2.5 per cent per annum from 2027–28. In past years, under the previously uncapped ABF, hospitals consistently delivered cost control below these estimates.

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 that supplements the current focus on activity-based funding — one that supports positive improvement, increases capacity, reduces demand, and puts an end to the blame game.

This section draws on the original AMA report, Public hospitals: cycle of crisis**,** with updated modelling adapted and extended to provide estimates between 2026–27 and 2030–31.[16]

Since the AMA report was released, the federal government has agreed to increase its share of future funding to 45 per cent of activity, as well as lift the cap on its contribution towards public hospitals in the next funding agreement. This aligns with previous AMA calls for increased federal funding. As outlined in the AMA report, What happens when we fund hospitals to perform, the introduction of activity-based funding has improved efficiency, but it has also come at a cost to quality improvement and innovation, particularly with the removal of performance funding. It is critical the federal government adheres to its commitment to fund 45 per cent of activity, and that all governments work to finalise the next NHRA, with the aim of improving patient access to care and ensuring a quality working environment for the many health professionals working in our public hospital system.

The AMA calls for the new funding agreement to include 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 the change in the funding split between the federal government and the states and territories, there has been no budgeted increase in overall funds compared with the AMA's 2021 predictions (see Figure 1 below). With the exception of small improvement in the single Budget year 2025–26, the total funding envelope has remained consistent with projections under the AMA's earlier 'do nothing' scenario.

The failure to increase funding in line with the AMA's call has meant hospital activity is falling behind community demand (see Figure 2 below). However, the single year of promised additional funding, together with contributions from some states, allowed activity to keep pace with the underlying trend and achieve slight improvement, rather than falling further behind.

This is because, while the federal government cap has been increased, it appears to be starting from a lower base than it should be, had funding in past years risen in line with the AMA's projections. Another issue is that unless states and territories commit additional funding, hospitals will not have the capacity to take advantage of the increase in the federal cap.

Finally, due to increasing health inflation, a part of the funding increase will be absorbed by higher service costs, rather than expanding the number of services provided. Hospitals operating near or at capacity have limited scope to improve efficiencies. Without spare capacity in terms of beds and staff, they cannot schedule blocks of surgical time dedicated to reducing waiting lists effectively. This undermines the efficiencies activity-based funding was able to deliver up to 2021–22 and further restricts the amount of activity achievable with the same level of funding.

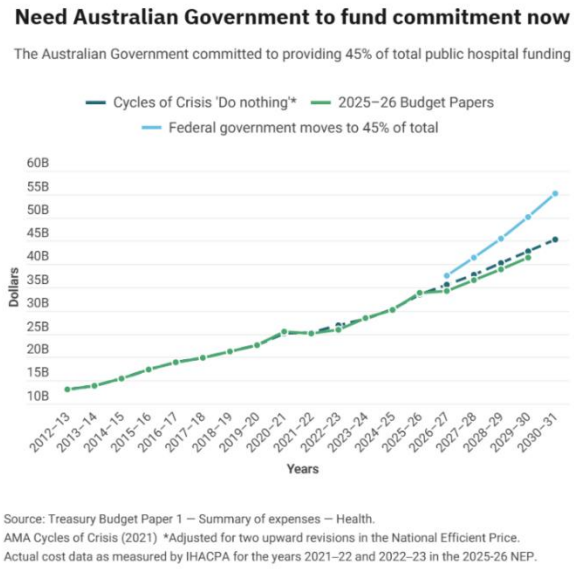

Figure 1: Historic and projected funding for public hospitals versus the AMA's projected 'do nothing' scenario

Figure 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.
- Hospital admissions and emergency department demand will continue to grow, putting more pressure on public hospitals.
- Beds will increasingly be taken up by emergency admissions.
- Emergency admissions will continue to struggle to find a bed in a timely manner, leading to more significant ambulance ramping.
- Waiting lists for elective surgery will continue to increase.
- Appropriate staffing levels will be harder to maintain while funding remains inadequate.

Risks and *implementation*

Blame game

Past NHRA negotiations have often deteriorated into a blame game, with governments frequently trying to pass the buck. Patients deserve better and should not be caught in the middle. It is time for all governments to work together to deliver a durable agreement that places our public hospitals on a sustainable footing and supports access to care within clinically appropriate timeframes.

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, and to lift the cap on its contribution towards public hospitals in the next funding agreement, states and territories will need to increase their capacity and funding to fully utilise this opportunity. Furthermore, the agreement should recognise and allow for periods where some of the additional funding is absorbed by the increasing costs of service delivery, and account 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 that increase capacity through improved processes. In addition, public hospitals should receive additional funding to expand capital infrastructure and staffing where needed. The additional funds must lift planned capacity and not simply pay for outsourced surgeries. The federal government should fund this in partnership with the states and territories; with the understanding it will improve both hospital efficiency and patient outcomes. This additional money could be allocated on a matched-funding basis, following proposals from the states and territories. The risk is that, without this, states and territories may not be able to use the additional funding on offer.

Funding to address demand

Activity-based funding should remain the primary funding model for most patients, but it should be supplemented by alternative models of care better designed for the holistic treatment of people with chronic and complex disease. Some alternative models of care have been trialled, but time and resources are needed to support and scale successful pilot projects into state-wide services and to enable further trials of innovative approaches. The federal government should partner with state and territory governments to provide additional up-front funding for this purpose. The return on investment would be realised through reduced public hospital costs, fewer admissions and readmissions, and improved patient outcomes.

Performance improvements

It is possible reforms will only stabilise performance (i.e. prevent further decline), rather than improve it. This is a risk given the dire situation public hospitals are facing 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 directed at targeting emergency department performance and capacity improvement, noting some state and territory governments have undertaken reviews into what is required.[17] However, there is no 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 additional funding called for in table 6 incorporates a higher level of funding than was provided in the most recent Budget. Following the early timing of the Budget, the IHACPA released the NEP Determination, which further increased the measured historic price of a National Weighted Activity Unit (NWAU) by more than 5 per cent above previous estimates. This has been incorporated into the AMA's 'Do Nothing' scenario costing.

The figures below include the additional funding necessary to lift activity to 'catch-up' to underlying demand, in addition to further performance improvement. Therefore, much of this ask is in addition to the $13 billion the federal government committed in December 2023 for the future five-year period. Going forward, a greater commitment will be required from the federal, state, and territory governments.

Costings for performance improvement, increased capacity, and addressing avoidable admissions and readmissions are not provided at this stage in this submission, as each state and territory remains 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 or matched funding under these streams. It is envisaged the requirements for each state and territory will differ, as will the timelines for development, implementation and expenditure.

In considering future outlays, the potential savings that will accrue over a longer term to the health system from more effective management of chronic disease should be acknowledged. Performance and infrastructure improvements will undoubtedly require additional expenditure — and are likely to increase patient throughput — however, they will also generate benefits for individuals and for productivity 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

	2026–27	2027–28	2028–29	2029–30	2030–31	Total
Australian Government ($billion)	$1.6	$3.1	$4.8	$6.7	$8.9	$25.1
State and territory governments ($billion)	$4.0	$3.8	$3.6	$3.3	$2.9	$17.6

The AMA is calling for an increase in the Australian Government's share to 45 per cent by 2030–31, which is included in the above estimates. This is faster than the government proposal.

Additional funding excludes the historic cost increases already announced in the 2025–26 NEP, which are not reflected in the most recent Budget. The impact of the NEP increase is about $9.6 billion across all five years.

Pillar 3
Private healthcare

Chapter 3: Private health

Problem statement

The private health system in Australia provides an important complement to the public system, offering patients a wide range of services and greater choice in their care. Private hospitals account for about two in five hospitalisations and seven in ten planned surgeries in Australia.[18] Retaining a strong private hospital sector reduces demand on the public health system, enables patients to have more control over their healthcare, and encourages innovation and quality improvement in healthcare services.

Private hospitals are largely funded by private health insurance (81.7 per cent[19]), and a healthy fiscal balance between the two supports a sustainable private system. However, this balance has not always been achieved. In the lead-up to the COVID-19 pandemic, private health insurers came under increasing pressure as participation rates declined, the insured population aged, and members were more likely to use their cover — continuously increasing insurer's outlays.

During the pandemic, participation rates rose (more Australians taking out private health insurance) while outlays decreased (less benefits paid out by insurers) due to the impact of lockdowns and workforce shortages, which lowered activity and claims. This strengthened the fiscal position of private health insurers, resulting in several years of record reported profits. Yet for private hospitals, this same low activity combined with rapidly rising costs (including wages, utilities, and consumables) and low indexation in existing contracts caused significant financial strain, leading to the closure of services, beds, and even entire hospitals. These closures make the case for the necessity of clinical leadership and should underline their requirements to act in the best interests of the community they serve.

Notwithstanding the recent increase in insurance uptake, people aged 60 years and over are set to become the largest insured population in the foreseeable future, while many younger and healthier Australians are increasingly opting for reduced cover. As the insured population ages, they are more likely to draw on their insurance to access care, and with fewer younger, healthier people in the system, pressure on insurance premiums will rise.

Consumers are paying more for their private health insurance products through higher premiums but are receiving less back from insurers when claiming for their care.

The Private Health CEO Forum, established following the completion of the Private Hospitals Viability Health Check in mid-2024, was welcomed by the AMA as a positive step and has been tasked with finding solutions to ensure private hospital viability.

Policy proposals

Fund hospital-in-the-home

This section draws on the AMA position statement Principles for private health insurance to cover out-of-hospital care from December 2024.

The AMA supports a wider range of hospital-in-the-home programs available to patients. However, the absence of clear rules governing the provision of private out-of-hospital care in Australia limits patient access to innovative models of care, such as home rehabilitation or hospital-in-the-home.

The AMA notes several private health insurers have developed their own models. However, these programs are designed to funnel patients into in-house services. Instead of expanding access to alternative models of care, they effectively control which services are available to patients and what those services can charge — through vertical integration and manage care.

There are many procedures for which clinically suitable patients should be able to access out-of-hospital care, such as rehabilitation following hip and knee replacements. Access should not be restricted to certain patients in specific areas who hold particular private health insurance policies.

To improve access to hospital-in-the-home services for privately insured patients, the AMA proposes the government work with stakeholders to develop and mandate a minimum payable benefit for out-of-hospital models of care in the private health system. This should be underpinned by legislative arrangements that enshrine patient safety, protect patient choice, and maintain clinical autonomy.

Risks and implementation

It is crucial to establish regulations, rules, and standards to ensure genuine contestability of services and equitable access to out-of-home models of care in the private health system. We envision a private health system in which, regardless of where they live in Australia, all patients with appropriate private health insurance cover can choose the best care option for themselves under the clinical guidance of their medical practitioner, funded by their private health insurer.

In our position statement Principles for private health insurance to cover out-of-hospital care, we set out principles that should define private out-of-hospital care. These include:

1. Protection of patient choice and clinical autonomy.
2. Quality and safety standards.
3. Effective management of patient deterioration and re-escalation of care.
4. A clear and equitable funding mechanism.

Risks of not taking action

The AMA supports greater provision of out-of-hospital care and services within the private health system. A considerable amount of evidence, much of which is cited in the AMA report Out-of-hospital models of care in the private health system,[20] suggests well-designed out-of-hospital models of care, when applied in clinically appropriate cases, can offer substantial benefits for patients, hospitals, and the health system.

For patients, these benefits may include improved health outcomes — for example, through a reduced risk of hospital-acquired infections. The ability to recover in the comfort of home, better manage caring responsibilities, and, where appropriate, continue working from home can all help reduce stress and anxiety during treatment and recovery.

Furthermore, patients who do not need to travel back and forth to hospital for treatment may benefit from reduced time commitments, less discomfort, and lower travel costs — particularly those living in regional and rural areas who may be a significant distance from the nearest hospital. With respect to benefits for hospitals and the wider health system, out-of-hospital care also provides an efficient way for hospitals to manage bed flow, thereby reducing pressure and potential wait times for patients.

In some cases, it is cheaper to deliver care in the home, as overheads are far greater when a patient is admitted overnight. Improvements in the private system will help relieve pressure on public hospitals, reduce pressure on private health insurance premiums, and offer better value for taxpayers. However, it is critical out-of-hospital care in the private system is equitable and clinically led, rather than the current model, which is largely insurer-led and only available to patients with specific private health cover policies in certain areas of Australia.

Timeframe and costing

Under this proposal, hospital-in-the-home services would be funded through a patient's private health insurance and private health insurers have generally described this as likely to result in significant cost savings. The development of a robust framework and funding model would be led by the Department of Health, Disability and Ageing, using existing resources.

This concept is something the department has previously identified as a reform that could potentially be delivered in the short term.

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 provide for estimates for the period between 2026–27 and 2029–30.

Regulatory arrangements were designed at a time when private health insurance was in a strong position, with high membership, when most private health insurers operated on a not-for-profit basis, and when private hospitals had larger profit margins. These arrangements remain effective in protecting the interests of consumers by maintaining insurer solvency, managing consumer complaints, and ensuring the safe delivery of healthcare. However, they offer limited flexibility for government policy to keep pace with a changing population, market imbalances in negotiated contracts, and economic shocks.

The AMA continues to call for the establishment of an independent and well-resourced Private Health System Authority to address gaps in the regulatory environment and to independently oversee the private healthcare system.

This independent umpire would have the capacity, objectivity, and expertise to ensure the system evolves in line with government policy, balancing the interests of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors. It would also provide a platform for all the stakeholders in the sector to come together and agree on the necessary once-in-a-generation reforms required to ensure the future viability of private healthcare in Australia.

Risks and implementation

An independent authority would consolidate regulatory functions previously carried out by other parts of government and agencies, enabling them to operate in a more cohesive and effective way. This would include relieving the department of its conflicted role as both regulator and policy maker.

It would also incorporate new functions and skills to address gaps in the regulatory environment, while supporting the regulatory and advisory functions performed by other agencies. Cost transfers for existing functions carried out by other agencies, as well as additional costs, would be required. Sufficient transition time and resources should be allocated to ensure this is done effectively; however, overall costs are not anticipated to be high.

Risks of not taking action

The current private health regulation and legislative framework is complex and limits innovation and reform. Additionally, the mechanisms in place to ensure the private health system evolves in a lasting way, as government policy intends, are limited and ad hoc. There are also few 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 in terms of reform, particularly in relation to out-of-hospital models of care, as outlined above. This will continue if the regulatory and legislative frameworks remain unfit for purpose. Furthermore, gaps in regulation affect patients through unexpected out-of-pocket costs, restricted choice, and added complexity.

Timeframe and costing

The direct cost of establishing an independent authority, which does not exist, is difficult to estimate; however, an indicative estimate can be made using similar agencies as a proxy.

At present, the Australian Prudential Regulation Authority (APRA) provides prudential regulation of private health insurers. APRA reported its total operating expenditure for the 12 months to 30 June 2025 was $229 million[21] (the most recent data available). In 2023–24, APRA also collected $240.7 million in levies to recover costs,[22] $10 million of which was directly attributed to revenue levied against private health insurers.[23] In 2024–25, APRA regulated a total of 30 insurers.[24]

This role, currently performed by APRA, represents only one of an expanded set of roles envisioned for the proposed authority. 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 million[25] cost reallocated from APRAs responsibilities.

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 were undertaken, this $11 million would be the only net cost to government between 2026–27 and 2029–30.

Table 7: Cost of a Private Health System Authority

	2026–27	2027–28	2028–29	2029–30	Total
Establishment cost ($m)	$11.0				$11.0
Ongoing cost ($m)	$33.3	$34.8	$36.5	$38.3	$142.8
Total cost to government ($m)	**$44.3**	**$34.8**	**$36.5**	**$38.3**	**$153.8**

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 provide estimates for the period between 2026–27 and 2029–30.

Private health insurers have been generating significant profits since the COVID pandemic, returning some of these to consumers who were unable to access care using their insurance due to lockdowns and restrictions on planned surgery, while still reporting substantial profits. In the 12 months to 30 June 2025, private health insurers reported an after-tax profit of $2.1 billion,[26] up from $1.8 billion the previous year.[27] A significant share of this profit was the result of higher investment returns, which rose materially in line with higher market interest rates.

Despite rising premiums and increasing memberships, these gains did not flow through to private hospitals. Private hospitals were severely impacted by fixed costs during the pandemic and the slow return of activity, further exacerbated by rapidly increasing costs and supply disruptions. Compounding these issues, many contracts between private hospitals and private health insurers last two to three years and did not anticipate the post-pandemic inflation that eventuated. As a result, several private health insurers posted near-record profits, while hospitals claimed underfunding, with insurers paying a smaller share of their total premium revenue to them.

Private health insurers generally aim to set premium levels to cover the expected benefit costs (the amount paid for members' medical treatment), as well as their own management expenses. Management expenses represent the portion of premiums per policy used to operate the business of the insurer. All private health insurers incur management expenses, and depending on their size, market share, and whether they are for-profit or not-for-profit, they can include varying marketing costs, salaries, overheads, incidental expenditure (such as cyber security upgrades to systems), and profit margins that must be built into these expenses.

The benefit payout ratio is the proportion of benefits paid out for patient care compared to the premium revenue generated over a given period. When management expenses account for a higher share of payments, a smaller proportion of premiums is directed toward treatment.

There is no government policy directing or indicating what the payout ratio should be. However, the Minister for Health, Mark Butler, asked private health insurers in March 2025 to outline steps to increase their payout rate,[28] which has dropped in recent years to 84 per cent in 2024–25, even as their profits have increased. The impact of this directive remains unclear

The AMA agrees 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. A standardised return higher than the current private health insurance industry average is needed.

Risks and implementation

The federal government increasingly plays a role in promoting private health insurance, particularly given its involvement in recent reforms and its contributions to supporting access (such as the private health insurance rebate).

As the department is both the policymaker and regulator, there is a risk that this conflict of interest may affect reforms (such as a minimum payout) if issues arise during implementation. Establishing an

independent Private Health System Authority could help mitigate this risk. Furthermore, some private health insurers may resist a mandated minimum payout, as it could affect their viability. A Private Health System Authority would be well placed to determine an appropriate minimum payout while also ensuring private health insurers remain solvent.

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 for-profit providers, erodes the perceived value of private health insurance in the eyes of the public. In addition, many private hospitals are struggling to remain viable. This issue needs to be urgently addressed, particularly if the federal government is called upon to invest additional taxpayer funds in the private health system, or if a significant number of private patients are forced to turn to the public sector because private services are no longer available. Australians therefore need assurances their investment in private health insurance will be returned in the form of appropriate coverage for services when it is needed.

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 show hospital treatment benefits of $19.4 billion, compared with premium revenue of $23 billion across the past four quarters, meaning the payout ratio is now 84 per cent. In addition, funds can now generate much higher investment income from premiums than the recent past, further enhancing their profitability.

Timeframe and costing

The direct cost to government of increasing the minimum payout ratio is zero. However, there would be indirect costs — the two main components being: (1) additional private health insurance policies leading to higher government outlays for the private health insurance rebate, and (2) lower rebate outlays from a reduction in the base premium. Some of these indirect costs may be offset by fewer patients attending public hospitals.

A behavioural shift towards more private health insurance policies would mainly occur among those not subject to tax penalties or incentives — that is, individuals earning $97,000 or less — as well as among those less likely to claim, given people with high expected claims are likely to already hold a policy.

With more people taking out private health insurance policies, there would be 'second-round effects' of lower premiums, further boosting uptake, including among 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, or those subject to Medicare Levy Surcharge, to take out private health insurance, as these groups already receive a larger benefit on average (through greater use) or a much stronger price incentive under existing policies. The policy is projected to result in net savings for the government of $219 million over the four years from 2026–27 to 2029–30.

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

	2026–27	2027–28	2028–29	2029–30	Total
Direct change in premium (%)	-6.39%	-6.39%	-6.39%	-6.39%	
Additional private health insurance policies	276,100	274,370	272,450	272,500	
Additional rebate for additional policies ($m)	$167	$169	$172	$175	$684
Reduction in rebate from lower premiums ($m)	$226	$226	$226	$226	$903
Total cost to government ($m)	**-$58**	**-$56**	**-$54**	**-$50**	**-$219**

Note: totals may not sum exactly due to rounding

Increase the Medicare Levy Surcharge

This section draws on the AMA report The repeat prescription for private health insurance, with some reworking of the modelling adapted and extended to provide estimates between 2026–27 and 2029–30.

Originally introduced in July 1997 for income earners over $50,000, the 1 per cent Medicare Levy Surcharge (MLS) was designed to encourage those who could afford it to take up private health insurance. 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.

At the time, an income of $50,000 was the threshold for the highest income bracket of taxation, with a marginal rate of 47 per cent. The comparable threshold is now $190,000 where marginal tax is paid at 47 per cent (a 45 per cent marginal tax rate plus a 2 per cent Medicare levy).[29] The additional MLS is now levied at the rates of 1 per cent, 1.25 per cent, or 1.5 per cent, depending on taxable income.[30]

The policy intent behind the MLS has been eroded by the federal government, which froze and applied low indexation to the high-income bracket threshold over several years. This was only recently unfrozen in 2023–24. Until recently, growth in premiums outstripped low wage growth, compounding the impact. For some cohorts, this has led to the perverse outcome of the MLS being applied to people at lower income levels 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 settings to be reconsidered, to ensure they best deliver on the original policy intent.

Risks and implementation

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

Any changes to policy levers must be carefully calibrated, as the settings for each lever have a powerful impact on the equity, efficiency, and effectiveness of the others. They also strongly influence the viability of other foundational policy settings, including community rating, the mixed public/private system, and the clinical autonomy of medical practitioners. It is critical changes improve the value proposition of private health insurance 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 the Private Health System Authority.

Risks of not taking action

For Australians to take out private hospital insurance and maintain coverage throughout their lives, they must perceive 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 them to understand. If changes to the MLS are not made, there is a risk the effectiveness of the MLS will decline.

Timeframe and costing

For the purpose of this costing, the AMA has demonstrated the impact of increasing the MLS to 2 per cent for those earning $118,001 or more. The total cost to government across the forward estimates is estimated at $1.5 billion. The primary source of this cost to government is the reduction in the MLS collected. This would also represent a saving to households. This policy cost estimate does not include any increase in the private health insurance rebate rate.

Many more households are now falling into these higher tiers as a result of the prolonged freeze in the thresholds. So far, there has been only a tepid response to the MLS disincentive in recent years, following a jump in nominal incomes post-COVID. The MLS is now a significant tax revenue driver, expected to collect more than $1 billion in revenue per year under the current policy settings.

Table 9: Impact of increasing Medicare Levy Surcharge to 2 per cent for people currently earning $118,001 or greater

	2026–27	2027–28	2028–29	2029–30	Total
Additional private health insurance policies	294,770	309,310	325,410	341,720	
Rebate for additional private health insurance policies ($m)	$62	$67	$73	$79	$202
Reduction in Medicare Levy Surcharge revenue ($m)	$452	$498	$547	$628	$1,497
Reduction in average premium (%)	1.4%	1.5%	1.6%	1.7%	
Save (Clawback of rebate) from lower premium ($m)	$60.2	$65.1	$70.4	$76.1	$196
Total cost to government ($m)	**$454**	**$500**	**$550**	**$631**	**$1,503**

Note: Totals may not sum exactly due to rounding.

Chapter 4: A health system for all

Problem statement

While governments recognise the importance of good health, investment in preventive health is often regarded as a cost rather than an investment. In Australia, spending on preventative health remains low by Organisation for Economic Co-operation and Development (OECD) standards, accounting for only 2.9 per cent of total health expenditure.[31] 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 rather than 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[32]
- 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.[33]

Public health encompasses a broad range of measures that aim to prevent disease, promote health and wellbeing, 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, regardless of their socioeconomic status, Indigenous status, or geographic location. For public health measures to be successful, they must encourage all the population to take preventive actions to improve their own health outcomes.

More than one-third (36 per cent) of the total burden of disease in Australia in 2024 could have been prevented by reducing exposure to the modifiable risk factors identified in the Australian Burden of Disease Study 2024.[34] Overweight and obesity were the leading risk factors contributing to total disease burden in 2024 (8.3 per cent), displacing tobacco use as the leading risk factor. Notably, the total disease burden attributed to tobacco use declined significantly (by 41 per cent) between 2003 and 2024, after adjusting for age. The scale of the overweight and obesity crisis is not surprising, given the significant consumption of unhealthy foods and drinks in Australia due to their wide availability and affordability. According to the United Nations' 2025 Child Nutrition Report,[35] the global prevalence of overweight and obesity among school-age children and adolescents has exceeded underweight for the first time.

Poor diet is compounded by low levels of physical activity and unhealthy food choices. The economic costs of overweight and obesity include direct healthcare expenses related to the treatment of these conditions and their associated comorbidities, such as type 2 diabetes, heart disease, hypertension, stroke, gallbladder

disease, osteoarthritis, sleep apnoea and other respiratory problems, mental health disorders, and certain cancers (including endometrial, prostate, breast, and colon). Indirect costs borne by individuals, families, businesses, government, and society include reduced quality of life, stigmatisation, and decreased workforce participation and performance. These indirect costs often surpass direct healthcare costs. In Australia, the total economic cost of overweight and obesity was estimated at $39 billion, or 1.9 per cent of GDP, in 2019. This figure is projected to rise to more than $62 billion by 2030, and more than $228 billion, or 3.5 per cent of Australian GDP, by 2060.

From a health perspective, it is far better to prevent obesity in the first place than attempt 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 2026–27 and 2029–30.

Sugar-sweetened beverages are a major contributor to the obesity crisis, with studies showing a strong association between the consumption of these drinks and obesity.[36] Additionally, sugar-sweetened beverages have a significant impact on oral health, as regular consumption is associated with dental caries/cavities (tooth decay) and erosion.[37]

Sugar-sweetened beverages contain 8–12 teaspoons (33–50 grams) of sugar in an average 375-millilitre can of soft drink.[38] Despite the high sugar content and associated health risks, Australians continue to consume these beverages in large volumes. In 2019–20, Australians consumed an average of 70 grams of free sugar a day, with more than a quarter (18 grams) coming from sugary drinks.[39] The AMA estimates Australians drink about 2.2 billion litres of sugar-sweetened beverages per year.[40]

In June 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 committee highlighted the importance of prevention and referenced the National Preventative Health Strategy 2021–2030, the National Diabetes Strategy 2021–2030, and the National Obesity Strategy 2022–2032. All three strategies recognise prevention is vital to addressing the rising tide of chronic diseases such as diabetes and obesity. Preventive action saves lives, reduces the impact of diabetes on Australia's economy, and eases pressure on the health system. Preventing diabetes is also financially advantageous, with prevention resulting in an estimated net economic benefit of $4.65 for every $1 invested.[41] Past policies that focused on personal responsibility — encouraging changes in eating habits and increased exercise to address diabetes and obesity — have led to limited systems-level action (i.e. policy, regulation, industry implementation). Multiple expert groups specialising in obesity and diabetes have called for a paradigm shift in policy making, moving from personal responsibility to shared responsibility, with greater accountability required from government and industry leaders.

The consumption of sugar-sweetened beverages is linked to weight gain and an increased risk of developing type 2 diabetes. Based on the evidence provided through public submissions and hearings, the committee recommended:

> *"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."*[42]

As of November 2025, the government has not issued its response.

A tax on the sugar content in sugar-sweetened beverages can deliver both a clear message to 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, Grattan Institute joined the AMA's calls for a sugar tax,[43] advocating for the introduction of a tax on sugary drinks and joining a growing list of leading public health groups.

Tax design

The AMA recommends that the tax be based on sugar content, using a sliding scale in which the tax increases as the sugar content rises. A sugar-content tax is the most logical option, given the harm caused is proportionate to the amount of sugar rather than the product's value or liquid volume. It is the only option that creates an incentive for manufacturers to reduce the sugar content of their products and is therefore the most targeted approach to reducing sugar consumption.

Sugar-sweetened beverages subject to the tax

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

Target of tax

The AMA recommends the tax be applied to both domestic and international manufacturers of sugar-sweetened beverages. The tax should target manufacturers to incentivise reformulation. An excise (and customs) tax is the most logical mechanism to achieve this.

Scale of tax

It is recommended the tax be set at $0.50 per 100g of 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.[44] Several comparable countries to Australia have implemented sugar-content taxes, some of which are set at a similar rate to that which is proposed. Such a tax would raise the price of a 375millilitre can of Coke (which contains 40g sugar) by $0.20. [45]

Risks and implementation

Australian surveys have consistently shown majority support for a tax on sugar-sweetened beverages. [46] Public support is even higher when tax revenue is hypothecated to fund initiatives aimed at tackling obesity. [47] A nationally representative survey conducted in 2017 found 60 per cent of Australians supported a tax on sugary drinks. This figure increased to 77 per cent when the proceeds were earmarked for obesity prevention. Risks associated with introducing a sugar-sweetened beverage tax are limited, as several other countries have successfully implemented such measures, reducing consumption and incentivising the reformulation of sugar-sweetened beverages. [48]

More than 130 jurisdictions, including more than 100 countries, have applied national-level excise taxes on at least one type of sugar-sweetened beverage. These jurisdictions include eight in the United States (Albany, California; Berkeley, California; Oakland, California; San Francisco, California; Seattle, Washington; Boulder, Colorado; Philadelphia, Pennsylvania; and Washington, District of Columbia); two in Canada, two in Europe, and four in the Pacific Islands. Although some countries adopted sugar-sweetened beverage taxes primarily for revenue raising reasons, 108 countries have implemented the sugar tax overall.[49]

In a number of countries, including the United Kingdom (2018), Mexico (2014), France (2012), Chile (2014), Catalonia, Spain (2016), and several jurisdictions in the United States (Portland, 1991; Cleveland, 2003; Berkeley, 2015 and 2024), robust evaluations have shown declines in the consumption of sugar-sweetened beverages following tax implementation. Furthermore, in the UK, modelling has shown that the amount of sugar consumed by children decreased to almost one teaspoon per day within a year of the sugar levy being introduced in 2018.[50]

This trend is also reflected in adults, whose sugar intake fell by the equivalent of more than two teaspoons per day.[51] Further, between 2015 and 2019, the percentage of supermarket drinks containing more than 5 gram of sugar per 100 millilitre decreased from 49 per cent to 15 per cent of available products. [52] Noteworthy in Hungary, a significant reduction in obesity prevalence in the general population ensued after the implementation of a public health product tax in 2011. Overweight and obesity rates have declined in Brazil, Hungary, and Panama, while slowing trends have been observed in El Salvador, Honduras, and France. Furthermore, a significant reduction in obesity levels has been observed in both Panama and Paraguay following the implementation of sugar-sweetened beverage taxation.[53]

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

Impact on obesity and healthcare expenditure

Reduced sugar consumption and an improved diet would likely lower the prevalence of overweight and obesity, resulting in substantial healthcare savings. According to previous Australian modelling in 2019, a sugar-sweetened beverage tax that raises the retail price by 20 cents could reduce the prevalence of obesity by about 2 per cent and generate healthcare expenditure savings of $609 million to $1.73 billion (over the lifetime of the population modelled).[54]

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 or income. This regressive effect is reduced if there is an untaxed substitute that consumers can easily switch to.[55] In the case of sugar-sweetened beverages, healthy substitutes such as water are readily available and affordable to most people. By making this change, consumers can avoid the tax while also improving their health.

Impact on sugar industry

There would be minimal impact on Australia's sugar industry, as about 80 per cent of domestic sugar production is exported (averaged over the past decade),[56] and only 4.8 per cent of total domestic production goes towards the domestic manufacture of sugar-sweetened beverages.[57] 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 experiences a much greater level of volatility than this change.[58]

The impact on the sugar industry is therefore anticipated to be minimal and does not appear to warrant a government assistance package. The government may wish to consider whether there are specific small-scale farmers who mainly supply the domestic market and who may warrant an assistance package (which could be funded from the tax revenue). The sugar industry is in a stronger position now than it has been in some time. The global benchmark sugar price is about US$0.14 per pound, whereas it often fell as low as US$0.10 per pound over the past decade, including as recently as 2020.[59]

Risks of not taking action

There is a strong association between the consumption of sugar-sweetened beverages and increased energy intake, weight gain, and overweight and obesity.[60] Conversely, reduced consumption of sugar-sweetened beverages are significantly associated with weight loss.[61] People living with overweight or obesity incur healthcare costs that are about 30 per cent higher than those of their healthy-weight peers.[62] Many of these 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 incurred an additional $41.5 billion in direct healthcare costs related to obesity (over the four years to 2029–30).[63]

Soft drink manufacturers have long argued that consumers are switching away from sugar-sweetened drinks towards artificially sweetened (zero sugar) beverages. However, the latest ABS publication *Apparent Consumption of Selected Foodstuffs* shows that in the most recent year, soft drink consumption actually increased (up 3.6million litres or 2.2 per cent).[64] Apparent consumption of energy drinks and electrolyte drinks (sports drinks) recorded the largest percentage increases in per-capita volumes over the most recent year, and recorded the fastest growth in sales over the six years to June 2024. Energy drink consumption rose by 64 per cent and electrolyte drinks by 60 per cent during the reporting period (2018–19 to 2023–2024). This growth undermines the shift of consumers towards drinking artificially sweetened beverages, which grew by 5.5 per cent compared with 1.5 per cent for sugar-sweetened varieties. Unfortunately, even the small health gains made from changing consumer preferences have now been lost.

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 2026–27 and by 25 per cent by 2029–30, while raising annual government revenue of $904 million in 2026–27, falling to $828 million in 2029–30. Over the four-year period (2026–27 to 2029–30), this would translate to government revenue of $3,463 million. More importantly, it would

reduce sugar intake from sugar-sweetened beverages by about 2.2 kilograms per person per year. The rate of tax per 100g of sugar is indexed at an assumed 2.5 per cent between 2026–27 and 2029–30.

Consumption of sugar-sweetened beverages is expected to drop the most when the tax is first introduced. One assumption in this modelling is that manufacturers will reformulate their products to reduce the impact of the tax and to align with an accelerated consumer preference for healthier beverages. These two factors are projected to result in lower tax revenue over time. The rate of reformulation is assumed to mirror the reduction in sugar per beverage (34 per cent) observed in the United Kingdom following introduction of a similar tax, but spread across a longer timeframe of five years, compared with three years in the United Kingdom.

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 using industry volume data from IBISWorld[65] industry projections, along with inflation data[66] and forecasts.[67] Inflation beyond the forecast period is assumed to average 2.5 per cent. It is also assumed there will be a gradual shift toward no- and low-sugar beverages, with these products gaining a one per cent increase in market share each year, in line with the aggregate industry trend.[68]

It is anticipated the government would use the existing Australian Taxation Office (ATO) policies and processes for excise and excise-equivalent goods to administer the new sugar-sweetened beverage tax. It is assumed there would be an initial cost to establish new internal processes — an indicative estimate of $2 million in set-up cost and $0.5 million per year thereafter for the ATO's ongoing compliance duties. The modest cost reflects the current excise programs and procedures already in place for other beverages (such as alcohol), which would need to be expanded rather than newly created.

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

	2026–27	2027–28	2028 –29	2029–30	Total
Sugar per person from sugar-sweetened beverages (kg/person)	6.3	6.0	5.6	5.3	
Excise rate per 100gram sugar ($)	$0.50	$0.51	$0.52	$0.53	
Sugar-sweetened beverages revenue ($m)	$904	$878	$853	$828	$3,463
Estimated cost of administration to the Australian Taxation Office ($m)	$2.00	$1.00	$1.00	$1.00	$5.00
Total revenue to government ($m)	**$902.0**	**$877.0**	**$852.0**	**$827.0**	**$3,458.0**

Pillar 5
A health system for the future

Chapter 5: A health system for the future (Workforce)

Problem statement

A strong, future-ready healthcare system depends on a sustainable, well-distributed workforce that can meet the evolving needs of all Australians. The availability of appropriately skilled healthcare professionals is a critical enabler of timely, high-quality care. However, the system is under increasing strain — not only due to persistent workforce maldistribution, particularly in rural, regional, and outer metropolitan areas[69] — but also because of rising rates of burnout and fatigue across the medical profession.[70]

Strengthening training pathways through to independent practice is essential as limited positions for new Fellows risk losing early-career doctors to other sectors and further reducing system capacity. At the same time, AI-driven change and evolving scopes of practice are increasing pressure on supervision, training, and workforce planning. Immediate resourcing is needed to address these emerging pressures.

At the same time, ensuring culturally safe care — particularly for Aboriginal and Torres Strait Islander peoples — requires sustained investment in cultural safety training, anti-racism initiatives, and the recruitment and retention of a diverse health workforce. Without these efforts, inequities in access and outcomes will persist.

For patients, these workforce challenges mean longer wait times, delayed diagnoses, and unmet health needs. For the system, they result in inefficiencies, increased pressure on emergency departments, and widening disparities in health outcomes.

Addressing these issues demand coordinated, long-term policy solutions that prioritise workforce planning, strengthen training pipelines, ensure cultural safety, and provide incentives to attract and retain healthcare professionals where they are most needed. This includes:

- **Establishing an independent health workforce planning agency** to provide robust, data-driven insights into current and future workforce needs, enabling more responsive and targeted policy interventions.
- **Expanding the Specialist Training Program (STP)** to increase specialist training places and improve access to care for patients. The STP should continue to focus on providing high-quality clinical experience for doctors in training, with priority given to funding training places that provide care for underserviced populations.
- **Making medical training a key focus of the next National Health Reform Agreement** by including commitments from each jurisdiction to provide adequate numbers of prevocational and specialist training places, based on the modelling and advice provided through the AMA's proposed independent health workforce planning agency.
- **Enhancing support for workplace-based assessments (WBAs) for international medical graduates (IMGs)** to streamline pathways into the workforce, reduce barriers to practice, and ensure IMGs are well-prepared to deliver safe, high-quality care across diverse settings.

Together, these investments form a cohesive strategy to strengthen the medical workforce, improve equity in access, and ensure the healthcare system is equipped to meet future demand.

Policy proposals

Investing in a future-focused independent health workforce planning agency

To ensure all Australians can access timely, high-quality care, the AMA is calling for funding to establish an independent national health workforce planning agency. Despite ongoing data collection, Australia lacks the modelling and strategic planning needed to align workforce supply with patient demand. Despite best efforts, the Department of Health, Disability and Aged Care has not been able to deliver the necessary outputs due to competing priorities.

An independent agency would fill this gap — using workforce data to forecast supply and demand, guide training and distribution, and inform evidence-based policy. This will ensure the right health professionals are in the right places, at the right time. With the National Medical Workforce Strategy 2021–2031 already in place, medical workforce planning should be the initial focus. This investment will build a proactive, responsive health system that puts patients first.

Risks and implementation

To ensure the success and sustainability of a new independent health workforce planning agency, a thorough analysis of the strengths and weaknesses of Health Workforce Australia (HWA) — abolished in 2014 — should be undertaken. This will help ensure valuable lessons from HWA's experience are applied to the design and operation of the new agency.

Functions identified as in-scope and out-of-scope during the 2022 consultation phase must be further refined in collaboration with key stakeholders. These functions should be clearly defined in the agency's establishing legislation to ensure transparent, accountable decision-making.

The agency must be empowered to access and utilise up to date employment data to independently advise government and inform policy and planning in a way that is verifiable, evidence-based, and focused on meeting patients' healthcare needs. The ultimate outcome will be ensuring the health workforce is equipped to deliver care where and when it is needed most.

The following key principles will underpin the agency:

- **Autonomy and independence**: Free from political influence, enabling evidence-based decisions that focus on patient and system needs.
- **Data-driven planning**: Supported by advanced analytics to forecast workforce supply and demand and guide strategic investment.
- **Stakeholder engagement**: Collaborating with jurisdictions, educators, and providers to ensure planning reflects real-world needs.
- **Sustainable funding**: Secured through upfront investment to establish robust infrastructure and capability.
- **Transparency and accountability**: Ensuring regular public reporting to build trust and verify decisions.
- **Jurisdictional collaboration**: Overcoming current fragmentation by fostering cooperation across states and territories, while maintaining independence.

Risks of not taking action

Australia, like many countries, face persistent health workforce shortages and an uneven distribution of healthcare professionals. These challenges directly impact patients, leading to longer wait times, reduced access to care in underserved areas, and variability in the quality of services. When healthcare professionals are concentrated in some regions but absent in others, patients in rural and remote communities often struggle to access timely care. This imbalance also creates inefficiencies in resource allocation and increased costs for both individuals and the health system.

Critically, the absence of an independent workforce planning agency limits Australia's ability to respond effectively during health crises — such as pandemics or natural disasters — when coordinated, data-driven

workforce deployment is essential. Establishing such an agency is a vital step toward building a health system that is equitable, resilient, and responsive to the needs of all Australians.

Timeframe and costing

To inform the establishment of a new independent national health workforce planning agency, the AMA has drawn on the final budget allocation for Health Workforce Australia (HWA) in 2012–13. While HWA included a significant grants program — totalling $773.6 million over four years — this component has been excluded from the AMA's cost estimate for the new agency.

The AMA estimates the cost of the agency at $191.5 million over the forward estimates, based on the operational funding allocated to HWA,[71] adjusted for wage growth using the Wage Price Index (WPI) at an average annual increase of 2.7 per cent from 2015–16 to 2026–27. An additional $5 million has been included to support establishment in the first year.

Importantly, this estimate reflects a more efficient operating environment. Since HWA's closure in 2014, technological advancements and improved data analytics have enhanced the capacity for streamlined data collection and analysis. The estimate also excludes potential offsetting savings from consolidating existing functions within the Department of Health, Disability and Aged Care, where initial staffing may be sourced.

Further savings are likely to be generated through better coordination across jurisdictions, which currently operate in silos. These efficiencies can be reinvested into innovative functions that improve workforce planning and ultimately enhance patient access to care.

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

	2026–27	2027–28	2028–29	2029–30	Total
Estimated cost of a health workforce planning agency ($m)	$44.5	$45.9	$47.3	$48.7	$186.5
Establishment cost ($m)	$5				
Total cost to government ($m)	**$49.5**	**$45.9**	**$47.3**	**$48.7**	**$191.5**

Expanding the Specialist Training Program (STP) for a sustainable specialist workforce

Australia's Specialist Training Program (STP) is a key national initiative designed to improve the quality of training by extending specialist medical training into non-traditional settings, including rural, regional, remote, and private practice environments. Available data shows doctors in training are increasingly unable to enter specialist training programs due to a shortage of training places. This initiative will support more doctors to access specialist training and help expand the availability of high-quality specialist medical care for the community.

The AMA proposes expanding the STP from 920 to 1,700 places over three years.[72] The program should continue to focus on providing high-quality clinical experience for doctors in training, with priority given to funding training places that deliver care for underserviced populations. Funding should also enable rurally based trainees to undertake rotations in metropolitan areas, giving them access to training opportunities that may not be available locally.

Risks and implementation

The STP has played a vital role in providing quality training places across diverse settings, broadening participants' experiences and expanding access to specialist medical training in non-traditional settings, including rural, regional, and community-based environments.

The AMA proposes a strategic redesign and expansion of the STP to ensure it delivers long-term value, flexibility, and workforce sustainability. The aim is to modernise the program so it better supports Australia's evolving health system and training needs. This reform would expand the number of funded

training places — particularly in rural, regional, and non-traditional settings — and introduce a Reverse STP model, enabling trainees based in these areas to rotate into metropolitan centres for short-term, high-skill training not available locally.

To support this, the AMA recommends strengthening governance and coordination between specialist colleges, health services, and training hubs; enhancing support for supervisors and infrastructure in expanded settings; and increasing flexibility in training pathways to reflect diverse clinical environments.

The AMA proposes a staged implementation strategy focused on flexibility, accountability, and strategic alignment:

- **Governance and transparency reform**: To ensure these additional places have an impact and are properly targeted, the AMA proposes the establishment of a new governance structure for the STP that encompasses key stakeholders, including the AMA, colleges, supervisors, doctors in training, jurisdictions, and other relevant bodies. This body will provide advice on allocation policies and decisions, monitor outcomes, and ensure alignment with national health priorities.
- **Data-driven workforce planning**: Integrate STP planning with national health workforce data, potentially in collaboration with the AMA's proposed independent health workforce planning agency, to identify priority areas for specialist training expansion. This includes mapping geographic and specialty gaps and forecasting future demand.
- **Reverse STP model**: Amend program guidelines to encourage and better support rurally based trainees to undertake short-term, high-skill rotations in metropolitan centres. This will be supported by a dedicated funding mechanism to cover travel, accommodation, and backfill costs.
- **College engagement and accreditation**: Ensure specialist colleges support curriculum mapping and accreditation for rotations from rural to metropolitan locations, enabling seamless integration into existing training pathways.
- **Outcome monitoring**: Introduce mechanisms to track training quality, workforce impact, and retention outcomes, ensuring the program delivers measurable value.

Risks of not taking action

Australia has dramatically expanded medical school places, and the federal government has committed to further increases. To ensure the full benefit of these increases is realised and community access to care is improved, sufficient specialist training places must be available. Evidence suggests this is not the case, with the number of available posts essentially flatlining and a growing number of doctors in training unable to progress to a specialist training program.

Without additional specialist training places, the community will not be able to access the care it needs in a timely way. This problem will be most acute in specialties facing workforce shortages, as well as in rural and remote Australia.

Timeframe and costings

Training places are assumed to ramp up over three years. A rural allowance loading is applied in line with the current program. Travel and placement costs for those undertaking a rotation of up to 12 weeks in a metropolitan area are assumed to be covered by the rural loading allocated to those rural placements.

Table 12: Cost of establishing and funding additional Specialist Training Program places

	2026–27	2027–28	2028–29	2029–30	Total
Number of additional places	260	520	780	780	
Cost of additional places ($m)	$39.6	$82.0	$127.3	$131.8	$380.7
Total cost to government ($m)	**$39.6**	**$82.0**	**$127.3**	**$131.8**	**$380.7**

All wage supplements and allowances are indexed at 3.5 per cent to maintain relativity with wages and ensure training and supervision costs are supported.

In addition to these costed places, it is anticipated that greater emphasis will be placed on planning and stakeholder engagement to deliver the training places where they are needed most. The AMA's proposed independent health workforce planning agency has a vital role to play in this process. Any costs associated with this additional governance and planning would fall within the proposed independent health workforce planning agency budgeted envelope.

Make medical training a key focus of the next National Health Reform Agreement

Medical workforce and training are a shared responsibility across all jurisdictions. Unless there is a shared understanding of the need to properly resource medical workforce and training — starting with medical school and continuing through to the completion of specialist training — we will be unable to meet the future needs of the Australian community.[73]

The former Council of Australian Governments recognised this in 2006, agreeing that the states and territories would provide high-quality clinical placements and intern training for federally funded medical students. The states and territories also committed to continuing significant investment in on-the-job and postgraduate training for these doctors.

The next NHRA must take a similar approach as part of a comprehensive strategy to address medical workforce shortages.

Informed by data and projections from the AMA's proposed independent health workforce planning agency, we are calling on all jurisdictions to commit to funding sufficient future prevocational and specialist training places to meet the number of medical graduates entering the workforce each year and to meet the long-term health needs of the community.

Risks of not taking action

A failure to invest in sufficient training places across all stages of the medical training pipeline will undermine the significant investment already made in expanding medical school places and will mean patients will not have the level of access to care they deserve.

A growing number of doctors will be working in unaccredited roles in public hospitals, with no clear career pathway and only limited access to career development. We need all jurisdictions to commit to increasing the number of training places they fund, including in specialty and geographic areas, so we build a medical workforce that is more accessible to patients and better meets community needs.

While the next NHRA should lock in long-term commitments to build and sustain Australia's medical workforce, immediate resourcing is required to address AI-driven change, evolving scopes of practice, and pressures on supervision and training. The NHRA can then provide sustained funding and accountability.

Timeframe and costings

This commitment should be incorporated into the next National Health Reform Agreement, with existing workforce modelling from the Department of Health, Disability and Ageing informing broad initial projections. These projections would then be updated once a new independent health workforce planning agency is in place. Once the updated projections are available, governments will be able to estimate any additional costs that might be involved, recognising that workforce needs will continue to evolve over time.

Supporting international medical graduates through nationally funded workplace-based assessments

IMGs are a vital and permanent part of Australia's medical workforce. They bring diverse experience and skills and play a critical role in delivering care to underserved communities, particularly in rural and remote areas. Despite their contributions, many IMGs face significant barriers to integration, including complex regulatory processes, limited access to supervised practice, racism, and insufficient support systems.

To improve access to medical professionals and support IMG integration, the AMA is calling for national investment in Workplace-Based Assessments (WBAs) as a flexible, practical and clinically relevant evaluation pathway. WBAs provide an alternative to traditional examination models by embedding assessment within supervised clinical practice, enabling real-time feedback, fostering professional development, and promoting safer patient care.

Risks and implementation

Currently, access to WBAs is limited and dependent on state-based funding, individual contributions, and local health network capacity, creating inequities in availability and uptake. While several health services have successfully implemented WBA programs, their reach remains constrained by inconsistent funding and infrastructure support.

Given IMG workforce challenges are a national issue, a nationally coordinated and funded approach is essential. This would ensure equitable access to WBAs across jurisdictions, reduce bottlenecks in the assessment process, and accelerate the safe integration of IMGs into the workforce — particularly in areas of greatest need.

Expanding access to WBAs delivers tangible benefits for both patients and the health system. By embedding structured, supervised assessment into real clinical settings, WBAs enhance patient safety and ensure IMGs are clinically prepared to deliver high-quality care from day one. This model supports faster workforce integration by reducing reliance on centralised, high-stakes examinations, enabling IMGs to contribute to patient care sooner — particularly in areas facing critical workforce shortages. Localised training and support also improve retention of IMGs in regional and rural communities, strengthening continuity of care. In addition, WBAs foster a more culturally competent and diverse medical workforce, while easing the financial burden on IMGs, who often face significant costs associated with traditional assessment pathways.

The expansion of WBAs represents a strategic investment in Australia's medical workforce. A nationally funded WBA program should include:

- **pilot programs** across diverse health settings and jurisdictions
- **national accreditation** through the Australian Medical Council (AMC) to ensure consistency and quality
- **investment in infrastructure, training, and supervision capacity** within local health networks
- **a robust evaluation framework** to monitor outcomes, quality, and workforce impact.

Risks of not taking action

Without investment to expand access to WBAs, IMGs face prolonged delays in workforce integration — delays that directly impact patients through longer wait times and reduced access to care, particularly in under-served areas. This not only hinders individual career progression but also contributes to stress, burnout, and attrition among IMGs, many of whom are navigating complex and unsupported pathways.

Critically, Australia risks underutilising a skilled and motivated workforce while undermining its reputation as a destination for international medical professionals — ultimately to the detriment of patients and communities in need.

Timeframe and costings

The AMA has costed a proposed rollout of an expanded WBA over a reasonable three-year timeframe. Initially, a modest expansion of existing sites is likely; however, it is anticipated more sites will come online once funding becomes available. These costs are based on figures from existing programs implemented at the state level, as well as current pass rates for the alternative AMC clinical exam.[74] The pass rate for those selected for WBA is expected to be lower than at present. Nevertheless, the AMA estimates future WBA candidates will still far exceed the current average pass rate of the AMC clinical exam.

There is also a reasonable approximation of the costs of supervision during the 12 months of the WBA program, based on past published estimates evaluating the program in the *Medical Journal of Australia.*[75] It is proposed the Australian government help fund this to incentivise states to provide more places.

Candidates are currently required to contribute a fee. The AMA is calling for the Australian government to cover at least one year's contribution of IMGs' fees towards WBA.

Separately, an estimate has been made of the ongoing supervision costs for doctors yet to pass their AMC clinical exam, as well as the number of additional months of supervised employment.

All costs for training, exam fees, and supervision have been indexed to hospital wage growth, approximated at 3.5 per cent.

Table 13: Cost of funding additional Workplace Based Assessment positions

	2026–27	2027–28	2028–29	2029–30	Total
Number of additional places	500	600	900	1,000	
Cost of additional WBA candidate fees ($m)	$7.0	$8.7	$13.5	$15.5	$44.8
Hospital WBA program supervision subsidy ($m)	$7.8	$9.6	$15.0	$17.2	$49.6
Hospital on-going supervision saving ($m)	$14.0	$17.4	$26.9	$31.0	$89.3
Total cost to government ($m)	**$14.8**	**$18.4**	**$28.5**	**$32.8**	**$94.4**

Note: Totals may not sum exactly due to rounding.

References

[1] Australian Commission on Safety and Quality in Health Care, 2025. *OECD Patient-Reported Indicator Surveys (PaRIS) Australian National Report 2025.* Retrieved 20 November 2025 from https://www.safetyandquality.gov.au/sites/default/files/2025-07/oecd-patient-reported-indicator-surveys-paris-australian-national-report-2025

[2] Australian Government Department of Health, Disability and Ageing, 2025. *Workforce Incentive Program (WIP) — Practice Stream.* Retrieved 20 November 2025 from https://www.health.gov.au/our-work/workforce-incentive-program/practice-stream

[3] Australian Institute of Health and Welfare, 2025. *Potentially preventable hospitalisations — Hospitals.* Retrieved 20 November 2025 from https://www.aihw.gov.au/hospitals/topics/admitted-patient-safety-and-quality/potentially-preventable-hospitalisations

[4] Australian Government. Australian Institute of Health and Welfare. (2025). *Hospitals at a glance.* Retrieved 16/9/2025 at: https://www.aihw.gov.au/hospitals/overview/hospitals-at-a-glance.

[5] Australian Institute of Health and Welfare (2025). Emergency department care 2023–24 data tables, Table 6.3: Proportion (%) of presentation to emergency departments with a length of stay of 4 hours or less, for all patients and patients subsequently admitted, states and territories, 2019-20 to 2023-24. Retrieved 16/9/2025 at https://www.aihw.gov.au/hospitals/topics/emergency-departments

[6] Australian Institute of Health and Welfare. (2024) Elective surgery waiting times 2023–24 data tables, Table 4.11: Selected statistics for admissions from public hospital elective surgery waiting lists, by clinical urgency category, New South Wales, 2023–24, to Table 4.17: Selected statistics for admissions from public hospital elective surgery waiting lists, by clinical urgency category, Australian Capital Territory, 2023–24, NT was unavailable at time of publication. Retrieved 16/9/2025.

[7] Australian Medical Association. (2024). *Measures needed to tackle rising threat of violence against doctors*. Retrieved 16/9/2025 at: https://www.ama.com.au/media/measures-needed-tackle-rising-threat-violence-against-doctors.

[8] Australian Medical Association. (2025). *Urgent support needed for doctors working in our public hospital system*. Retrieved 16/9/2025 at: https://www.ama.com.au/media/urgent-support-needed-doctors-working-our-public-hospital-system#:~:text=At%20present%2C%20these%20doctors%20often,the%20profession%20out%20of%20frustration.

[9] Australian Institute of Health and Welfare. (2025). *Hospitals. Data table: Table 4.5: Average available beds and beds per 1,000 population, public hospitals, 2018–19 to 2022–23.* Retrieved 16/9/2025 at: https://www.aihw.gov.au/hospitals/topics/hospital-resources.

[10] Australian Bureau of Statistics. (2025). *Australia's population by country of birth*. Retrieved 16/9/2025 at: https://www.abs.gov.au/statistics/people/population/australias-population-country-birth/jun-2024.

[11] Australian Institute of Health and Welfare. (2025). *Hospital Resources. Data table 4.5: Average available beds and beds per 1,000 population, public hospitals, 2018–19 to 2022–23.* Retrieved 16/9/2025 at: https://www.aihw.gov.au/hospitals/topics/hospital-resources.

[12] Australian Institute of Health and Welfare. (2025). *Hospitals at a glance.* Retrieved 16/9/2025 at: https://www.aihw.gov.au/hospitals/overview/hospitals-at-a-glance.

[13] Productivity Commission (2025). Report on Government Services 2025: Chapter 14, Aged care services. Table 14A.30. Retrieved 15/9/2025 at: https://www.pc.gov.au/ongoing/report-on-government-services/2025/community-services/aged-care-services.

[14] Productivity Commission (2025). Report on Government Services 2025: Chapter 14, Aged care services. Table 14A.30. Retrieved 15/9/2025 at: https://www.pc.gov.au/ongoing/report-on-government-services/2025/community-services/aged-care-services.

[15] Australian Medical Association. (2023). *Hospital exit block: a symptom of a sick system*. Retrieved 16/8/2025 at: https://www.ama.com.au/articles/hospital-exit-block-symptom-sick-system.

[16] Australian Medical Association. (2021). *Public Hospitals – Cycles of Crisis.* Retrieved 16/9/2025 at: https://www.ama.com.au/sites/default/files/2022-10/Public%20hospitals%20-%20cycle%20of%20crisis.pdf.

[17] Commission On Excellence and Health Innovation, Government of South Australia (2024) *Ambulance Ramping Review Report.* Retrieved 2/11/2025 from: https://www.sahealth.sa.gov.au/wps/wcm/connect/dc0fec30-eb95-4dc5-8747-995396f371f8/Ambulance+Ramping+Review+Report+January+2024.pdf?MOD=AJPERES

[18] Australian Institute of Health and Welfare (2025). Admitted patient care 2023–24. Retrieved 11/9/2025 from: https://www.aihw.gov.au/hospitals/topics/admitted-patient-care

[19] Australian Institute of Health and Welfare (2025). Admitted patient care 2023–24. Data cube 7: Cost and funding, Table 7.5 Separations by funding source, public and private hospitals, 2019–20 to 2023–24. Retrieved 11/9/2025 from: https://www.aihw.gov.au/hospitals/topics/admitted-patient-care

[20] Australian Medical Association. (2023). *Out-of-hospital models of care in the private health system*. Retrieved 16/9/2025 at: https://www.ama.com.au/articles/out-hospital-models-care-private-health-system.

[21] Australian Prudential Regulation Authority (2025). Annual Report 2024–2025, Cash flow statement, page 93. Retrieved 5/11/2024 from: https://www.apra.gov.au/sites/default/files/2025-10/APRA%20Annual%20Report%202024-25.pdf

[22] Australian Prudential Regulation Authority (2025). Annual Report 2024-2025, Table 1: Financial Institutions Supervisory Levies revenue by type, page 102. Retrieved 5/11/2024 from: https://www.apra.gov.au/sites/default/files/2025-10/APRA%20Annual%20Report%202024-25.pdf

[23] Australian Prudential Regulation Authority (2025). Annual Report 2024-2025, Table 1: Financial Institutions Supervisory Levies revenue by type. Retrieved 5/11/2024 from: https://www.apra.gov.au/sites/default/files/2025-10/APRA%20Annual%20Report%202024-25.pdf

[24] Australian Prudential Regulation Authority (2025). Annual Report 2024-2025, Table 1: Financial Institutions Supervisory Levies revenue by type, page 14. Retrieved 5/11/2024 from: https://www.apra.gov.au/sites/default/files/2025-10/APRA%20Annual%20Report%202024-25.pdf
[25] Australian Prudential Regulation Authority (2025). Annual Report 2024–2025, Table 1: Financial Institutions Supervisory Levies revenue by type, page 102. Retrieved 5/11/2024 from: https://www.apra.gov.au/sites/default/files/2025-10/APRA%20Annual%20Report%202024-25.pdf
[26] Australian Prudential Regulation Authority (2025). Quarterly private health insurance performance statistics, four quarters to June 2025. Retrieved 11/9/2025 from: https://www.apra.gov.au/quarterly-private-health-insurance-performance-statistics
[27] Australian Prudential Regulation Authority (2025). Quarterly private health insurance performance statistics, four quarters to June 2025. Retrieved 11/9/2025 from: https://www.apra.gov.au/quarterly-private-health-insurance-performance-statistics
[28] *The Guardian.* (2025). Mark Butler calls Australia's private hospitals and insurers to urgent meeting amid Healthscope financial crisis. Retrieved 18/11/2025 at: https://www.theguardian.com/australia-news/2025/mar/07/mark-butler-calls-australias-private-hospitals-and-insurers-to-urgent-meeting-amid-healthscope-financial-crisis#:~:text=The%20first%20meeting%20of%20CEOs,of%20the%20next%20federal%20election.
[29] Australian Tax Office (2025). Australian resident tax rates, 2020 to 2026. Retrieved 11/9/2025 from https://www.ato.gov.au/tax-rates-and-codes/tax-rates-australian-residents
[30] Australian Tax Office (2025). Medicare levy surcharge income thresholds and rates. Retrieved 11/9/2025 from https://www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/medicare-levy-surcharge/medicare-levy-surcharge-income-thresholds-and-rates
[31] Australian Institute of Health and Welfare. (2025). *Government spending on public health activities returns to pre-pandemic levels*. Retrieved 26/11/25 from: https://www.aihw.gov.au/news-media/media-releases/2025/november/government-spending-on-public-health-activities-returns-to-pre-pandemic-levels
[32] Parliament of Australia (2014). Australian National Preventative Health Agency (Abolition) Bill 2014. Retrieved 03/07/2024 from: https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r5203
[33] Stepanek, M., Hafner, M., Taylor, J., Grand-Clement, S., & van Stolk, C. (2017). The return on investment for preventative healthcare programmes. RAND Corporation. Retrieved 01/11/2024 from: https://www.rand.org/content/dam/rand/pubs/research_reports/RR1700/RR1787/RAND_RR1787.pdf
[34] Australian Institute of Health and Welfare. (2024). *Australian burden of disease study 2024: Summary*. Australian Government. https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024/contents/summary
[35] UNICEF. (2025). *Feeding profit: Data tables*. https://www.unicef.org/media/174086/file/CNR%202025%20-%20Feeding%20Profit%20-%20Data%20Tables-%20English%20-%20FINAL.pdf.pdf
[36] Te Morenga, L., Mallard, S., & Mann, J. (2013). Dietary sugars and body weight: systematic review and meta-analyses of randomised controlled trials and cohort studies. British Medical Journal 346, e7492. Doi: 10.1136/bmj.e7492
[37] Valenzuela MJ, Waterhouse B, Aggarwal VR, Bloor K, Doran T. (2021). Effect of sugar-sweetened beverages on oral health: a systematic review and meta-analysis. Eur J Public Health. 1;31(1):122-129. Doi:10.1093/eurpub/ckaa147
[38] Miller, C., Wakefield, M., Braunack-Mayer, A., Roder, D., O'Dea, K., Ettridge, K. & Dono, J. (2019). Who drinks sugar sweetened beverages and juice? An Australian population study of behaviour, awareness and attitudes. BMC Obesity 6(1). Doi: 10.1186/s40608-018-0224-2
[39] Australian Bureau of Statistics (2022). Apparent Consumption of Selected Foodstuffs, Australia. Retrieved 12/01/2023 from: https://www.abs.gov.au/statistics/health/health-conditions-andrisks/apparent-consumption-selected-foodstuffs-australia/latestrelease#added-and-free-sugars
[40] https://www.ama.com.au/sites/default/files/2025-03/ama-budget-submission-2025-2026-sugar-tax.pdf
[41] Parliament of Australia (2024). *The State of Diabetes Mellitus in Australia in 2024*. Retrieved 3/12/2024 from: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Inquiry_into_Diabetes/Report
[42] Parliament of Australia (2024). *The State of Diabetes Mellitus in Australia in 2024*. Retrieved 3/12/2024 from: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Inquiry_into_Diabetes/Report
[43] Grattan Institute (2024) *Sickly sweet: It's time for a sugary drinks tax*. Retrieved 4/12/2024 from: https://grattan.edu.au/report/sickly-sweet/
[44] World Health Organization (2016). *Fiscal policies for diet and prevention of noncommunicable diseases.* Technical Meeting Report. 5-6 May 2015, Geneva, Switzerland. WHO: Geneva. pp9, 24. Retrieved 21/10/2024 from: https://apps.who.int/iris/bitstream/handle/10665/250131/9789241511247-eng.pdf?sequence=1
[45] Rethink Sugary Drink (2023). *How much sugar is in…?'* Retrieved 08/11/2024 from: https://www.rethinksugarydrink.org.au/how-much-sugar
[46] Obesity Evidence Hub (2024). *Case for a tax on sugar-sweetened beverages (SSBs) in Australia*. Retrieved 4/12/2024 from https://www.obesityevidencehub.org.au/collections/prevention/the-case-for-a-tax-on-sweetened-sugary-drinks#:~:text=Over%2020%20key%20health%20and,such%20as%20obesity%20prevention%20progra
[47] Miller, C.L., Dono, J., Wakefield, M.A., Pettigrew, S., Coveney, J., Roder, D., … & Ettridge, K.A. (2019). Are Australians ready for warning labels, marketing bans and sugary drink taxes? Two cross-sectional surveys measuring support for policy responses to sugar-sweetened beverages. *BMJ Open 9*, e027962.
[48] Sainsbury, E., Hendy, C., Magnusson, R. & Colagiuri, S. (2018). Public support for government regulatory interventions for overweight and obesity in Australia. BMC Public Health 18, 513. Doi: 10.1186/s12889-0185455-0

[49] World Health Organisation (2023). *Global report on the use of sugar-sweetened beverage taxes, 2023.* Retrieved 2/9/2024 from: https://www.who.int/publications/i/item/9789240084995
[50] London School of Hygiene & Tropical Medicine (2024). Expert Comment – 'Sugar tax' on soft drinks shown to reduce sugar intake. Retrieved 3/8/2024 from: https://www.lshtm.ac.uk/newsevents/news/2024/expert-comment-sugar-tax-soft-drinks-shown-reducesugar-intake#:~:text=A%20levy%20on%20sugar%20in,an%20analysis%20of%20UK%20data..%20-%20sugar%20tax%20success%20story%201
[51] UCL NEWS (2024). Fall in daily sugar intake following introduction of UK sugar tax. Retrieved 3/8/2024 from https://www.ucl.ac.uk/news/2024/jul/fall-daily-sugar-intake-following-introduction-uk-sugar-tax
[52] Miller, C.L., Dono, J., Wakefield, M.A., Pettigrew, S., Coveney, J., Roder, D. & Ettridge, K.A. (2019). Are Australians ready for warning labels, marketing bans and sugary drink taxes? Two cross-sectional surveys measuring support for policy responses to sugar-sweetened beverages. BMJ Open 9, e027962.
[53] Sassano, M., Castagna, C., Villano, L., Quaranta, G., Pastorino, R., Ricciardi, W., Boccia, S. (2024). National taxation on sugar-sweetened beverages and its association with overweight, obesity, and diabetes. The American Journal of Clinical Nutrition, 119(4), 990-10006. Doi: 10.1016/j.ajcnut.2023.12.013
[54]Teng, A.M., Jones, A.C., Mizdrak, A., Signal, L., Genc, M. & Wilson, N. (2019). Impact of sugar-sweetened beverage taxes on purchases and dietary intake: Systematic review and meta-analysis. Obesity Reviews 20, 1187-1204. Doi: 10.1111/obr.12868;
[55]See full paper for explanation of how this was calculated: Australian Medical Association (2021). *A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue.* Retrieved 08/08/2024 from:https://www.ama.com.au/articles/tax-sugar-sweetened-beverages-what-modelling-shows
[56],Backholer, K. & Baker, P. (2018). Sugar-sweetened beverage taxes: The potential for cardiovascular health. Current Cardiovascular Risk Reports 12. Doi 10.1007/s12170-018-0593-6
[57] Sugar production estimates are from Australian Bureau of Agricultural and Resource Economics and Sciences (ABARES). Agricultural Commodity Statistics 2022— Rural Commodities — Sugar. Retrieved 25/11/2025 from: https://www.agriculture.gov.au/abares/research-topics/agricultural-outlook/september-2025https://www.agriculture.gov.au/abares/research-topics/agricultural-outlook/september-2025https://www.agriculture.gov.au/abares/research-topics/agricultural-outlook/september-2025
[58] See full paper for explanation of how this was calculated: Australian Medical Association (2021). A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue. Retrieved 08/08/2024 from:https://www.ama.com.au/articles/tax-sugar-sweetened-beverages-what-modelling-shows
[59] Bloomberg (2024). Markets Data Sugar, Generic 1st 'SB' Future. Retrieved 4/12/2024 from: https://www.bloomberg.com/quote/SB1:COM
[60] See full paper for explanation of how this was calculated: Australian Medical Association (2021). A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue. Retrieved 03/08/2024 from: https://www.ama.com.au/articles/tax-sugar-sweetened-beverages-what-modelling-shows
[61] Malik, V.S., Schulze, M.B. & Hu, F.B. (2006). Intake of sugar-sweetened beverages and weight gain: a systematic review. The American Journal of Clinical Nutrition 84(2), 274-288. Doi: 10.1093/ajcn/84.2.274; Vartanian, L.R., Schwartz, M.B. & Brownell, K.D. (2007). Effects of Soft Drink Consumption on Nutrition and Health: A Systematic Review and Meta-Analysis. American Journal of Public Health 97(4), 667-675. Doi: 10.2105/AJPH.2005.083782
[62] Chen, L., Appel, L.J., Loria, C., Lin, P., Champagne, C.M., Elmer, P.J., … & Caballero, B. (2009). Reduction in consumption of sugar-sweetened beverages is associated with weight loss: the PREMIER trial. The American Journal of Clinical Nutrition 89(5), 1299—1306. Doi: 10.3945/ajcn.2008.27240
[63] The calculation utilised Colagiuri et al's (2010) estimate of $714 for the annual direct healthcare costs in 2004-05 for an obese person over normal weight range, and PwC's (2015) estimate of 33% of the population by 2025 being in the obese weight range. The Australian Institute of Health and Welfare's Health Cost index was used to convert 2004-05 costs into 2025-26 dollars: Table 39a: Total health price index and industry-wide indexes, 2012–13 to 2022–23 (reference year 2022–23 = 100). Retrieved 02/02/2021 from: https://www.aihw.gov.au/reports/health-welfareexpenditure/health-expenditure-australia-2022-23/data . The calculation was: cost in year T = adults in Australian population at time T * share of the adult population at time T that is obese * direct cost per obese person at time T (indexed from 2004-05).
[64] Australian Bureau of Statistics. (2025). *Apparent consumption of selected foodstuffs, Australia*. Retrieved 26/11/25 from: https://www.abs.gov.au/statistics/health/food-and-nutrition/apparent-consumption-selected-foodstuffs-australia/latest-release
[65] This is a conservative assumption based on reported market trends in IBISWorld (2023). Soft Drink Manufacturing in Australia.
[66] Reserve Bank of Australia (2024). Statement on Monetary Policy: Economic Outlook November 2023. Retrieved 5/12/2024 from: https://www.rba.gov.au/publications/smp/2024/nov/outlook.html
[67] Australian Bureau of Statistics (2023). Consumer Price Index, Australia: Series A3604418F - Non-alcoholic beverages. September Quarter 2024. Retrieved 5/12/2024 from: https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-indexaustralia/latest-release
[68] This is a conservative assumption based on reported market trends in IBISWorld (2023). Soft Drink Manufacturing in Australia.
[69] Australian Institute of Health and Welfare. (2025). Health workforce. Retrieved 21/11/2025 at: https://www.aihw.gov.au/reports/workforce/health-workforce
[70] Australian Government Department of Health and Aged Care. (2021). National Medical Workforce Strategy 2021–2031. Retrieved 21/11/2025 at: https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf

[71] Australian Government Department of Health. (2014). Portfolio Budget Statements 2014–15. Budget related paper no. 1.10. Health portfolio. Retrieved 21/11/2025 at: https://www.health.gov.au/sites/default/files/health-portfolio-budget-statements-2014-15.pdf
[72] Australian Government Department of Health and Aged Care. (2024). Specialist Training Program (STP) Evaluation Report. Retrieved 21/11/2025 at: https://www.health.gov.au/resources/publications/specialist-training-program-stp-evaluation-report-2024?language=en
[73] Australian Government Department of Health and Aged Care. (2020). National Health Reform Agreement (NHRA). Retrieved 21/11/2025 at: https://www.health.gov.au/our-work/national-health-reform-agreement-nhra
[74] Nair, B., et al. (2014). Workplace-based assessment for international medical graduates: at what cost? Medical Journal of Australia, 200(1), 41-44. Retrieved 21/11/2025 at: https://www.mja.com.au/journal/2014/200/1/workplace-based-assessment-international-medical-graduates-what-cost
[75] https://www.mja.com.au/journal/2014/200/1/workplace-based-assessment-international-medical-graduates-what-cost#:~:text=Revenue%20collected%20by%20the%20WBA,10%C2%A0226%C2%A0per%20candidate