2026–2027 Pre-Budget Submission

Chapter 1: General practice

Pillar 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.[i] 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.[ii] 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.[iii] 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**

References:

[i] 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

[ii] 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

[iii] 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