AMA

VISION FOR AUSTRALIA'S HEALTH 2024–2027

Contents

Acknowledgements

The Australian Medical Association (AMA) acknowledges we work on the traditional lands of many Aboriginal and Torres Strait Islander clans, tribes, and nations. The AMA pays respect to Elders past, present, and emerging, and recognises the enduring connection Aboriginal and Torres Strait Islander peoples have to this country and their rich cultural heritage.

The AMA is committed to working in collaboration with Aboriginal and Torres Strait Islander communities and peoples to advocate for government investment and cohesive and coordinated strategies to improve health outcomes for Aboriginal and Torres Strait Islander peoples.

The AMA would also like to extend its sincere gratitude to the AMA members and stakeholders who dedicated their time, expertise, and insights to actively participate in the collaborative development of this document.

Foreword

Professor Steve Robson
Federal AMA President

Three years ago, the AMA embarked on a mission to reform Australia's health system through its first Vision for Australia's Health. This document served as a guide for the AMA to advocate for transformative changes across the health system and ignite a national conversation about the future of healthcare.

Three years on from the release of the AMA's first Vision for Australia's Health, we can reflect on the progress that has been made and the AMA's significant achievements across our health system. We have seen significant investment in general practice and public hospitals, continued efforts to break down the silos in the health system, and deeper collaboration across governments. Additionally, we have seen recognition that health extends beyond just the clinical setting into social determinants, environmental factors, and individual behaviours.

The work however is far from over. In the development of the AMA's Vision for Australia's Health 2024–2027, we sought input from across the medical profession to better understand the challenges they are facing every day. The biggest challenges voiced by the profession were those that are impeding timely and equitable access to care — long waiting lists for appointments, workforce shortages, public hospitals that are over capacity, the increasing costs of healthcare, and inadequate supply of services in many areas of Australia. Concerns regarding the increasing complexity of patient presentations were also raised, with chronic disease now entrenched as the predominant health challenge in our nation, affecting nearly half of all Australians and claiming the status of leading cause of illness, disability, and death. As a result, many doctors are experiencing burnout due to high clinical workloads and non-clinical stresses — administrative burden, poor professional development, the impact of inadequate Medicare rebates and increasing cost of delivering care on practice viability, and the challenges navigating the labyrinth of regulatory and compliance requirements.

The AMA's Vision for Australia's Health 2024–2027 — which draws on the breadth of our members' expertise — offers a blueprint to transform our health system into one that values prevention as much as treatment, and views healthcare as an investment to be made, as opposed to a cost to be managed. This transformation will require the collective effort of policymakers, healthcare professionals, community leaders, and patients to advocate for a better health system — a health system that is responsive, efficient, and centred on the needs of those it serves.

The road to a healthier Australia however will need to be paved with more than just plans — it will require purposeful action. The AMA stands ready to act and is uniquely positioned to leverage the expertise of our broad member base in shaping policy and driving change.

Professor Steve Robson
Federal AMA President

Context

Studies show that when individuals are asked to reflect on what matters most in life, their personal health and the health of their loved ones consistently emerges as one of the top priorities. The absence of good health not only diminishes an individual's quality of life, but also impairs their capacity to partake in social activities and interactions and contribute to the workforce. Additionally, the repercussions of poor health extend beyond the individual level, impacting our friends, families, communities, as well as the health system and broader economy.

The COVID-19 pandemic had an unprecedented and profound impact on health in Australia. It put health at the forefront of decision making, and showed us that without good health, we cannot function as individuals or as a society. It also caused a dramatic and permanent shift in how, when, and where healthcare is delivered, and how remarkable things can be achieved when governments, healthcare professionals, and communities work together.

Importantly, the pandemic exposed significant shortcomings in our system that were present well before the pandemic. Australia is now facing major health workforce shortages, increased demand, increased costs of providing high-quality healthcare, the aftermath of COVID-19, including delayed care and long COVID, and rising costs of providing healthcare. The AMA's Vision for Australia's Health 2024–2027 represents a blueprint for addressing these challenges and building a sustainable healthcare system.

Australia is facing an increasing burden of disease

In 2023, Australians lost 5.6 million years of healthy life due to living with illness or injury and dying prematurely.[1] In 2023, Australians were estimated to live about 11.5 years (females) and 9.7 years (males) in poor health. This is about 13.5 per cent (females) and 11.9 per cent (males) of their lives, with the number of years lived in ill health increasing over time for both males and females (Figure 1 and Figure 2). The five disease groups that caused the most burden of disease in 2023 were cancer, mental health conditions and substance use disorders, musculoskeletal conditions, cardiovascular diseases and neurological conditions — chronic and long-lasting conditions that together account for about two-thirds (64 per cent) of the total disease burden. Almost half of all Australians now live with at least one chronic disease, and one in five live with two or more chronic conditions.[2]

The latest Australian Bureau of Statistics National Health Survey demonstrates that for most conditions the burden of disease has been increasing over time and will likely continue to grow if not addressed (Figure 3).

Figure 1: Australian female life expectancy and health, 2003 to 2023[3]

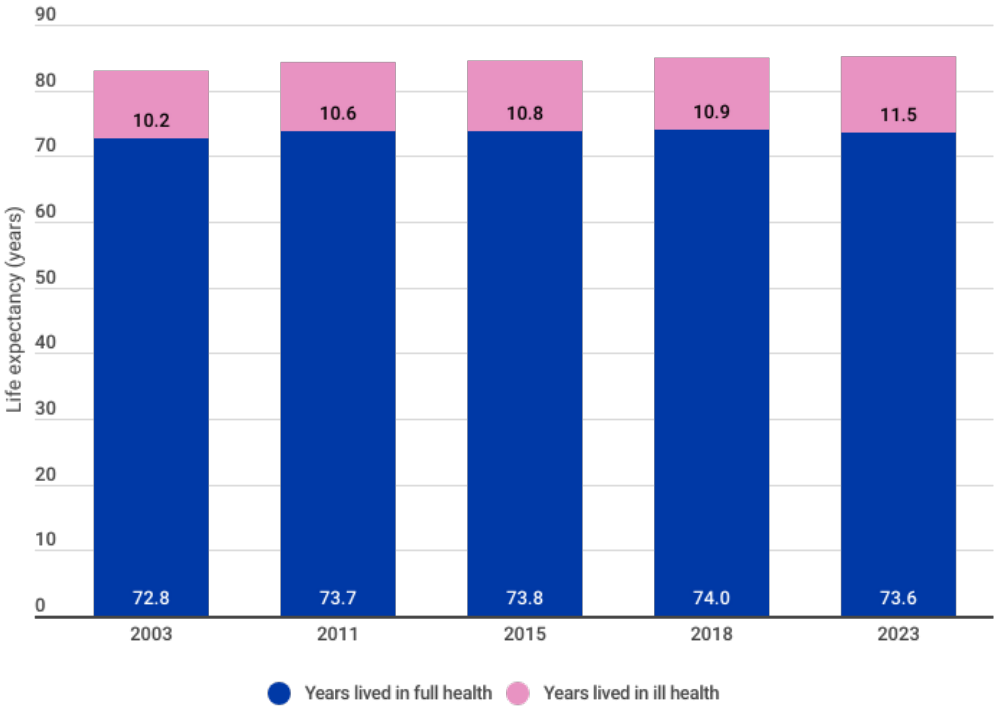


Figure 2: Australian male life expectancy and health, 2003 to 2023[4]

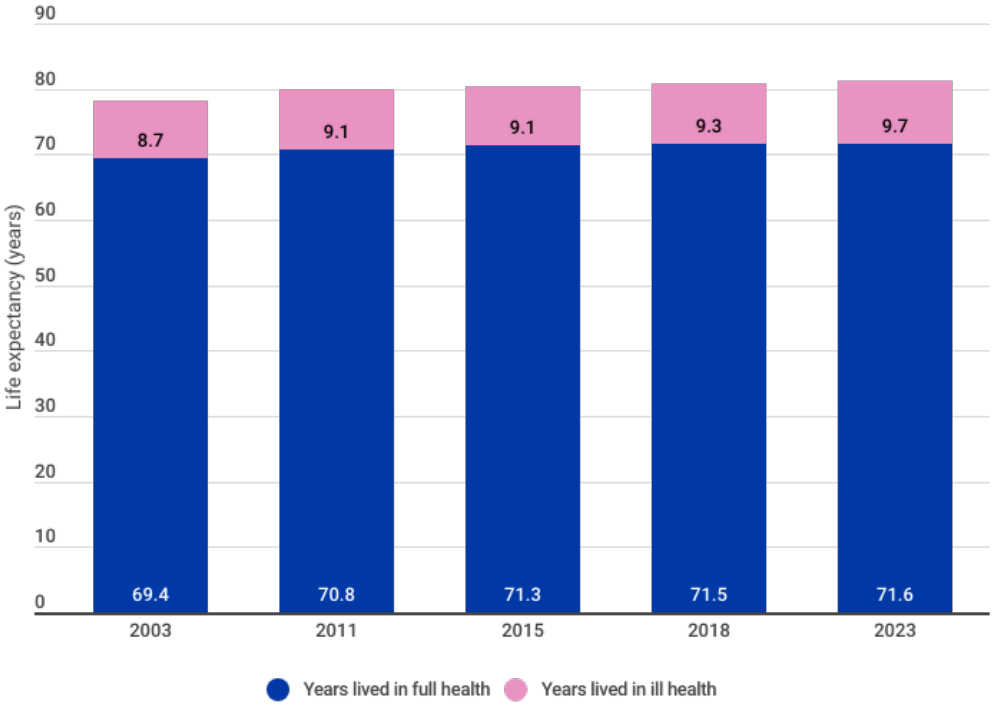
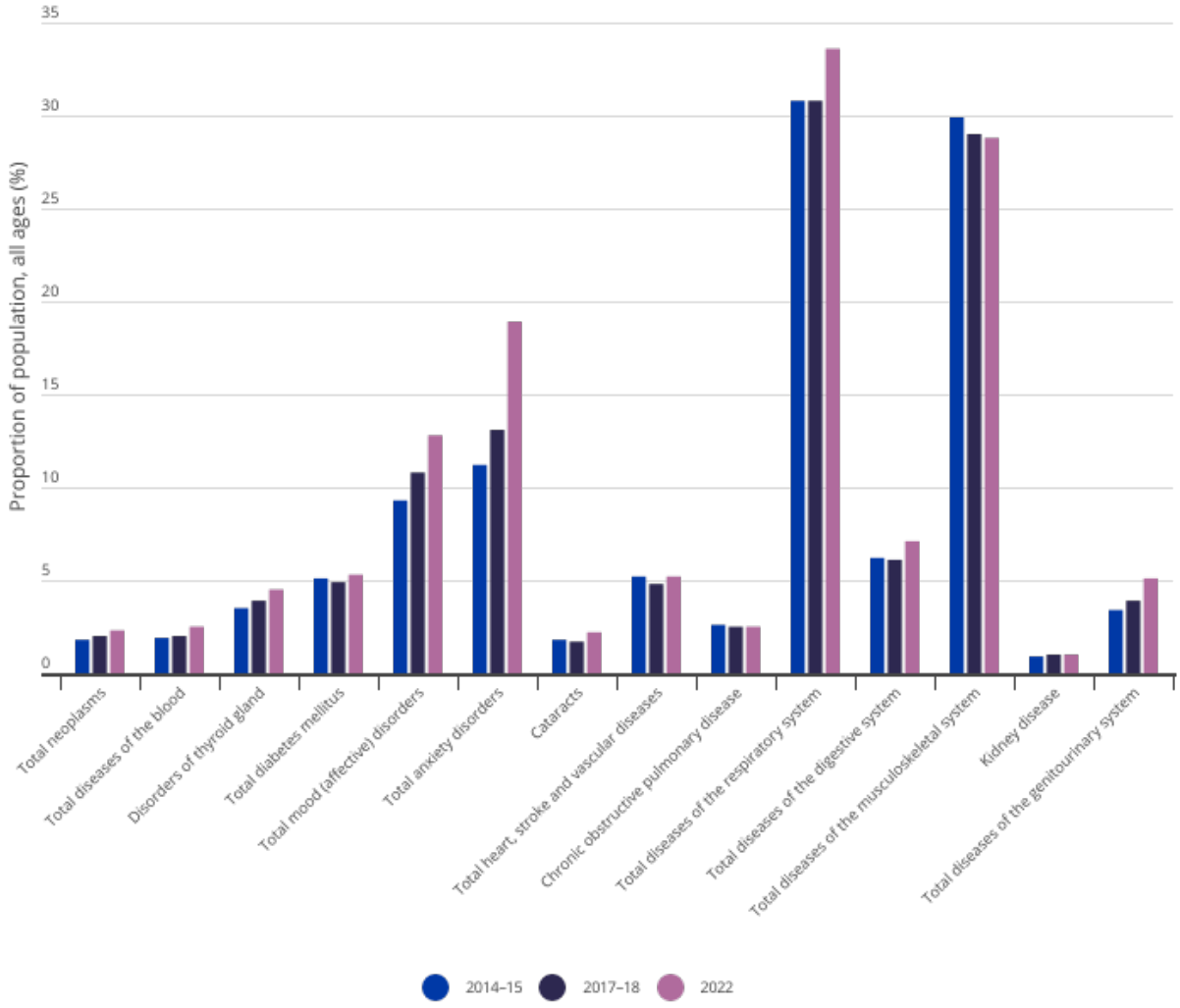


Figure 3: Proportion of the total Australian population living with disease by disease group, 2014–15, 2017–18, 2022[5]



This burden of disease is experienced unevenly in Australia, with many groups experiencing health inequities and challenges that result in a disproportionately higher burden of disease. It is important to recognise individuals may belong to many of these groups simultaneously, and this intersectionality compounds the challenges they face, underscoring the need for tailored, multifaceted approaches to address health inequities. These groups include:

Older Australians

It is well known that the Australian population is ageing and the burden of disease for many conditions increases with age. For example, Figure 4 demonstrates the 45–54-year-old cohort has a below average rate of people living with neoplasms. In the next age cohort, 55–64, the share is about double the average, and the subsequent age cohort (65–74) is about three times the average. As the Australian population continues to age over the next two decades and this burden of disease continues to grow, the impact on healthcare costs, as well as broader economic output, will be substantial. Governments will therefore need to look at ways to reduce this disease burden in older cohorts, and where this is unachievable, offer treatment options which maximise quality of life. There are many conditions however that disproportionately impact younger Australians, for example mood disorders, which are more likely to impact younger Australians (Figure 5).

Figure 4: Proportion of the Australian population with neoplasms by age group, 2014–15, 2017–18, 2022[6]

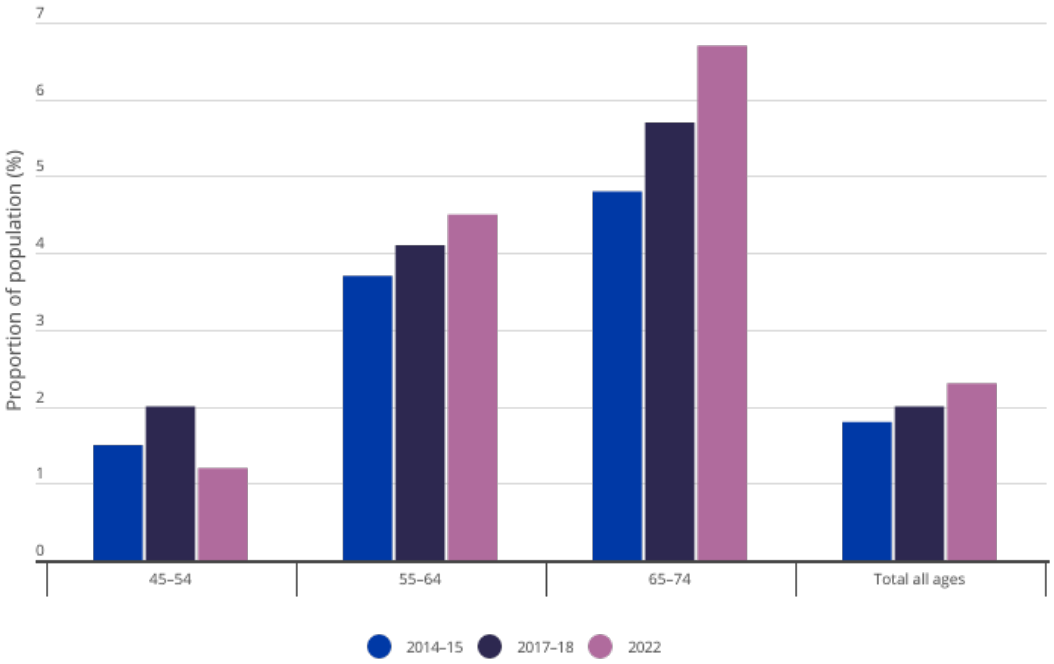
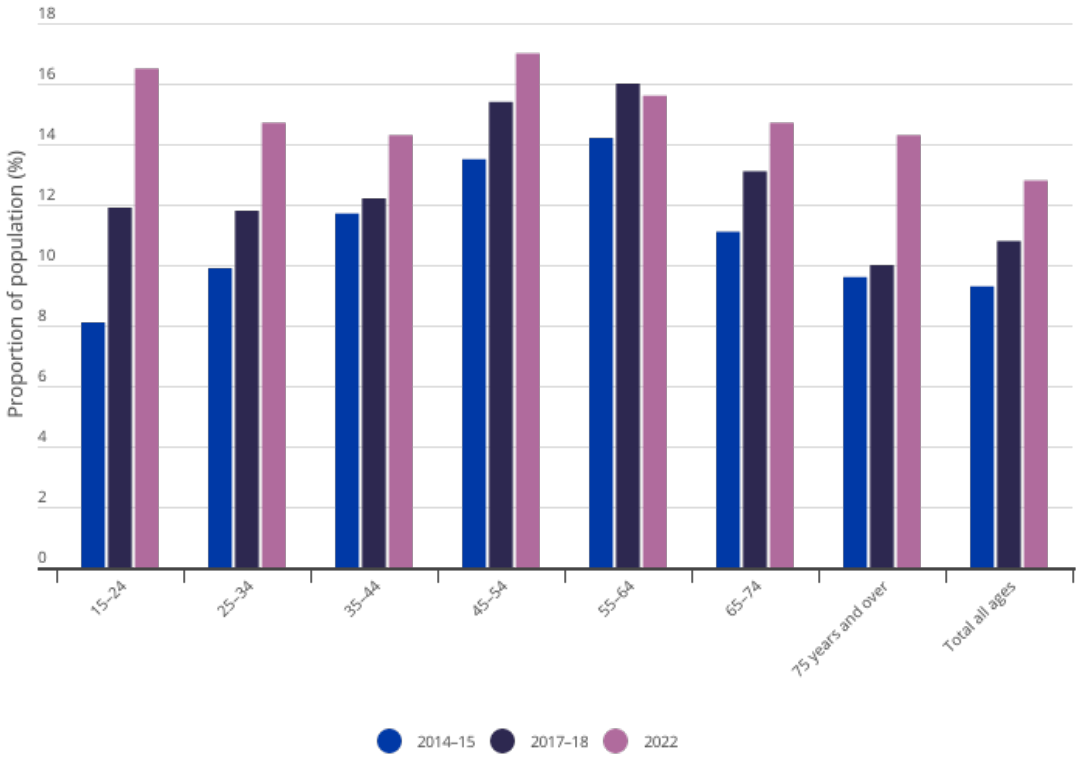


Figure 5: Proportion of the Australian population with mood (affective) disorders by age group, 2014–15, 2017–18, 2022[7]



Lower socioeconomic groups

One of the most well-documented health disparities exists among lower socioeconomic groups. Australians in lower socioeconomic groups have less access to healthcare facilities and preventive healthcare services as well as determinants of health, such as education, healthy foods, and safe housing. As a result, these groups are at greater risk of poor health, have higher rates of illness, disability, and death, and have lower life expectancies compared to people in higher socioeconomic groups.[8]

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples have a right to access appropriate, affordable, and culturally safe healthcare wherever they are in Australia, and in whichever setting they choose. Providing culturally safe healthcare requires truth telling, redressing the historical impacts of colonisation — which continue to persist — and eliminating the institutionalised racism that currently exists in the Australian health system.[9] This will be achieved by ensuring self-determination for decisions that impact Aboriginal and Torres Strait Islander peoples and their health, and supporting and growing the Aboriginal and Torres Strait Islander health workforce.

Aboriginal and Torres Strait Islander peoples experience some of the most pronounced health disparities, with the rate of disease burden more than double (2.3 times) that of non-Indigenous Australians and a gap in life expectancy of 8.1 years (females) and 8.8 years (males).[10] The key contributors to disease burden include mental and substance use disorders, injuries, cardiovascular disease, cancer, and musculoskeletal conditions. It is estimated 35 per cent of this health gap can be explained by social determinants (e.g. employment, income, education, housing) and 30 per cent can be explained by selected health risk factors (e.g. smoking, poor diet).[11] The rest of the gap is likely due to more complex factors, such as access to affordable and culturally safe healthcare, connection to Country and language, and the impact of colonialism, racism, and discrimination.[12]

Culturally and linguistically diverse groups

Australia is one of the most culturally and linguistically diverse countries in the world, with three in 10 people living in Australia born overseas.[13] Research demonstrates many people from culturally and linguistically diverse (CALD) backgrounds face greater challenges navigating Australia's healthcare system, including language barriers, lower health literacy, cultural differences, socioeconomic disadvantage, and discrimination.[14] The diversity in cultures, languages, religions, social values, and migration trajectories makes it difficult to measure the impact of these challenges on the burden of disease, however the evidence suggests CALD populations have a higher burden of chronic conditions.[15]

LGBTQIASB+ community

Members of the LGBTQIASB+ community experience unique health challenges related to their sexual orientation and gender identity.[16] Discrimination, stigma, and lack of understanding from healthcare providers can create barriers to accessing adequate healthcare. LGBTQIASB+ individuals have higher rates of mental health issues, substance abuse, and some sexually transmitted infections.[17] Additionally, transgender individuals may face challenges accessing gender-affirming healthcare.[18]

Australians living in rural and remote locations

Australians living in rural and remote areas of Australia face distinct health challenges due to geographical isolation and limited access to healthcare services.[19] The scarcity of healthcare facilities and specialists can lead to delays in diagnosis and treatment. Additionally, travelling long distances to receive care can be costly and time-consuming, impacting individuals' ability to seek timely medical attention.[20] Rural populations also have higher rates of injury, suicide, and chronic diseases compared to urban areas.[21]

Males and females

Gender has a significant impact on health experiences and outcomes. Males generally bear a higher total burden of disease due to premature death, while women face a greater risk of ill health because they tend to survive longer and are more susceptible to chronic health conditions and poor mental health.[22] In particular, males experience more than three times the amount of disease burden due to suicide and self-inflicted injuries compared to females. They also experience an increased burden from coronary heart disease and lung cancer, whereas females experience more disease burden from dementia and osteoarthritis.[23] Women also have several specific sexual and reproductive health needs that evolve throughout their lives.[24] They are also more likely to experience family and intimate partner violence, which directly impacts their health outcomes.[25] There is a growing body of evidence indicating systemic issues in healthcare delivery and medical research contribute to poorer health outcomes for women, with disproportionate delays in diagnosis, overprescribing, and inadequate investigation of symptoms.[26]

Children and young people

Every child in Australia has the right to a healthy start to life, a safe and secure home environment, and equal access to opportunities to help them learn, develop, and thrive. The mental wellbeing of children is imperative to their mental health into adulthood, with children's mental health currently impacted by a range of social, economic, political, and cultural

factors.[27] This includes concerns about climate, as children are going to face the full consequences of environmental change, which will have an impact on their health.[28] To ensure a safe future and liveable environment for next generations, rapid transformation of energy systems and the economy to reduce the dependence on fossil fuels is needed, with further sustainability in the health system also needing consideration.[29] Young people are highly susceptible to the marketing of harmful products, with specific protections needed against the predatory tactics used by the tobacco, gambling, and other harmful product industries.[30]

Factors contributing to Australia's high burden of disease

Constrained capacity of Australia's health system

Australia is facing **significant capacity constraints**, with major health workforce shortages, increased demand, rising costs of delivering healthcare, and the aftermath of COVID-19

Australia is projected to be **short 10,600 GPs** over the next decade if strategies are not implemented to attract and retain general practitioners

Australia is facing significant capacity constraints, with major health workforce shortages, increased demand, rising costs of delivering healthcare, and the aftermath of COVID-19, including delayed care and long COVID, and rising costs of providing healthcare. While these capacity constraints have existed for several years, the COVID-19 pandemic shock highlighted these constraints when Australia's health system was required to respond to a surge in demand. Despite having one of the most well-resourced healthcare systems globally, Australia was not adequately prepared for the scale and complexity of the COVID-19 pandemic. In particular, public hospitals were struggling to meet demand before the pandemic largely due to workforce and hospital bed shortages.[31] The increased demand created by the COVID-19 pandemic led to delays in elective surgery and outpatient appointments as public hospitals were not equipped with consumables, medical equipment, and appropriate personal protective equipment and protocols, and had limited capacity to scale up and meet increased demand created by the pandemic.

As access to hospitals and other healthcare settings was limited during the pandemic, much of the demand fell onto general practices. General practices had to adapt rapidly to the change in circumstances with many practices transitioning to telehealth appointments, implementing unfamiliar infection control measures, and preparing to deliver thousands of COVID-19 vaccines. Pre-existing shortages of general practitioners meant that general practices faced several challenges meeting the increased demand, with many practices needing to increase their opening hours. Adding more hours per general practitioner, however, was not sustainable, particularly as underinvestment in general practice by successive governments has put a significant strain on practices.

Three years on from the onset of the pandemic, many general practices are struggling to remain viable, the costs of delivering high-quality healthcare are increasing, public hospitals are operating at or over capacity, the nation is facing unprecedented workforce shortages, and there is a major backlog in elective care. The COVID-19 pandemic is still impacting communities, and we are only beginning to understand the implications of long COVID. As much of Australia's pandemic response relied on the goodwill of healthcare workers — a group that has gone beyond normal expectations to keep Australia safe — we are now seeing a surge in healthcare worker burnout. We are also seeing increasing health workforce maldistribution and shortages, with AMA analysis projecting a shortage of 10,600 GP full-time equivalents (FTE) by 2031–32 if strategies are not implemented to attract and retain GPs.[32] Additionally, while significant strides were made with respect to telehealth, telemedicine, and virtual care, many of these learnings have not been consolidated for widespread implementation, and many parts of the health system are struggling to become interoperable.

If another pandemic or similar event was to occur in the next few years, Australia would likely be in a worse position than before the COVID-19 pandemic as there is even less capacity in the system now. Despite this risk, Australia is not prioritising investment in expanding capacity to prepare for future events that could increase demand for healthcare services. Additionally, the loss of Health Workforce Australia — a Commonwealth statutory authority that delivered a national, coordinated approach to health workforce planning and reform — in 2014[33] left a significant hole in Australia's workforce planning capability and has likely contributed to the current workforce shortages and capacity constraints.

Declining access to healthcare

One in three patients will wait longer than the clinically recommended 30 minutes to receive urgent care in the emergency department

One in three patients will wait longer than the clinically recommended 90 days for category two elective surgery

The Medicare Benefits Schedule no longer bears any relationship to the **actual cost** of providing services to patients

Access to timely and affordable healthcare is fundamental in preventing, treating, and managing health conditions. Access to healthcare services has been an issue in Australia for many years and can be attributed to a complex interplay of geographical, cultural, social, and demand/supply barriers. This issue was only exacerbated by the COVID-19 pandemic, with delays in appointments and procedures creating a significant backlog of care.

We are now at a point where more than one in three patients will wait longer than the clinically recommended 30 minutes to receive urgent care in the emergency department.[34] One in three patients will also wait longer than the clinically recommended 90 days for Category 2 elective surgery[35] — procedures like heart-valve replacements or coronary artery bypass surgery.[36] Waiting times for specialist outpatient appointments are sometimes more than triple the recommended time,[37] and it has been reported that wait times for an appointment with a general practitioner have increased over the past few years.[38] It has also been reported that patients are waiting longer for essential diagnostic tests, such as medical imaging.[39,40,41,42,43,44, 45,46]

Access to general practice remains a key issue, with shortages of GPs as well as the increasing cost of delivering high-quality care resulting in many general practices struggling to remain viable.[47] Additionally, the rising cost of living renders healthcare less affordable for many Australians, and the Medicare Benefits Schedule (MBS) no longer bears any relationship to the actual cost of providing services to patients.[48]

These access issues create missed opportunities for prevention and early intervention, resulting in patients presenting with more advanced disease and comorbidities that are a direct result of delayed care — which in some cases requires emergency care — ultimately making it more challenging and more costly to deliver care.

Complex funding arrangements

Australia spent **$241.3 billion** on health in 2021–22, approximately $9,365 per person and 10.5% of GDP

Australia has a high number of **years spent in ill-health** compared to other OECD countries and is lagging when it comes to factors such as prevention of chronic disease and access to care

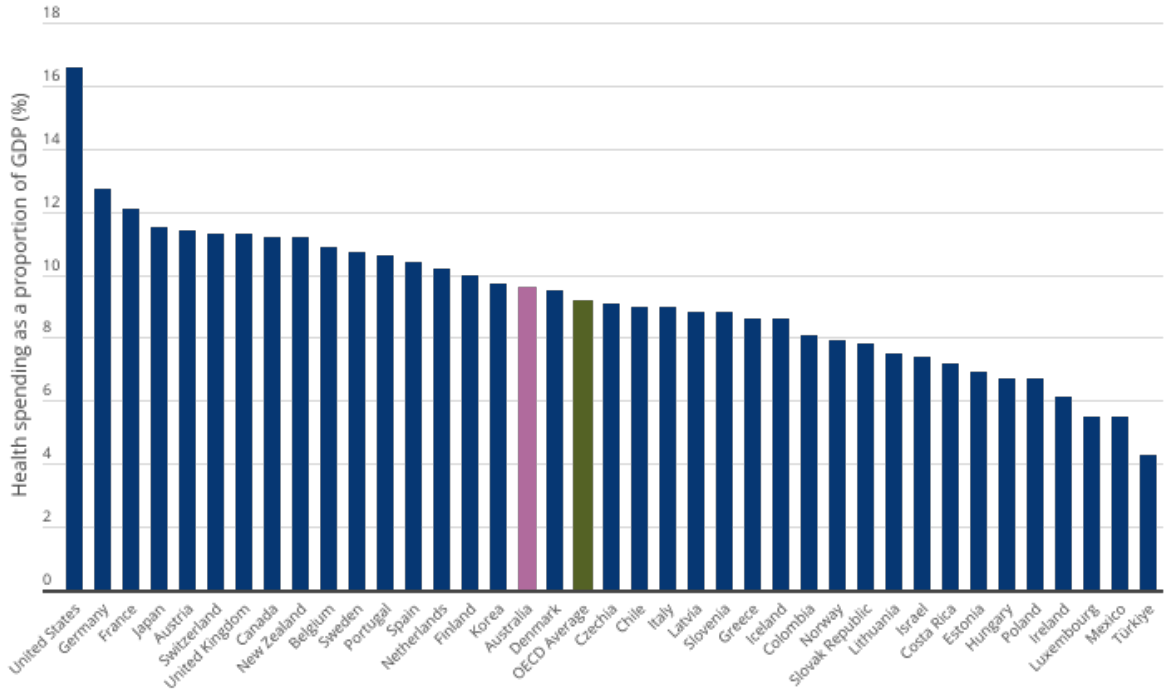
Australia's health system governance and funding arrangements tend to be **complex**, at times **inflexible**, often **fragmented**, and typically focused on activity rather than outcomes

Australia spent $241.3 billion on health in 2021–22, equating to about $9,365 per person and 10.5 per cent of Gross Domestic Product (GDP).[49] About $176.0 billion of this was directly funded by government, with the remaining $65.3 billion funded by non-government entities, individuals, private health insurers, and injury compensation insurers.[50] While annual expenditure on healthcare has been increasing year on year — largely due to a growing and ageing population that is developing more complex and chronic disease — healthcare funding as a portion of the federal budget has remained between 15 per cent and 17 per cent for the past 30 years.[51,52,53]

Compared with other Organisation for Economic Co-operation and Development (OECD) countries,[i] Australia's health system appears to be cost effective, with lower healthcare spending compared with many other OECD countries — including key peer countries Canada, France, and the United Kingdom — for comparable or better life expectancy (Figure 6).[54,55] Australia's average life expectancy of 83.2 years is the third highest in the OECD,[56] with life expectancy at birth in Australia steadily increasing over the past three decades to now be one of the highest in the world.[57] This high life expectancy is partially attributable to the high-quality healthcare in Australia, with Australia's healthcare system ranked third in the Commonwealth Fund's comparison of 11 high-income country healthcare systems.[58]

[i] As a member of the OECD, Australia is assessed against the international standards for healthcare quality and performance and compared against other OECD countries.

Figure 6: OECD healthcare expenditure as a proportion of GDP, 2022[59]



Average life expectancy is only one measure of health outcomes and is often considered to be a superficial measure as it does not capture factors such as quality of life, disease burden, disability, wellbeing, and health inequalities. While Australia has a high life expectancy, it also has a high number of years spent in ill-health compared to other OECD countries,[60] and is lagging compared to other countries when it comes to factors such as prevention of chronic disease and access to care. Additionally, compared with other OECD countries, Australia's healthcare system is often considered complicated for patients to navigate, which creates barriers to coordinated, high-quality, and efficient healthcare.[61]

Successive reviews have found that the current governance and funding arrangements tend to be complex, at times inflexible, often fragmented, and typically focused on activity rather than outcomes.[62,63,64,65] In particular, the lack of connection between the different levels of government commonly results in duplication of effort and gaps in service delivery and funding, which adds to the complexity of, and inefficiency in, the health system.[66,67,68,69] It also results in disagreements and cost-shifting between the different levels of government and the private sector. Previous reviews have recommended refining agencies and their structures to improve transparency and accountability, reduce inefficiencies, improve coordination, and address gaps in service delivery.[70]

Australia has a "sickcare" health system

38 per cent of Australia's disease burden (**49 per cent** for Aboriginal and Torres Strait Islander peoples) could be prevented through a reduction in modifiable risk factors

Spending on prevention remains low by OECD standards — **less than two per cent** of annual health expenditure in the pre-pandemic years since 2011–12

While some chronic diseases are difficult to prevent, such as those with an underlying genetic basis, it is estimated that 38 per cent of disease burden, (49 per cent for Aboriginal and Torres Strait Islander peoples), could be prevented by reducing modifiable risk factors, such as obesity and being overweight, physical inactivity, poor

nutrition, smoking and vaping, and alcohol, tobacco and other drug use.[71] Since the *Intergenerational Report 2002* — one of the first government reports to examine the whole-of-government fiscal impact of the burden of ageing and disease — there has been an increasing focus on addressing the burden of disease in a few key areas. For example, the burden associated with heart, stroke, and vascular diseases has improved for the 65–74-year-old cohort, and has stabilised for the

55–64-year-old cohort (Figure 7), likely a result of investments in preventive health measures and public awareness campaigns to address obesity and reduce smoking, as well as early intervention for conditions such as high blood pressure and high cholesterol. Similarly, the proportion of the population with chronic obstructive pulmonary disease (COPD), of which smoking is one of the leading causes, has declined among the 45–54-year-old cohort (Figure 8). This cohort would have been teenagers and young adults when the anti-smoking measures began in Australia, such as the Tobacco Advertising Prohibition Act 1992.

Figure 7: Proportion of the Australian population with heart, stroke, and vascular disease by age group, 2014–15, 2017–18, 2022[72]

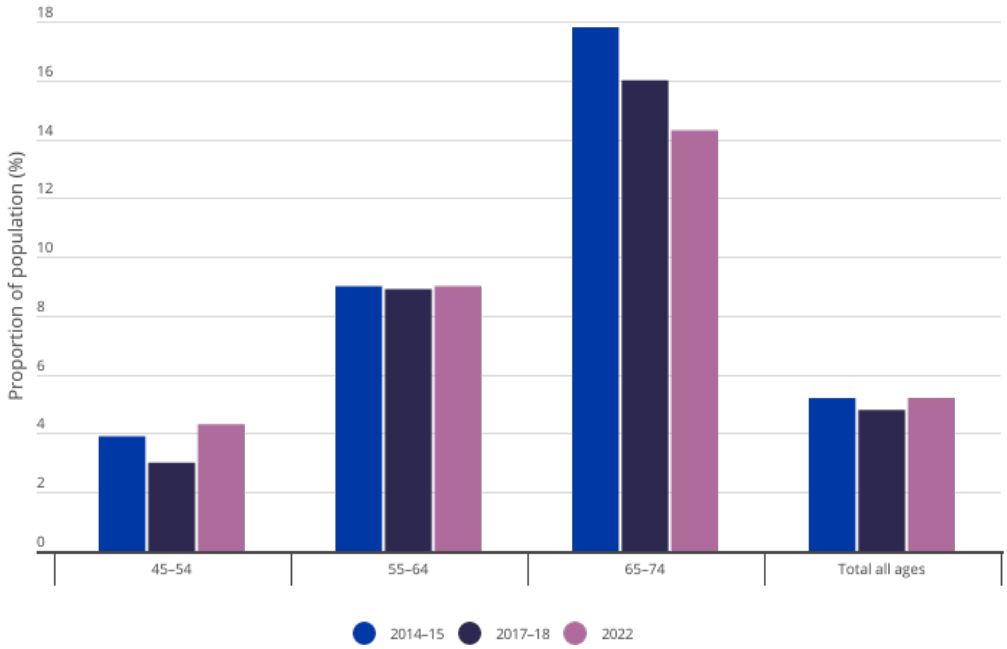
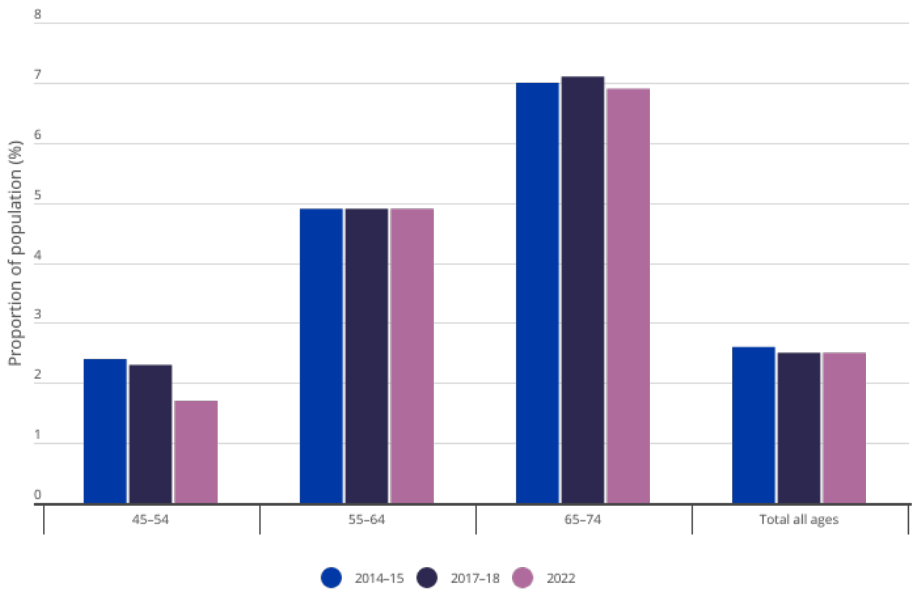


Figure 8: Proportion of the Australian population with chronic obstructive pulmonary disease by age group, 2014–15, 2017–18, 2022[73]



Despite these improvements, Australia still has the seventh highest prevalence of obesity in the OECD.[74] Additionally, rates of smoking and risky alcohol consumption remain high,[75] and vaping has more recently emerged as a significant risk factor for chronic disease,[76] particularly among younger populations.[77,78] Additionally, there are areas that require more attention, particularly mental health. It is clear that while governments recognise the pervasive impact of poor health, healthcare in Australia is still viewed as a cost rather than a strategic investment, which perpetuates a system that predominantly responds to poor health outcomes rather than actively preventing them. This is a significant contributor to Australia's high burden of disease. This perspective is evident when we examine spending on preventive health, which remains low by OECD standards — less than two per cent of annual health expenditure in the pre-pandemic years since 2011–12, and about 1.5 per cent in 2018–19 and 2019–20.[79,ii] There are several interrelated reasons for this lack of investment, including:

- investment in prevention often does not show immediate return
- short-term political cycles incentivise initiatives that will deliver demonstrable short-term rewards, often with a focus on infrastructure, rather than less physical strategies focussed on long-term benefits
- there are challenges in collating the evidence to determine what preventive measures have the greatest efficacy
- there are many 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 Preventative Health Agency — an independent agency focused on providing evidence-based advice to the federal government and state and territory governments on preventive health and the effectiveness of interventions — in 2014[80]
- healthcare needs and outcomes are not uniform across the Australian population
- preventive health programs often consist of a variety of different initiatives, leading to challenges in identifying those which are most successful, and therefore should be continued and expanded.[81]

This prevailing paradigm has inadvertently shaped a "sickcare" system rather than a holistic healthcare system that tackles both existing health issues and prioritises prevention. With a population that is growing, ageing, and developing more complex and chronic disease, Australia should be looking at how healthcare expenditure can be maximised to improve health outcomes.

[ii] Spending on preventive health increased in 2020–21 and 2021–22, however this was likely due to the COVID-19 pandemic.

Insights from the medical profession

To support the development of AMA's Vision for Australia's Health 2024–2027, the AMA sought the perspectives of its members and other stakeholders to ensure the document would foster effective decision-making and policy formulation. The AMA would like to extend its sincere gratitude to the members and stakeholders who dedicated their time, expertise, and insights to actively participate in the collaborative development of this document.

Key concerns of the medical profession

The resilience of our medical professionals and their ability to meet the needs of a growing and ageing population is being tested by systemic inadequacies and structural deficiencies across Australia's healthcare system. The biggest challenges voiced by the profession were the hurdles impeding patients — in particular diverse populations — from accessing timely and equitable care. These hurdles include long waiting lists for appointments, workforce shortages, public hospitals that are over capacity, the increasing costs of healthcare, and the challenges of access to care in regional, rural, and remote areas. Additionally, many doctors expressed concerns about the increasing complexity of patient presentations due to the diminishing focus on preventive healthcare to address determinants of health. As a result, many doctors are experiencing burnout due to high clinical workloads and non-clinical stresses, including administrative burden, poor professional development, the impact of inadequate Medicare rebates, the impact of the increasing cost of delivering care on practice viability, and the challenges of navigating the labyrinth of regulatory and compliance requirements.

In addition, many doctors expressed concerns about the inconsistent leadership and governance of the health system and the blame-shifting between different levels of government, which leads to fragmented and uncoordinated care. There were also concerns about the health system's failure to prepare for the future, including limited proactive measures to support environmental sustainability, poor adoption of new infrastructure and technology, and slow progression towards interoperability. Furthermore, many doctors raised concerns about the viability of the private health system, and the impact of insurer-led healthcare and vertical control.

Strengths of Australia's healthcare system

The medical profession offered valuable insights into the strengths of Australia's healthcare system. There was considerable appreciation for government funding of the MBS, the Pharmaceutical Benefits Scheme (PBS), public hospital services, and many community services which support patient access and set Australia apart from many other countries. General practice was celebrated for its central role in promoting preventive care, managing chronic conditions, and providing continuity of care to patients. Public hospitals were recognised for the indispensable role in providing high-quality emergency care and critical services, and the private sector was praised for its role in expanding access to elective surgeries and alleviating pressure on public hospitals. Doctors also highlighted the profound impact of preventive health initiatives and public health campaigns on population health outcomes, citing examples such as smoking cessation programs, vaccination campaigns, and screening initiatives. These efforts were credited with reducing the burden of disease and improving overall health outcomes for the population.

There was also widespread acknowledgement of the high standard of care provided by healthcare professionals in Australia, underscored by Australia's high standards of education and training and the unwavering dedication and expertise of Australia's health workforce. Collaboration and communication between healthcare professionals were identified as key strengths, with doctors noting the increased emphasis on multidisciplinary teamwork in delivering comprehensive and coordinated care and the strides that have been made towards fostering a culture of collaboration. Additionally, the adoption of technology, including telehealth and digital health records, was celebrated as a positive development that enhances healthcare delivery, supports collaboration, and improves patient outcomes.

Pillars and principles of AMA's Vision for Australia's Health

Pillars

The AMA's Vision for Australia's Health is a key part of the AMA Strategic Plan 2024–2027 and provides a blueprint for healthcare investment across five pillars:

Pillar 1
General practice

A sustainable and thriving general practice at the heart of primary care

General practice is the cornerstone of successful primary healthcare, underpinning population health outcomes. It is key to ensuring a high-quality, equitable, and sustainable health system. National and international research shows a well-funded and resourced general practice sector is pivotal for the success of primary healthcare, improving the health outcomes of individuals and communities. It also shows it can create significant savings through better care, greater efficiency, and by reducing the burden on other more expensive parts of the health system.

Pillar 2
Public hospitals

Public hospitals that are funded to provide high-quality and timely care

The provision of timely elective and emergency treatment in public health systems is crucial in ensuring patients receive the care they need while minimising costs for both patients and the healthcare system. Investing in timely treatment can prevent the need for more costly medical interventions, as patients are less likely to develop complications or other associated health conditions that may require more expensive surgeries, extended hospital stays, or readmissions to hospital. Additionally, investing in hospital programs that support the timely discharge of patients from hospitals or provide out-of-hospital care can generate savings as well as reduce the burden on hospitals.

Pillar 3
Private healthcare

A sustainable private health system

Private healthcare is an essential pillar of our healthcare system, working in partnership with the public sector to ensure Australians have access to safe, high-quality, and affordable private healthcare. Demographics, chronic disease, and technology are all changing rapidly, and as such, the way we deliver healthcare must also change accordingly. Having cleared the first hurdles for telehealth and home-based hospital care, we need to develop them further as part of a deliberate design of a better system — a system that provides innovative programs which are patient-centred, cost effective, medical practitioner led, and insurer funded.

Pillar 4
A health system for all

Public health that empowers communities and improves health outcomes

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

Pillar 5
A health system for the future

A health system prepared for the challenges of tomorrow

Australia's health system must be ready to respond to emerging and growing challenges, such as pandemics, workforce shortages, the escalating costs of providing healthcare, an ageing population, increasing chronic disease, climate change, and antimicrobial resistance. Creating a health system that is ready for the future will require the sector to embrace change and innovations in how and where healthcare is provided.

Prevention

Preventing disease and disability will be critical if Australia's healthcare system is to withstand future challenges. It is widely acknowledged that preventing disease and disability reduces healthcare costs and alleviates the burden on our health system, while also driving economic growth and productivity.

Funding and models of care

Funding mechanisms and models of care will need to evolve to meet the future needs of patients and communities. This will require exploring models that incentivise quality and efficiency in the context of increasing demand and costs of providing high-quality care.

One Health

A health system that is prepared for the future will require policy underpinned by a One Health approach that recognises the link between human, animal, and environmental health to improve population health outcomes.

Regulation

Fit-for-purpose and contemporary regulation and compliance is needed that supports the delivery of ethically appropriate, safe and high-quality healthcare services across the health system into the future.

Technology and data

A health system prepared for the future will build on lessons from the COVID-19 pandemic to incorporate new technologies that enhance healthcare delivery. This will include embracing advancements such precision medicine, telehealth and telemedicine, and real-time analytics to enable informed decision-making and improve health outcomes.

Workforce and training

Workforce and training programs are needed that can adapt to meet evolving needs and ethical challenges, fostering a diverse and skilled health workforce.

Principles

The five pillars are underpinned by six principles, based on strong ethical foundation and adherence to the values of medical professionalism with every policy and advocacy priority proposed under each pillar meeting each of these principles:

Equitable access

Equitable access to appropriate healthcare for all Australians

Equitable access to appropriate healthcare is about more than just providing medical services; it is about ensuring all Australians, regardless of their socioeconomic status, geographic location, disability, gender, or cultural background, have access to high-quality, integrated, and patient-centred care.

Independence

Independence of the medical profession

Clinical autonomy and independence allow doctors the freedom to advocate for their patients and the health and well-being of the wider community without undue external pressures, while protecting the integrity of the doctor-patient partnership. This collaboration fosters trust and ensures the patient's healthcare interests remain at the centre of their care.

Sustainability

Sustainability of the health system

A sustainable health system not only meets the needs of today's population but anticipates and prepares for future challenges. This includes factors like population growth and demographics, the rise of chronic diseases, and the impacts of climate change on health. By investing in sustainability, we can create resilient healthcare systems that are efficient, cost-effective, and equitable.

Quality

Quality healthcare

High-quality care encompasses a range of elements, including evidence-based practices, patient-centred approaches, and efficient care coordination. The delivery of high-quality healthcare requires a health system that is contemporary and embraces the latest innovations, research, data, and technologies to improve

quality and patient experience. It also requires commitment to ensuring healthcare professionals are equipped with the knowledge and skills to identify and respond to ethical challenges, undertake effective communication with patients and others and deliver the best possible care.

Patient empowerment

Patient empowerment to enable Australians to take charge of their health

The doctor-patient partnership promotes respect, collaboration and shared decision-making, supporting and empowering patients to be active participants in their care. Patient empowerment gives individuals the tools, technology, knowledge, and confidence to make informed decisions about their own health journey. This empowerment builds stronger relationships between patients and healthcare providers and empowers patients to take proactive steps towards prevention and early intervention.

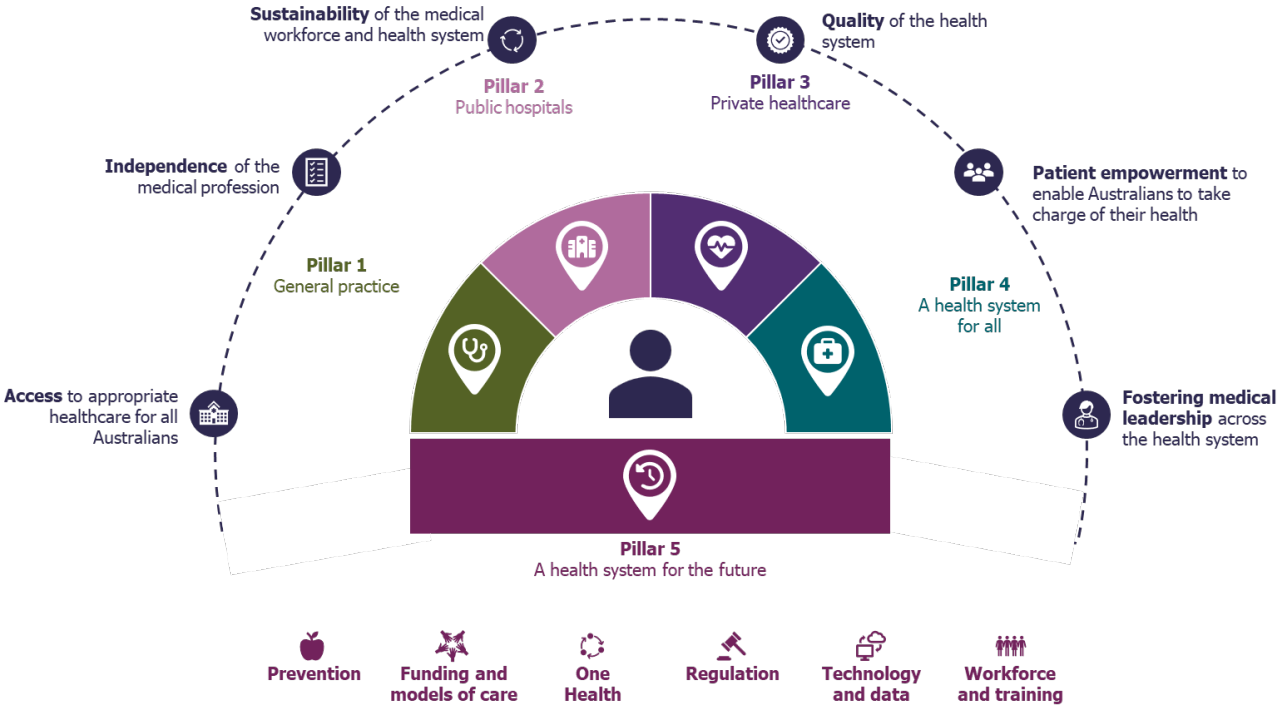
Fostering medical leadership

Fostering medical leadership across the health system

Fostering medical leadership across the health system involves cultivating and empowering medical practitioners to take on leadership roles to influence positive change, innovations, safety, and efficiency and to ensure patients are always at the centre of the system. Achieving this requires medical leadership that represents the diversity of the medical profession and has received training opportunities to develop management and leadership skills alongside their clinical expertise.

Interconnected pillars and principles

The pillars and guiding principles of AMA's Vision for Australia's Health are interconnected and are centred around the health needs of the patient. This ensures our policy and advocacy delivers care that is accessible and equitable, independent, sustainable, of high quality, empowering for patients, and led by capable medical professionals. This cohesive approach fosters a health system that not only meets current needs but anticipates and adapts to the evolving healthcare landscape.



Pillar 1: General practice

A sustainable and thriving general practice at the heart of primary care

General practice is the cornerstone of successful primary healthcare, underpinning population health outcomes. It is key to ensuring a high-quality, equitable, and sustainable health system. National and international research shows a well-funded and resourced general practice sector is pivotal for the success of primary healthcare, improving the health outcomes of individuals and communities. It also shows that it can create significant savings through better care, greater efficiency, and reducing the burden on other more expensive parts of the health system.

Goals	Policy enablers	Measures of success
1.1: General practice is funded and resourced to thrive, transform, and innovate.	• Continued support from the federal government to embed MyMedicare, particularly focused on seamless integration with practice systems and targeted programs linked to MyMedicare enhance levels of support available to patients.	• Increase in patient cohorts, services and programs that are eligible to participate in MyMedicare.
	• Funding for general practice data collection and analysis to support research to demonstrate the value proposition of MyMedicare for the patient, GP and broader care team allowing for more services for patients.	• Implementation of a monitoring and evaluation framework. • Ongoing research and analysis on the value proposition of MyMedicare.

	• Issues that threaten the viability of general practice, for example payroll tax, are addressed.	• State and federal governments working together to improve the viability of general practice.
		  ○ Policy changes, exemptions, or compensation to address the issue of payroll tax.
		  ○ Increase in the implementation of initiatives to improve the viability of general practice.

	• Adoption of new technologies, including artificial intelligence, to enhance patient access and care and support general practices, with funding to support this adoption and funding for future-proofing (e.g. power outages).	• Increase in uptake of new technologies in general practice. • Implementation of change management, education, and training, to support adoption of new technologies.
	• Funding to support innovative models of care in general practice to improve patient access and the patient experience.	• Implementation of innovative models of care in general practice.

Goals	Policy enablers	Measures of success
1.2: Patients can access the care they need through their general practice, when they need it.	• Improve funding associated with after-hours services for patients to improve access to general practice after-hours, including reform of the definition of after-hours for in-clinic GP services.	• Increase in general practices offering after-hours services.
1.3: General practices are supported to manage patients with complex and chronic diseases.	• Restructure GP MBS consultation items to recognise the increasing complexity of patient consultations, including patients with complex and chronic disease.	• MBS consultation items that value longer consultations.
	• Expand the wound consumables scheme to all patients with chronic wounds.	• Reduction in wound-related complications and hospital admissions.
1.4: Patients can access evidence-based multidisciplinary care through team-based primary care models led by their GP.	• Funding models that support the delivery of team-based care, led by the GP.	• Increase in utilisation of other healthcare professionals in the delivery of multidisciplinary care.
	• Explore ways to improve access to medicines in general practice, for example the introduction of dispensing pharmacists in general practices.	• Improved access to medicines through general practice.
	• General practitioners are supported as clinical leaders, while also enabling the general practice team to work to their full scope of practice within strong clinical governance frameworks.	• Expansion of GP-led multidisciplinary models of care.
1.5: Enhanced access to primary healthcare services for patients in residential aged-care facilities	• Introduction of telehealth items that enable GPs to consult with residential aged-care facility staff and families, on behalf of the patient.	• Introduction and utilisation of new telehealth items.
	• Improved incentives to encourage general practices to deliver healthcare in residential aged-care facilities, as outlined in the AMA research report Putting health care back into aged care.	• Increase in general practice services in residential aged-care facilities.
1.6: More doctors are encouraged and supported to choose a career in general practice.	• Reform employment conditions for GP trainees to ensure pay and entitlements for GP trainees match their hospital-based counterparts as well as support and funding for GP training supervisors and practices.	• Equitable pay and entitlements between GP and non-GP trainees. • All Australian General Practice Training (AGPT) Program training places are filled.

Goals	Policy enablers	Measures of success
	• Increase high-quality exposure to general practice in medical school and prevocational training, with funding to support general practices to provide this exposure.	• Embed high-quality exposure to general practice during medical school and prevocational training in medical education and training accreditation standards. • Increase in number of general practices providing high-quality general practice exposure to trainees. • All Australian General Practice Training (AGPT) Program training places are filled.
1.7: Improved access to mental healthcare through general practice.	• Increase mental health MBS patient rebates (for GPs and psychiatrists) so they have parity with rebates for other chronic illness consultations.	• Increase in patient access to mental healthcare.
	• Funding to embed mental health practitioners in general practice as part of a multidisciplinary care model.	• Increase in utilisation of other healthcare professionals in the delivery of team-based mental healthcare.
	• Remove barriers for high-risk, acute, and complex patients to improve access to psychological therapy, psychiatric care, and other allied healthcare. • Develop initiatives specifically tailored for patients in regional, rural, and remote areas to remove these barriers.	• Increase in patient access to mental healthcare.
	• Reduce the number of practitioners required for a multidisciplinary case conference for patients with a mental health plan from three to two.	• Reduction in complexity associated with mental health plans.
1.8: Support for general practices to create high-quality learning and teaching environments for medical students and trainees, GPs, other practice healthcare professionals, and support staff.	• Additional funding and financial incentives to support general practices and GP training supervisors to develop and maintain structured teaching programs, including dedicated teaching time and resources.	• Development and maintenance of teaching programs.
	• Funding to support the development and implementation of e-learning platforms, simulation tools, and other infrastructure in general practice.	• Increase in adoption of e-learning platforms, simulation tools, and infrastructure to support education.
	• Funding to evaluate the effectiveness of general practice teaching programs to support continuous improvement.	• Ongoing evaluations of teaching programs.

Pillar 2: Public hospitals

Public hospitals that are funded to provide high-quality and timely care

The provision of timely elective and emergency treatment in public health systems is crucial in ensuring patients receive the care they need while minimising costs for both patients and the healthcare system. Investing in timely treatment can prevent the need for more costly medical interventions, as patients are less likely to develop complications or other associated health conditions that may require more expensive surgeries, extended hospital stays, or readmissions to hospital. Additionally, investing in hospital programs that support the timely discharge of patients from hospitals or provide out-of-hospital care can generate savings as well as reduce the burden on hospitals.[82]

Goals	Policy enablers	Measures of success

2.1: Patients requiring outpatient care, emergency treatment, hospital admission and planned surgery are treated within the clinically recommended timeframe.	• In addition to existing reporting, national, consistent, and public reporting of:
	  ○ patient off-stretcher times (the time taken for patients to be transferred off an ambulance stretcher into a hospital emergency department)
	  ○ waiting times for hospital outpatient appointments (the time between referral and outpatient appointment, often referred to as the hidden waiting list)
	  ○ the number of days patients who are clinically eligible for discharge are waiting in hospital for aged-care or disability services (often referred to as exit block).
		• Implementation of national, consistent, and public reporting.

	• Introduction of funding for performance improvement.	• Improvements in hospital performance.
	• Funding to address the growing elective surgery backlog.	• Reduction in the number of patients waiting for elective surgery.
	• Funding and programs to support timely discharge of patients who are clinically eligible for discharge but are waiting for aged-care or disability services.	• Reduction in the number of patients waiting in hospital for aged-care or disability services.
	• Funding to improve transport between healthcare settings.	• Reduction in the time waiting for transport between healthcare settings.
2.2: Strengthened communication between public hospitals and general practices.	• Hospitals follow best practice, with timely, full discharge summaries to general practices.	• Increase in proportion of discharge summaries that meet best practice standards.
	• Integration of clinical systems between hospitals and the community to facilitate information sharing.	• Successful integration of clinical systems.

Goals	Policy enablers	Measures of success
2.3: Prevention of avoidable admissions and readmissions to reduce the burden on public hospitals.	• Governments fund community-based programs to prevent avoidable admissions and readmissions, including programs that involve general practice, residential aged-care facilities, Aboriginal Community Controlled Health Services, out-of-hospital care, and disability services.	• Reduction in avoidable hospital admissions and readmissions.
2.4: Patients have genuine and informed choice regarding being treated as a private patient in a public hospital.	• A consistent approach to enable patients to elect to be treated as a private patient in a hospital, including appropriate consent and choice.	• Patients use their private health insurance for admitted care, where appropriate and is their choice. • Increase in hospitals using best-practice approaches to treating private patients in public hospitals.
2.5: Public hospitals provide a safe and supportive work environment for all staff as part of delivering safe patient care. **For more information see the AMA Position Statement Safe, healthy and supportive work environments for hospital doctors 2023.**	• Hospitals and health services are required to annually report on incidents, frequency, remediation taken to embed best-practice response, and cultural change in the workplace.	• Increase in hospitals and health services annually reporting.
	• Review of the National Safety and Quality Health Service (NSQHS) Standards to require health services to provide for and promote the health, safety, and wellbeing of those staff within the workplace (including the psychosocial health, safety and wellbeing of staff).	• Adoption of evidence-based risk-management approaches in the NSQHS Standards to address psychosocial hazards in the workplace. • Implementation of policies and procedures that support psychosocial health, safety, and wellbeing. • Measurement against key performance indicators.
2.6: Enhanced continuity of care and community support for patients with mental health issues.	• Expand hospital bed capacity and design to accommodate the acute mental healthcare needs of patients, reducing excessive waiting times in emergency departments. • Increase investment in the healthcare workforce, including psychiatrists and GPs, to provide longitudinal and coordinated care across general practice, community care, and hospitals.	• Increase in patient access to mental health services. • Reduction in emergency department mental health presentations.
2.7: Patients can access high-quality public hospital services in regional, rural, and remote areas.	• Public hospitals in regional, rural, and remote areas are well resourced (both infrastructure and workforce) to meet the needs of communities (see Goal 5.20 for further details).	• Improvements in the performance of regional, rural, and remote hospitals.

Goals	Policy enablers	Measures of success
	• Investment in infrastructure to support seamless communication between regional, rural, and remote hospitals and metropolitan centres.	• Improvements in the communication between regional, rural, and remote hospitals and metropolitan centres.

Pillar 3: Private health

A sustainable private health system

Private healthcare is an essential pillar of our health system, working in partnership with the public sector to ensure Australians have access to safe, high-quality, and affordable private healthcare. Demographics, chronic disease, and technology are all changing rapidly, and as such the way we deliver healthcare must also change accordingly. Having cleared the first hurdles for telehealth and home-based hospital care, we need to develop them further as part of a deliberate design of a better system — a system that provides innovative programs which are patient-centred, cost-effective, medical practitioner-led, and insurer funded.

Goals	Policy enablers	Measures of success
3.1: A sustainable and thriving private health system that provides patients with choice of hospital, medical practitioner, and their treatment plan.	• Recalibration of the private health insurance policy levers, including Lifetime Health Cover (LHC) loading, Medicare Levy Surcharge (MLS), and the private health insurance premium rebate to better reflect consumer behaviour and changing demographics and better support the objectives of the healthcare system.	• Increase in uptake and retention rates of private health insurance.
	• Reforms to default benefits and risk equalisation promote the sustainability of the private health system.	• Improvements in the sustainability of private health system.
	• Regular review of the private health insurance policy leavers, supported by ongoing data and evidence collection.	• Private health insurance policy levers remain contemporary.
	• Greater incentives to support uptake and retention of the appropriate levels of private health insurance.	• Increase in uptake and retention rates of private health insurance.
	• Address private hospital sustainability issues to ensure patients with private health insurance can continue to use their insurance to access private hospital care.	• Improvements in the sustainability of private hospitals. • Continued patient access to private hospitals.
3.2: A private health system that is attractive to patients, transparent, accessible, and delivers value.	• Mechanisms to increase the value proposition of private health insurance, including a mandated average minimum return amount (e.g. 90 per cent) to the health consumer for every premium dollar paid.	• Increase in uptake and retention rates of private health insurance.
	• Mechanisms to increase the value proposition of private health insurance in rural areas.	• Increase in uptake and retention rates of private health insurance in rural areas.
	• Policy settings that support consumers to maximise the value of their private health insurance.	• Improvements in consumer awareness and understanding of their private health insurance benefits. • Increase in patients using their private health insurance. • Reduction of complaints associated with private health insurance.

Goals	Policy enablers	Measures of success
	• Improved product design transparency to ensure consumers have the appropriate cover.	• Improvements in consumer awareness and understanding of private health insurance products. • Reduction of complaints associated with private health insurance.
	• A higher standard of transparency so patients can determine out-of-pocket costs.	• Broad adoption of informed financial consent processes. • Improvements in consumer understanding of out-of-pocket costs. • Reduction of complaints associated with private health insurance.
3.3: A private health system that is attractive for medical practitioners to work in.	• Establishment of an independent and well-resourced Private Health System Authority to oversee contracting arrangements between insurers, hospitals, and medical practitioners, as outlined in the AMA discussion paper A whole of system approach to reforming private healthcare.	• Implementation of a Private Health System Authority. • Reduction in contract negotiation issues.
	• Policy settings and legislation that ensures medical practitioners — not insurers — have the clinical autonomy and independence to decide the type of clinical care with their patients, and where and when they receive it.	• Implementation of policy and legislation.
	• Financial incentives to improve information technology infrastructure to support digital capability and interoperability.	• Introduction of financial incentives. • Improvement in information technology infrastructure.
3.4: Australia's private health system leads in the development of innovative models of care and comprehensive reforms that are underpinned by patient choice, and clinical autonomy.	• Establishment of an independent and well-resourced Private Health System Authority to oversee the private health system and create a platform for system-wide reforms, as outlined in the AMA discussion paper A whole of system approach to reforming private healthcare.	• Implementation of a Private Health System Authority. • Regular sector discussions regarding reform. • Early identification of potential system issues.
	• Deliberate design of new and innovative models of care that are underpinned by the principles of patient choice, equitable access, safety and quality, and clinical autonomy, as outlined in the AMA research report Out-of-hospital models of care in the private health system.	• Implementation of new models of care.

Goals	Policy enablers	Measures of success
	• Stronger regulations to prevent selective and restrictive contracting and vertical control which threaten patient choice, clinical autonomy, safety and quality, and viability of the system.	• Introduction of stronger regulations to prevent selective and restrictive contracting.
	• Adoption of new technologies to support new models of care and reforms.	• Increase in adoption of new technologies.
3.5: Modernised procurement and regulatory processes ensuring patient access to essential prostheses and other medical technology and devices.	• Effective implementation of prescribed list (formerly the prostheses list) reforms with close sector consultation to ensure medical practitioners can keep choosing the right device to suit their patients' clinical needs.	• Implementation of prescribed list reforms.
	• Regular review of the prescribed list to ensure the private health system is paying competitive prices for all medical devices and supports best-practice usage, with any savings passed on to consumers. • Robust processes are established to ensure Australian patients have safe and cost-effective access to new and emerging medical technologies.	• Implementation of a regular review cycle for the prescribed list.

Pillar 4: A health system for all

Public health that empowers communities and improves health outcomes

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

Goals	Policy enablers	Measures of success
4.1: Reduce health inequities by addressing underlying social and other determinants of health, thereby improving the overall	• Establishment of a cross portfolio ministerial body to consider and provide advice on policies that may impact on health outcomes equity.	• Establishment of the ministerial body. • Improvements in policies that impact health outcomes and equity.

Goals	Policy enablers	Measures of success
health and well-being of the population in Australia. **Refer to the AMA Social Determinants of Health position statement for more details.**	• All governments take a proactive role in addressing the social determinants of health through: ○ establishment of a baseline and realistic key performance indicators ○ sophisticated monitoring, reporting and publishing on progress to expose areas of inequality ○ conducting health equity assessments of relevant policies.	• National ongoing monitoring, reporting, and publishing on progress in reducing health inequities. • Regular health equity assessments of policies. • Reduction in heath inequities.
	• Improvements in health literacy and education, with a focus on priority groups.	• Implementation of educational campaigns and programs. • Increase in health literacy rates among the population.
	• Improve access to affordable and appropriate housing and nutritious foods, regardless of participation in paid employment, and investment in measures that support retraining and re-employment for those who are affected by underemployment or unemployment.	• Reduction in health issues related to inadequate living standards. • Increase in employment participation rates.
	• Recognition of the contribution of the social determinants of health as they apply to harmful product use (such as tobacco, junk foods and gambling), including investment in interventions that seek to reduce their impact as opposed to reliance.	• Implementation of interventions to address root causes of harmful product use. • Increase in individuals accessing support services for harmful product use. • Reduction in harmful product use.
	• Undertake revision of the jurisdictional challenges to providing healthcare services to those in custody. • Highlight the need for continuity of care post-release from prison.	• Increase in healthcare services available in custodial settings. • Reduction in preventable physical and mental illnesses, as well as deaths, among incarcerated individuals.
4.2: Aboriginal and Torres Strait Islander voices, knowledge and experiences are prioritised in policy setting, service delivery and evaluation of Aboriginal and Torres Strait Islander health.	• Meaningful input from Aboriginal and Torres Strait Islander peoples in all policies, service delivery, and evaluations of Aboriginal and Torres Strait Islander health.	• Ongoing incorporation of Aboriginal and Torres Strait Islander perspectives and knowledge into policy development and decision-making processes.
	• Aboriginal and Torres Strait Islander peoples are represented across hospital and health service governance and leadership.	• Increase in the number of Aboriginal and Torres Strait Islander peoples in governance and leadership roles.

Goals	Policy enablers	Measures of success
	• Full implementation of the National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 and other supporting plans, with a commitment to long term (10+ years) needs-based and coordinated cross-sectional funding by all governments.	• Progress in achieving the priority reforms outlined in the *National Agreement on Closing the Gap*. • Progress in achieving the recommendations in the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* and other supporting plans. • Comparable health outcomes between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.
	• Investment in Aboriginal and Torres Strait Islander-led data development at the local level and uphold the principals of Data Governance and Sovereignty by empowering communities and individuals to access place-based data to design community-driven initiatives.	• Development of local Aboriginal and Torres Strait Islander-led data systems. • Increase in data accessibility for communities.
	• Development of an Aboriginal and Torres Strait Islander-led research agenda for health and wellbeing, prioritising the acknowledgement of the impacts of systematic racism in all health systems. This should include an investment in knowledge translation and research impact.	• Identification and funding of research priorities by Aboriginal and Torres Strait Islander communities. • Increase in research projects focused on the impacts of systemic racism.
	• Proactive engagement and partnership with Aboriginal and Torres Strait Islander organisations, including the Australian Indigenous Doctors' Association and the National Aboriginal Community Controlled Health Organisation.	• Increase in collaborative projects with Aboriginal and Torres Strait Islander organisations. • Positive feedback from Aboriginal and Torres Strait Islander organisations on the effectiveness of partnerships.

Goals	Policy enablers	Measures of success
4.3: Improve health outcomes for aged-care recipients and people living with disabilities.	• Improved integration within the broader care sector to facilitate seamless coordination between aged care, disability services, and healthcare, including: ○ mechanisms to support team-based care, collaboration, and continuity of care ○ technology that facilitates data sharing and interoperability between care settings ○ funding models that support integration and collaboration ○ regular reporting to identify opportunities to improve the delivery of streamlined and patient-centred care.	• Increased adoption of team-based care models and continuity of care. • Increased adoption of technology that facilitates data sharing and interoperability. • Reduction in duplicated tests and procedures. • Reduction in medication errors. • Ongoing reporting on care coordination and health outcomes. • Increase in formalised partnerships or agreements between healthcare settings. • Improvements in quality of life for residents in aged-care facilities and people living with disabilities.
	• Improved incentives to encourage healthcare professionals to deliver care in the aged-care and disability sectors, as outlined in the AMA research report Putting health care back into aged care.	• Increase in healthcare professionals working in aged-care and disability sectors.
	• Urgent implementation of the outstanding recommendations from the Royal Commission into Aged Care Quality and Safety.	• Significant progress in implementing recommendations from the Royal Commission into Aged-Care Quality and Safety.
4.4: Create environments that promote health for Australians, in particular children.	• A tax on sugar-sweetened beverages that raises the retail price by 20 per cent, as recommended by the World Health Organization. See AMA report A sweet deal: the case for taxing sugar-sweetened beverages.	• Implementation of a tax on sugar-sweetened beverages. • Reduction in the amount of sugar consumed through sugar-sweetened beverages. • Change in purchasing behaviour towards healthier alternatives. • Reduction in obesity rates and related health conditions.
	• Banning the promotion of junk food products to children through advertising and marketing channels.	• Reduction in exposure of children to junk food advertising. • Changes in sales of junk food products. • Improvement in children's knowledge of healthy eating.
	• World-leading policies to tackle nicotine addiction and prevent new harmful products from entering the market.	• Improvement in children's knowledge of the long-term health consequences of nicotine addiction. • Reduction in smoking-related diseases. • Social disconnection between nicotine containing products and acceptability. • Improved nicotine cessation tools.

Goals	Policy enablers	Measures of success
	• A complete ban on all online gambling advertising and sponsorship. • An independent regulator to coordinate a national and consistent regulatory response to protect Australians from the harms of gambling.	• Reduction in exposure to online gambling advertisements. • Change in online gambling revenue. • Reduction in problem gambling rates and gambling-related harm indicators (e.g. mental health issues). • Establishment of an independent regulator.
	• Education and awareness on the health impacts of online materials. • Independent regulation of online materials that present a risk to health.	• Increase in public awareness of the health risks associated with online materials. • Increase in the number of educational campaigns and programs. • Changes in online behaviour towards healthier choices. • Reduction in harmful online behaviours.
4.5: Improve health outcomes for Australia's veterans.	• Increase fees under the Department of Veterans' Affairs schedule to ensure continued access to care. • Improve equity and access to supports for Australia's veterans.	• Increase in the number of veterans able to receive care without financial barriers. • Increase in the number of healthcare providers who accept veteran patients.
4.6: Improve access to health services in regional, rural, and remote areas.	• Funding models that support the viability of health services operating in regional, rural, and remote areas. ○ Dedicated funding and resources for rural health services that support the provision of high-quality facilities, access to diagnostic services, and workforce attraction and retention.	• Reduction in closures of regional, rural, or remote health facilities. • Increase in services offered by regional, rural, or remote health facilities. • Increase in healthcare providers recruited or retained in regional, rural, or remote areas. • Reduction in wait times for appointments or services in regional, rural, or remote areas.
	• Develop and evaluate rotational commuting workforce models of service delivery (e.g. fly-in-fly-out) that meet the health needs of rural communities and support healthcare professionals who provide regular services to communities through these models.	• Implementation and evaluation of rotational commuting workforce models of service delivery. • Increase in the number of healthcare professionals participating in rotational commuting workforce models. • Increase in the healthcare services provided through rotational commuting workforce models. • Reduction in healthcare professional burnout or turnover in regional, rural, and remote areas.

Goals	Policy enablers	Measures of success
	• Continued improvement of mobile and broadband coverage and performance in rural areas to support new and innovative models of care.	• Increase in telemedicine and telehealth usage. • Increase in the number of healthcare facilities with reliable internet access.
	• Support for rural health services to integrate new technologies and capabilities.	• Increase in adoption of new technologies in regional, rural, and remote healthcare facilities. • Increase in remote diagnostic capabilities. • Reduction in patient transfers to urban centres.

Pillar 5: A health system for the future

A health system prepared for the challenges of tomorrow

Australia's health system must be ready to respond to emerging and growing challenges, such as pandemics, workforce shortages, escalating costs of providing healthcare, an ageing population, increasing chronic disease, climate change, and antimicrobial resistance. Creating a health system that is ready for the future will require the sector to embrace change and innovations in how and where healthcare is provided.

Prevention

Preventing disease and disability will be critical if Australia's healthcare system is to withstand future challenges. It is widely acknowledged that preventing disease and disability reduces healthcare costs and alleviates the burden on our health system, while also driving economic growth and productivity.

Goals	Policy enablers	Measures of success
5.1: Prevention of illness, injury, and chronic disease becomes a foundation of Australia's health system policy and funding response in the immediate future.	• Increased funding and resources directed towards preventive health, as part of a preventive health strategy, including: ○ regular data collection, monitoring, reporting and publishing outcomes against the preventive health strategy to monitor progress and direct funding to effectively and holistically respond. ○ GPs are supported to be at the centre of preventive health system design. ○ meaningful and goal-directed collaboration between healthcare professionals.	• Budget allocations for preventive health initiatives, with the goal of preventive health representing at least five per cent of the health budget. • Increase in the number of preventive health programs implemented with increased funding. • Frequent reports on preventive health outcomes. • Budget allocations for data collection, analysis, and reporting. • Increase in preventive screens and interventions provided by GPs. • Reduction in preventable disease and conditions. • Increase in early detection of communicable and non-communicable diseases. • Increase in public awareness and participation in preventive health activities. • Increase in use of collaborative care plans. • Incorporation of the broader economic impact in cost-benefit analysis.
5.2: Reduce, mitigate, and respond to health risks associated with climate change.	• Promotion of the health benefits of addressing climate change, including: ○ recognition of the relationship between health and climate change ○ measurement and reporting of the health risks associated with climate change.	• Increased public awareness of the impact of climate change on health. • Increase in the number of policies that recognise the relationship between health and climate change. • Regular reporting on the health risks associated with climate change.
	• Implementation of the actions in the National Health and Climate Strategy to protect health and wellbeing from the impacts of climate change.	• Progress in implementing actions outlined in the *National Health and Climate Strategy*, including appropriate budget allocations and resources for implementation.

Goals	Policy enablers	Measures of success
5.3: Work towards decarbonising the Australian healthcare sector.	• Implementation of the actions in the National Health and Climate Strategy to build a sustainable, high-quality, net-zero health system.	• Progress towards implementation of the actions in the National Health and Climate Strategy. • Achieve 80 per cent reduction by 2030, and net-zero emissions by 2040 (as outlined in the Australian Medical Association and Doctors for the Environment joint statement). • Reduction in climate-related illnesses.

Funding and models of care

Funding mechanisms and models of care will need to evolve to meet the future needs of patients and communities. This will require exploring models that incentivise quality and efficiency in the context of increasing demand and costs of providing high-quality care.

Goals	Policy enablers	Measures of success
5.4: Funding models that incentivise funders to prevention and early intervention to reduce acute and more costly care in the long term.	• Explore innovative and longitudinal funding models, for example single-payer funding models, for patients at high risk of preventable hospitalisations.	• Reduction in the number of preventable hospitalisations, and the associated costs.
	• Funding for performance improvement to encourage prevention and early intervention.	• Increase in the use of prevention and early intervention services.
5.5: A fit-for-purpose Medicare, with patient rebates that accurately reflect the cost of delivering care, are responsive to advances in medicine, and ensure accessible, equitable, and effective healthcare for all.	• Appropriate indexation of MBS patient rebates to accurately reflect the rising costs of delivering high-quality healthcare.	• Annual indexation that reflects the rising costs of delivering high-quality care.
	• Reintroduce appropriate indexation for pathology and diagnostic imaging MBS patient rebates.	• Reintroduction of indexation for pathology and diagnostic imaging MBS patient rebates.
	• MBS patient rebates are updated regularly to reflect advances in medicine.	• MBS patient rebates are contemporary and reflect advances in medicine.
5.6: Evidence-based, value-based, patient-centred, and innovative care models, led by medical practitioners, that improve patient access to comprehensive multidisciplinary care.	• Funding models that support the delivery of multidisciplinary care, led by medical practitioners.	• Increased collaboration and communication among healthcare professionals. • Increase in access to multidisciplinary care led by medical practitioners.
	• Mechanisms to ensure medical practitioners maintain independence with respect to clinical decision-making.	• Introduction of mechanisms to maintain clinical decision-making independence.
	• Mechanisms to improve integration and simplify transitions between general practice, hospitals, aged care, disability care, and community care.	• Reduction in transition times between healthcare settings. • Increase in collaboration and communication between healthcare settings.

Goals	Policy enablers	Measures of success
	• Establishment of systems and frameworks to measure patient outcomes.	• Ongoing use of systems and frameworks to measure patient outcomes. • Improvement in patient outcomes over time.
	• Leverage technologies that support the delivery of patient-centred care, tailored to patient preferences and needs.	• Increase in adoption of technologies. • Increase in patient uptake of technology-enabled services. • Improvement in patient digital literacy.

One Health

A health system that is prepared for the future will require policy underpinned by a One Health approach that recognises the link between human, animal, and environmental health to improve population health outcomes.

Goals	Policy enablers	Measures of success
5.7: A One Health approach to protecting public health that recognises the link between human, animal, and environmental health to improve population health outcomes. **Refer to the AMA One Health position statement for more details.**	• Leadership from Aboriginal and Torres Strait Islander communities in all aspects of One Health policy and implementation.	• Increase in Aboriginal and Torres Strait Islander representation in One Health decision-making bodies.
	• A well-funded and resourced Australian Centre for Disease Control (CDC) which is focused on current and emerging communicable disease threats, global health surveillance, antimicrobial resistance, health security, epidemiology, research, and evaluation, and a view to expanding scope to include prevention.	• Ongoing budget allocation for the CDC. • Increase in early detection of communicable disease threats. • Improvements in timeliness and coordination of response to emerging disease outbreaks. • Ongoing adoption of CDC research into health policies.
	• The development of an overarching surveillance framework, led by the CDC, that includes disease monitoring and reporting across human, animal, and environmental health. This framework should feed into a global One Health surveillance network.	• Development and implementation of a surveillance framework. • Integration of the framework into health policies. • Increase is cross-sector and global partnerships.
	• All legislation considers and measures the current and future impact on the health of humans, animals, and the environment.	• Integration of One Health impact assessment process into legislative decisions.

Regulation and compliance

Fit-for-purpose and contemporary regulation and compliance that supports the delivery of ethically appropriate, safe and high-quality healthcare services across the health system into the future.

Goals	Policy enablers	Measures of success
5.8: A regulatory and compliance system that upholds the wellbeing of medical	• Medical practitioners are involved in all regulatory and compliance processes.	• Improvement in regulatory and compliance processes due to medical practitioner involvement.

Goals	Policy enablers	Measures of success
practitioners and all healthcare professionals.	• Regular feedback on regulatory and compliance processes is sought to support continuous improvement.	• Implementation of mechanisms to gather regular feedback on regulatory and compliance processes.
	• Regulatory and compliance bodies (e.g. Australian health Practitioner Regulation Agency (Ahpra), Professional Services Review) operate and uphold their guiding principles. • The National Scheme operates in a "transparent, accountable, efficient, effective and fair way" — the guiding principles outlined under the National Law. • Mandatory reporting legislation is amended in all states to mirror the Western Australian model, which exempts treating doctors from reporting their patients who are registered with Ahpra. • The Professional Services Review conducts its business according to its values and behaviours of "fair, transparent, and professional".	• Investigations are completed within acceptable timeframes and according to guiding principles. • Regular reporting on how regulatory and compliance bodies uphold their guiding principles. • Increase the initial screening of complaints to complaints bodies to reduce the burden on practitioners required to respond to inappropriate and low-level complaints.
5.9: Reduced complexity of the MBS to facilitate provider compliance.	• Implementation of a more responsive process to clinical concerns regarding MBS complexity.	• Reduction in complexity. • Take a more educative and less punitive approach to compliance.
	• Improvements in supporting systems to facilitate quality care.	• Reduction in compliance activities.
5.10: Proportionate growth in fees associated with costs of regulation, registration, and medical indemnity.	• Transparency surrounding fee setting for compulsory fees.	• Improved clarity regarding compulsory fees and what they are being spent on.

Technology and data

A health system prepared for the future will build on lessons from the COVID-19 pandemic to incorporate new technologies that enhance healthcare delivery. This will include embracing advancements such as precision medicine, telehealth and telemedicine, and real-time analytics to enable informed decision-making and improve health outcomes.

Goals	Policy enablers	Measures of success
5.11: A more connected and interoperable health and human services sector that enables efficient data collection and exchange to support efficient and effective healthcare delivery and whole of person care.	• Implementation of the Fast Healthcare Interoperability Resource (FHIR) standard across the health and human services sector, accompanied by incentives and legislation to encourage implementation.	• Implementation of FHIR standard. • Implementation of a procurement guide at all levels of the health system to support adoption of FHIR standard. • Increase in adoption of the FHIR standard across healthcare settings. • Improvement in data sharing between healthcare settings. • Reduction in duplicated tests and procedures.
	• Ongoing investment in digital healthcare technologies to ensure equity of access.	• Increase in adoption of digital healthcare technologies and use in healthcare delivery. • Improvement in access to healthcare due to digital technologies.
	• Automatic coding of input clinical data, and the development of clinical software and systems that can code patient data efficiently, validly and in a meaningful way within medical practitioners' usual documentation processes and methods.	• Increase in clinical data that is automatically coded. • Reduction in clinician time spent on coding. • Increase in adoption of efficient clinical software.
	• Education and training for medical practitioners and the broader health workforce to support interoperability.	• Increase in uptake of education and training. • Improvement in skills related to data exchange and interoperability. • Increase in workforce supporting interoperability.
	• Support for patients and consumers to build their digital health literacy, enabling them to access and control their own health data, and to know who is using their data and for what purposes.	• Increase in patient digital health literacy. • Increase in patients accessing their own health data.
	• Evaluation of the application of interoperable healthcare systems to measure benefits for the health system.	• Implementation of mechanisms to support evaluation.
5.12: Innovative technologies are used to support the delivery of high-quality, patient-centred, and innovative care.	• Continued investment in technology to support virtual care, including telehealth, telemedicine, electronic prescribing, remote monitoring etc.	• Increase in delivery of virtual care services. • Increase in access to healthcare services.
	• Patients are supported with education for, and access to, virtual models of care.	• Increase in health literacy regarding virtual models of care.
	• A national focus on improving the digital maturity of the health workforce through education and training.	• Increase in the digital health literacy of the health workforce.

Goals	Policy enablers	Measures of success
	• Investment in infrastructure to support adoption of new and innovative technologies. • Equitable funding to ensure new and innovative technologies can be accessed by all patients.	• Budget allocations for infrastructure. • Increase in delivery of virtual care services.
	• Telehealth MBS patient rebates that fairly compensate medical practitioners for patient and non-patient contact time, while ensuring appropriate oversight and governance to ensure continuous improvement.	• Increase in patient access to healthcare through telehealth.
	• Artificial intelligence is leveraged to assist in the delivery of healthcare services, with robust governance and regulation to ensure patients, consumers, and healthcare professionals are protected.	• Introduction of governance and regulation related to artificial intelligence that has been developed in consultation with medical practitioners and the broader health workforce. • Increase in healthcare facilities leveraging artificial intelligence.

Workforce and training

Workforce and training programs that can adapt to meet evolving needs and ethical challenges, fostering a diverse and skilled health workforce which is supported by the capability to collect and analyse workforce data to plan for the future.

Goals	Policy enablers	Measures of success
5.13: Australia's health workforce meets the current and future healthcare needs of the population.	• Establish and fund an independent national health workforce planning agency to collate, analyse, and use health workforce data to inform evidence-based policies and strategies.	• Establishment of a national health workforce planning agency. • Implementation of a regular monitoring and evaluation process for health workforce planning. • A medical workforce that meets community health needs.
	• Implement and fund the recommendations of the National Medical Workforce Strategy 2021–2031.	• Progress towards implementation of the National Medical Workforce Strategy 2021–2031.
	• Ensure the prevocational and vocational training pipeline can support the number of medical school graduates.	• The number of prevocational and vocational training places are aligned with medical school graduates.
	• Ensure medical school intakes, including domestic and overseas full fee-paying places, are linked to workforce planning and community need.	• Medical school intakes are linked to workforce planning and community need.
	• Review Commonwealth Government medical training programs (e.g. Specialist Training Program (STP), Bonded Medical Program, John Flynn Prevocational Doctor Program) to ensure they are fit-for-purpose and meeting policy objectives.	• Reviews are conducted and recommendations are implemented.

Goals	Policy enablers	Measures of success
5.14: Growth of the Aboriginal and Torres Strait Islander workforce as an enabler to delivering culturally safe healthcare.	• Full implementation of the priority actions outlined in the Commonwealth Aboriginal and Torres Strait Islander Workforce Strategy 2024–24.	• Progress towards implementation of the Commonwealth Aboriginal and Torres Strait Islander Workforce Strategy 2024–24. • Increase in the number of Aboriginal and Torres Strait Islander healthcare professionals. • Improvements in the delivery of culturally safe healthcare.
	• A commitment across all education, training, and healthcare settings to grow the Aboriginal and Torres Strait Islander health workforce as a key enabler to the delivery of culturally safe healthcare and Closing the Gap, including: o medical practitioners across all specialities o nurses o allied health o Aboriginal and Torres Strait Islander Health Practitioners o Aboriginal and Torres Strait Islander Health Workers.	• Increase in the number of Aboriginal and Torres Strait Islander healthcare professionals. • Improvements in the delivery of culturally safe healthcare. • Increase in Aboriginal and Torres Strait Islander peoples accessing healthcare.
	• Regular and public reporting on progress to growing the Aboriginal and Torres Strait Islander workforce, and evaluation of programs to determine effectiveness.	• Implementation of regular reporting mechanisms.
	• Provision of culturally safe environments for Aboriginal and Torres Strait Islander peoples, and implementation of mechanisms to reduce cultural load.	• Increase in healthcare settings that have implemented culturally safe practices. • Increase in Aboriginal and Torres Strait Islander peoples accessing healthcare.
5.15: Medical practitioners are supported to provide culturally safe healthcare. **For more information see *AMA Position Statement on Cultural Safety*.**	• A commitment across all healthcare settings for equity of access to healthcare services that are culturally appropriate and free of racism. • Promote cultural safety accountability across health systems, including state health departments, medical teaching hospitals, custodial settings, medical organisations, specialist medical colleges and medical specialty societies.	• Increase in the number of healthcare settings that have implemented cultural competence training and culturally safe practices. • Increase in Aboriginal and Torres Strait Islander peoples accessing healthcare.
	• All medical education and training providers are required to integrate cultural safety into education, training and continuing professional development programs at all stages of the medical education and training continuum.	• Cultural safety training is integrated into medical education. • Improvements in medical practitioner understanding of delivering culturally safe care.

Goals	Policy enablers	Measures of success
	• Mandate all medical practitioners to undertake reflective practise about their role in integrating cultural safety into their clinical practice at all stages of their career, outside of and in addition to formal medical education and training.	• Cultural safety training is integrated into all stages of the medical practitioner career journey. • Improvements in medical practitioner understanding of delivering culturally safe care.
5.16: International medical graduates are supported to succeed in the healthcare system.	• Migration and assessment pathways are streamlined while maintaining standards.	• Reduction in the time associated with migration and assessment.
	• Implementation of mechanisms to support international medical graduates to achieve general or specialist registration, in line with a broader medical workforce strategy. • Barriers to registration and employment are identified and addressed, including financial, social, and professional barries. • International medical graduates are provided with tailored supports including relocation support, access to leave and subsidies for training, as well as programs to support training and employment within the Australian health system. • Employment conditions for international medical graduates are fair and transparent, and comparable with domestically trained medical practitioners.	• International medical graduates are supported to train and work in the Australian health system.
	• Increased financial support for supervising practice settings to enable them to support international medical graduates.	• Increase in supervising capacity of practice settings who support international medical graduates.
	• Phase out the 10-year moratorium to implement more robust incentives and support mechanisms to attract and retain international medical graduates, as well as the broader medical workforce, in regional, rural and remote practice.	• A sustainable medical workforce in regional, rural, and remote areas. • Improved access to healthcare services for those living in regional, rural, and remote areas.
5.17: A healthy and resilient medical profession that works and studies in environments across their career continuum that support wellbeing and enable quality patient care.	• Implementation of the actions under the Every Doctor, Every Setting Framework.	• Progress to implementing the actions in the Every Doctor, Every Setting Framework.
	• Safe rostering of medical practitioners.	• Increase in compliance with safe rostering guidelines. • Reduction in burnout among medical practitioners.

Goals	Policy enablers	Measures of success
	• Greater availability and uptake of training programs on bullying, racism, discrimination, and harassment.	• Increase in the number of medical practitioners that participate in training programs on bullying, racism, discrimination, and harassment.
	• Avenues for reporting racism, sexism, harassment, violence, and discrimination in the workplace, including the Australian Health Practitioner Regulation Agency reporting mechanism, are safe, evidence-based, and effective.	• Safe workplaces that are free of discrimination, harassment and violence.
5.18: Equity, inclusion, and diversity is advanced across the medical profession. **Refer to the AMA Equity, Inclusion and Diversity Plan 2023–25 for further information.**	• Diverse representation of medical practitioners across hospital and health service governance and leadership to foster diversity in views and clinically-informed decision making as fundamental enablers of high-quality care.	• Increase in diverse representation across hospital and health service governance and leadership.
	• Policies and pathways that support work participation and career progression for international medical graduates, doctors with disability, doctors with caring responsibilities, and doctors returning to work after a prolonged absence.	• Increase in participation of international medical graduates, doctors with disability, doctors with caring responsibilities, and doctors returning to work after a prolonged absence.
	• Collaboration to support Aboriginal and Torres Strait Islander doctors, doctors from culturally and linguistically diverse backgrounds, and LGBTQIASB+ doctors to work and train in culturally safe environments, free from racism and discrimination.	• Increase in culturally safe healthcare settings. • Reduction in reports related to racism and discrimination.
5.19: High-quality education and training environments that support timely progression and trainee wellbeing across the medical career continuum.	• Accreditation of prevocational training prior to vocational training to provide a structured, safe, high-quality training experience.	• Accreditation of prevocational training.
	• Development of a framework to support prevocational doctors to progress into vocational training in a timely manner.	• Prevocational doctors progress to vocational training in a timely manner.
	• Prevocational doctors who do not wish to enter specialist medical training have access to structured training and support to allow them to progress into defined and valued hospitalist roles.	• Increase in retention of career hospitalists. • Reduction in doctors in training working in unaccredited positions.

Goals	Policy enablers	Measures of success
	• Trainees are supported to make informed career decisions and to undertake training in specialties in line with community need. • Recognition of prior learning supports trainees to enter specialties in line with community need.	• Doctors are training in specialties in line with community need.
5.20: A sustainable regional, rural, and remote health workforce capable of addressing the health needs of Australians in rural regions	• Develop a National Rural Health and Workforce Strategy, linked to the National Medical Workforce Strategy 2021–2031.	• Development of a National Rural Health and Workforce Strategy. • Progress towards achieving objectives outlined in the strategy.
	• Implement innovative and evidence-based regional, rural, and remote medical workforce policy and programs to incentivise and support medical practitioners to thrive and practice in regional, rural, and remote areas.	• Increase in access to medical workforce in regional, rural, and remote areas.
	• Expand the John Flynn Prevocational Doctor Program (JFPDP) from 110 full-time equivalent (440 rotations) in 2022 to 200 full-time equivalent (800 rotations) by 2025 to provide doctors in training with prevocational general practice placements in regional, rural, and remote areas.	• Increase in prevocational general practice placements in regional, rural, and remote areas.
	• Provide financial incentives to attract and retain both prevocational doctors and specialist trainees to live and work in regional, rural, and remote areas, and to choose general practice and/or rural generalism as a career. • Rural communities, local government, and health services work collaboratively to provide social connections and access to services e.g. childcare providers, accommodation, to support doctors to live, train, and work in rural areas, thereby contributing to the productivity, sustainability of a region.	• Increase in the number of general practitioners/rural generalists in regional, rural, and remote areas. • Access to medical practitioners contributes to the productivity, sustainability of a region.
	• Complete the rollout of National Rural Generalist Program with a commitment to ongoing funding.	• National Rural General Program rollout is complete.

Goals	Policy enablers	Measures of success
	• Build on efforts to date to build a training pipeline which takes students through to the completion of specialist fellowship training in regional, rural, and remote areas.	• Increase in the number of medical practitioners in regional, rural, and remote areas.
	• Introduce accountability measures to ensure medical schools are training medical graduates that meet community and workforce needs.	• Increase in exposure to regional, rural, and remote practice during medical training. • Historically under-represented groups are supported to study medicine.
	• Invest in regional teaching, training, and research hubs.	• Increase in regional teaching, training, and research hubs.
	• Set a target to expand academic positions for GPs and rural generalists in regional, rural, and remote to teach in medical schools.	• Increase in exposure during medical school to GP and regional, rural, and remote healthcare delivery. • Increase in the number of medical practitioners in regional, rural, and remote areas.

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