



2024-25 Pre-Budget considerations

About us

ForHealth is the **second largest General Practice provider** in Australia serving ~7 million consults p.a. with a mission of **accessible healthcare for all Australians**.

Our network is focused on health vulnerable communities predominantly in **outer metropolitan and regional Australia**.

Our sites are large-scale and include General Practice, Dental, Specialists, Allied, Women's Health, Skin, Imaging, Pharmacy and Pathology.

ForHealth is the **national leader in Urgent Care Clinics** (UCCs) with >30 UCC sites in partnership with the Commonwealth, Victorian, South Australian and NSW governments.

2023-24 Budget impact

We commend meaningful reform in relation to patient access over the past year by the *Albanese Government* and *Commonwealth Department of Health and Aged Care*.

The impact of a **sustainable indexation rate**, the **tripling of the bulk-billing incentive**, the rollout of **58 Urgent Care Clinics**, and a comprehensive review of **workforce regulatory settings**, directly targets the most urgent issues facing the sector.

Initiatives to further *Strengthen Medicare* including *MyMedicare*, team-based multi-disciplinary care, and *Endometriosis and Pelvic Pain* clinics have further promoted access.

2024-25 Budget considerations

The 2024-25 Budget is an opportunity to extend two of three signature policies to materially impact both healthcare access and household cost-of-living:

Signature policy		Sector issue	2023-24 focus	2024-25 considerations	Δ \$ p.a.
A	Bulk-billing incentive (BBI)	BB decline & rising "gap" fees	• 3x BB incentive	• Make 2m low-income Australians BBI eligible	~\$370m
			• 4.1% indexation	• 5.0% indexation @ 3-year average CPI	~\$260m
B	Urgent Care	Declining access impact to EDs	• 58 Medicare Urgent Care Clinics	• Total 100 sites • "Peak" capacity • Equal regional grants	~\$125m
C	Workforce reform	GP pipeline & maldistribution	• MMM/DPA and Kruk IMG reviews ¹		

This submission addresses the above 2024-25 Budget considerations in detail.

It does not specifically address GP workforce maldistribution in outer-metro and regional Australia recognising this is the subject of a current detailed review.

¹ MMM (Modified Monash Model); DPA (Distribution Priority Area); IMG (International Medical Graduate)

A. Bulk-billing incentive, and MBS indexation

The issue

The issue of declining bulk-billing rates and rising private “gap” fees is well documented following a decade of 1% indexation (on average) and a -32% *real* decline in MBS rates².

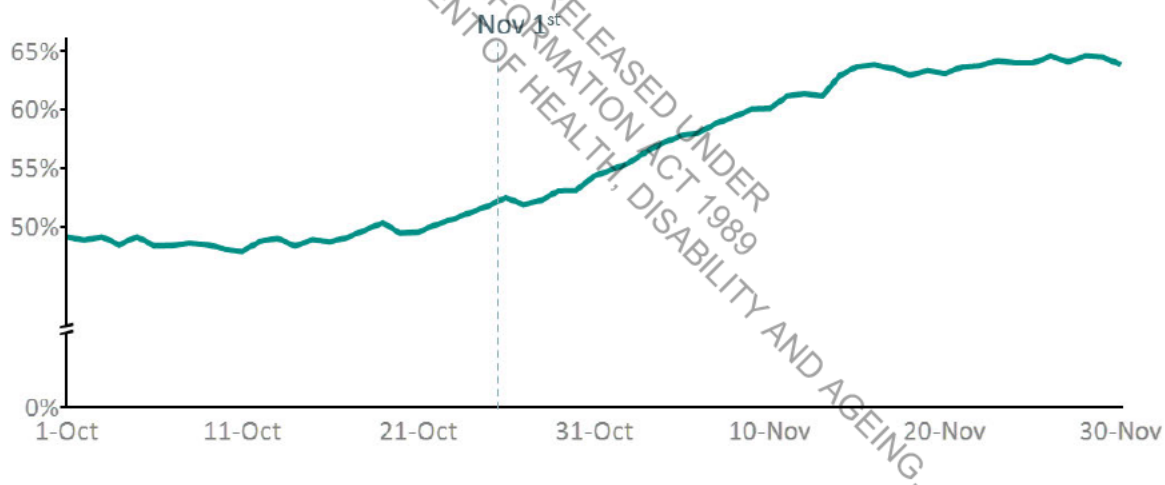
- From June 2018 – Feb 23 the % of *Item 23* consults bulk-billed declined 26% pts³
- From FY19 – FY23 the average private “gap” fee (or out-of-pocket) increased 11%⁴.

The **impact to healthcare access, Hospital ED presentations, and cost-of-living** is significant. In addition to the first-order impact of prohibitive patient costs, there are also second-order impacts including **a migration of GP workforce to affluent areas** (that accept private fees) and a **collapse in afterhours access** (which is largely unviable).

Policy impact

Our data suggests the November tripling of the **bulk-billing incentive arrested this decline**. At mixed billing practices we have seen a **~5% pt increase in bulk-billing consult rates** including some as high as ~15% points (see Caringbah, NSW example below).

Example: Caringbah, NSW practice bulk-billing rate (% of visits)



A **sustainable level of base MBS** indexation (+4.1% in FY23) also impacted the trajectory of average private “gap” fees. Standard GP consults reduced from \$39.29 to \$39.00 in 2023-24 versus an annual increase of GP Non-Referred Attendances in each of the previous 12 years at an average of ~5% per annum.

Policy extension

The **bulk-billing incentive is available to Healthcare Card holders and Children under 16**. This represents ~40% of Australians including Pensioners, Job Seekers, and Students.

It also includes low-income households. However, the incomes thresholds for these are low.

² Healthcare Inflation from ABS quarterly reporting & Annual MBS indexation FY14-FY23.

³ Average Item 23 bulk billing rate across PCBC companies

⁴ MBS Quarterly Statistics



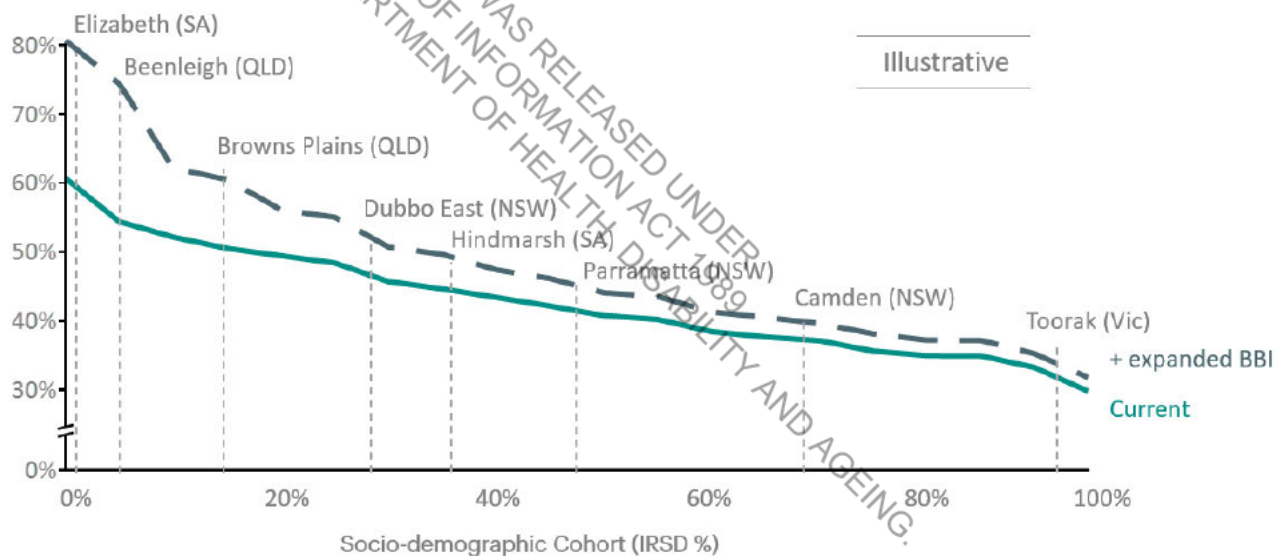
We recommend increasing these income thresholds and extending the age cut-off from 16-to-18 years to offer **cost-of-living support for ~2m more Australians**.

Cohort		Current cut-off	New cut-off	Pop ⁿ	Δ \$ p.a.
A1	Low-income with child	• Earn \$67k p.a. for household	• Extend to \$88k p.a. for household	~900k	~\$210m
A2	Low-income singles	• Earn \$39k p.a.	• Extend to \$62k p.a.	~550k	~\$130m
A3	Children	• 16 or under	• Extend 18 or under	~400k	~\$30m ⁵
				~1.9m	~\$370m

We view this as a **non-inflationary measure that targets cost-of-living**, incentivises workforce in outer-metro and regional areas, and alleviates Hospital ED strain.

It is also progressive in nature and targets the most vulnerable per the illustration below.

Illustration: Bulk-billing incentive eligibility (% of popⁿ) by socio-demographic cohort⁶



A **Low-income Healthcare Card** holder from **Services Australia** is also generally eligible for **additional cost-of-living relief** agreed with individual states, including:

PBS	Energy	Education	Phone / Post	Recreation
Water	Rates	Transport	Finance	Hardship

Additional state-base benefits have not been costed.

⁵ Funding required for children 16-18 lower than other cohorts driven by relatively low number of visits to GP and existing coverage from student-based concession cards

⁶ Australian Department of Social Services Benefit DSS Benefit and Payment Recipient Demographics, Sept 2023 QTR, ABS Population Data by age group, SEIFA IRSD 2016 by SA2

In parallel to expanding *Healthcare Card* eligibility, we recommend increasing base MBS indexation to 5.0% to match the 3-year CPI and bring average gap fees down in FY24.

		Current	New	Δ \$ p.a.
A4	Indexation	• 4.1%	• 5.0%	~\$260m

B. Urgent Care Clinics

The issue

The issue of **Emergency Department (ED) wait times** is well documented.

The relationship **between ED strain and declining GP access** in terms of bulk-billing, afterhours availability, and workforce maldistribution is also well understood.

These issues are acute in low-socioeconomic **outer-metro and regional areas** where **GPs per capita are often 2-3x less** than in affluent inner-metro areas.

This culminates in “urgent, but not life-threatening” GP-like presentations (*Category 4 & 5*) at public EDs, where care is funded, “walk-ins” are accepted, operating hours are extended, and wait times are often less than for a GP.

It means that our primary and secondary systems are **not working at the “top-of-scope”** compromising patient and taxpayer outcomes.

Policy impact

In addition to workforce and bulk-billing reform, the rollout of **58 Urgent Care Clinics** (UCCs) is an important change based in global precedent.

- For example, Auckland has a mature network of Urgent Care Clinics and one of lowest ED incidence rates worldwide (~40% below Australia⁷).

Early data is still emerging, but on the front-line we already see a significant impact:

- Our sites typically **see 30-50 patients a day and are full**. This is especially true in regional areas, with unprecedented demand over the seasonal period.
- ~60% of patients state they would have gone to the ED**⁸; *Category 4 & 5* presentations appear to be lower (e.g. **Logan -10%, Ipswich -25%**⁹); and EDs tell us **YoY wait-times have fallen** (e.g. Rockhampton, Epping).
- 9-out-of-10 patients recommend** the service, and the median time to start treatment after triage is **~35 minutes** (noting an increase in the seasonal period).

⁷ RNZCUC & Clearwater research

⁸ Data from ForHealth’s established Victorian Urgent Care Clinics

⁹ The Australian, 19th December 2023

Policy extension

We welcome the additional commitment to UCCs following *National Cabinet* and believe three areas warrant consideration in the 2024-25 Budget:

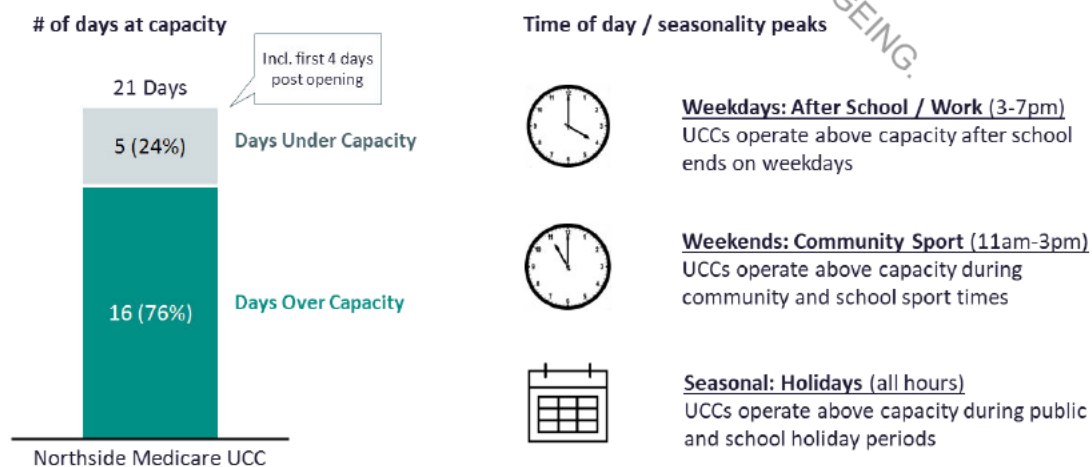
- Network:** Expand network from 58 to 100 sites, prioritised by Category 4 & 5 presentations and wait-times, network “gaps” and socio-economic status.
- Capacity:** Add “peak capacity” by giving operators the option to add a second GP and RN at “peak times” (peak shifts and seasonal periods).
- Sustainability:** Regional funding is ~20-25% less than metro sites but is more costly due to workforce rates. Regional funding needs to be matched for viability.

			Assumption	Cost p.a.
B1	Network	From 58 to 100 sites	42 sites @ \$1.8m grant (excl. establishment)	~\$75m
B2	Capacity	Add 2nd GP and RN at “peak” times	58 sites @ \$900k grant¹⁰	~\$40m
B3	Sustainability	Lift regional grants to minimum \$1.8m p.a.	25 sites @ \$400k increase	~\$10m
				~\$125m

For “peak” periods, both an additional GP and RN (Registered Nurse) are required to open the ‘triage funnel’ and meet demand. Practices can also be given the option to staff a NP (Nurse Practitioner) in lieu of an additional GP where workforce is available.

The additional “peak” capacity grants can be paid in arrears based on demonstrated additional workforce during “peak shifts” (3pm-7pm weekdays, 11am-3pm weekends) and seasonal periods (public and school holiday periods).

Example: Capacity analysis (Northside Medicare UCC, QLD first 3-weeks)



¹⁰ Assumes 80% uptake of additional capacity grants for “peak” shifts and public and school holiday periods.

2025-26 Pre-Budget considerations

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ForHealth is the [national leader in Urgent Care Clinics](#) (UCCs) with 35 UCC sites in partnership with the Commonwealth, Victorian, South Australian and New South Wales governments.

Recent policy impact

We recognise the meaningful reform by the *Albanese Government* and *Commonwealth Department of Health and Aged Care* regarding primary care access.

The impact of a [sustainable indexation rate](#), the [tripling of the bulk-billing incentive](#), and the rollout of [87 Urgent Care Clinics](#) directly address the most urgent issues facing the sector. In addition, the suite of comprehensive reviews into [workforce regulatory settings](#), [after-hours](#) access and practice incentives will help set the industry up for long-term success.

Initiatives to further *Strengthen Medicare* including *My Medicare*, team-based multi-disciplinary care, and *Endometriosis and Pelvic Pain* clinics have further promoted access.

2025-26 Budget considerations

The 2025-26 Budget is an opportunity to expand two signature policies to materially impact both primary care access and household cost-of-living. [Both proposals aim to implement the Strengthening Medicare Taskforce recommendations to increase access to primary care](#)¹

Signature policy		Sector issue	Focus to date	2025-26 considerations	\$ p.a.
A	Bulk-billing incentive (BBI)	BB decline & rising “gap” fees	3x BB incentive from Nov-23	Expand eligibility to all Australians.	~\$1,010m
B	Urgent Care	Declining access impact to EDs	87 Medicare Urgent Care Clinics	- Add 113 clinics across Australia - Add “Peak” capacity - Equity of funding for regional & rural areas	~\$280m

This submission addresses the above 2025-26 Budget considerations in detail.

¹ [Strengthening Medicare Taskforce, Vision 1 “Increase Access to Primary Care”, recommendations 5 and 6](#)

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The issue

The issue of declining bulk-billing rates and rising private “gap” fees is well documented following a decade of 1% indexation (on average) and a -32% *real* decline in MBS rates².

- From June 18 – Feb 23 the % of *Item 23* consults bulk-billed declined 26% pts³
- From FY19 – FY23 the average private “gap” fee (or out-of-pocket) increased 11%⁴.

The **impact to healthcare access, Hospital ED presentations, and cost-of-living** is significant. In addition to the first-order impact of prohibitive patient costs, there are also second-order impacts including **a migration of GP workforce to affluent areas** (that accept private fees) and a **collapse in after-hours access** (which is largely unviable).

Policy impact

The tripling of the Bulk Billing Incentive on November 1st 2023 has **stopped the erosion bulk billing rates, which have risen by 17%pts in the year since**. This improvement has been most significant in regional areas where the size of the incentive is boosted by rural loadings.

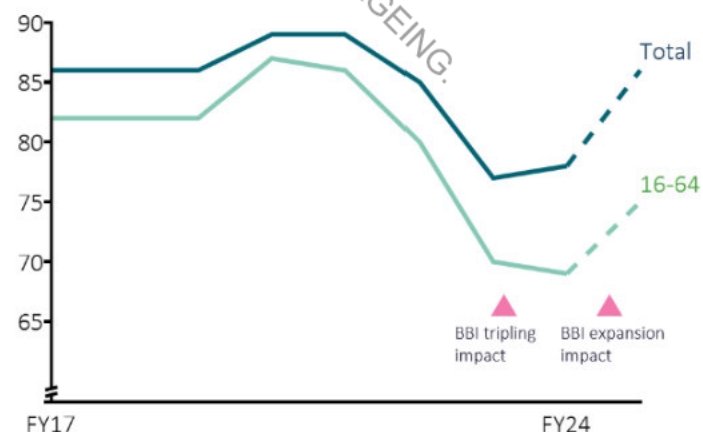
Policy extension

The **bulk-billing incentive is currently available to Healthcare Card holders and Children under 16**. This represents ~40% of Australians including Pensioners, Job Seekers, and Students who account for 60% of GP visits.

However, many Australians are now delaying visits the GP due to the once-in-a-generation cost of living crisis. In 2024, 9.5% of NSW residents delayed visiting the GP due to cost, (3x on prior year). The **negative impacts of delaying care and future costs incurred should be a primary focus for the Government**.

We recommend the Government expand the eligibility of the Bulk Billing Incentive to all Australians, increasing access from ~12 million to 26 million Australians. This policy would **save everyday Australians an estimated ~\$550m per annum** in out-of-pocket healthcare expenses, resulting in an increase of the bulk billing rate from 77% to 86% (+9% pts).

% GP bulk-billing rates, 2017 - 2024



² Healthcare Inflation from ABS quarterly reporting & Annual MBS indexation FY14-FY23.

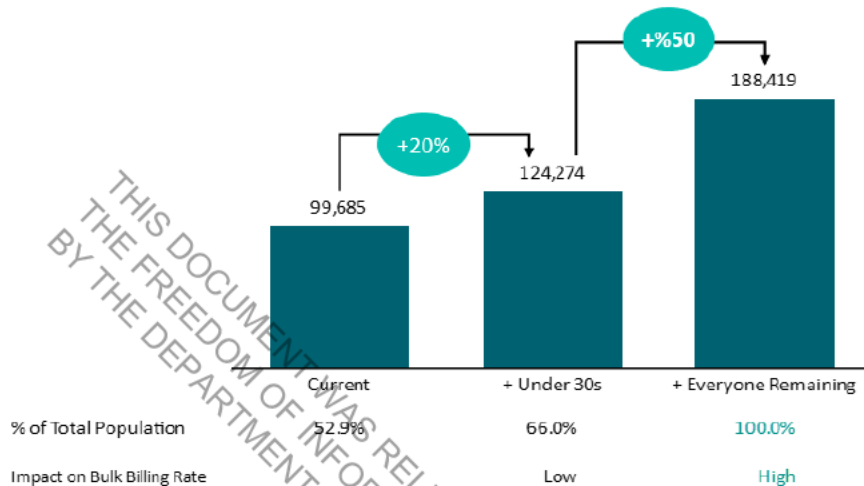
³ Average Item 23 bulk billing rate across PCBC companies

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In practice, **most wealthy Australians are not sensitive to price so GPs would likely continue to charge them higher out of pocket fees** of \$50+ vs. the bulk billing incentive of ~\$21, resulting in a progressive policy despite universal access.

Suburbs that will benefit most are lower socioeconomic areas where ‘mixed billing’ has recently become the standard. For example, suburbs like Browns Plains (Qld) will benefit most from this policy extension, as nearly all the residential population would likely utilise the incentive.

Impact of BBI expansion on Browns Plains, Qld



This policy is a non-inflationary measure given **>12 million** more consultations will be bulk billed.

B. Urgent Care Clinics

The issue

The issue of **Emergency Department (ED) wait times** is well documented.

The relationship **between ED strain and declining GP access** in terms of bulk-billing, afterhours availability, and workforce maldistribution is also well understood.

These issues are acute in low-socioeconomic **outer-metro and regional areas** where **GPs per capita are often ~2-3x less** than in affluent inner-metro areas.

This culminates in “urgent, but not life-threatening” GP-like presentations (*Category 3, 4 & 5*) at public EDs, where care is funded, “walk-ins” are accepted, operating hours are extended, and wait times are often less than for a GP.

It means that our primary and secondary systems are **not working at the “top-of-scope”** compromising patient and taxpayer outcomes.

Policy impact

In addition to workforce and bulk-billing reform, the rollout of **87 Urgent Care Clinics (UCCs)** is an important change based on global precedent.

- For example, Auckland has a mature network of Urgent Care Clinics and one of

lowest ED incidence rates worldwide (~40% below Australia⁵).

Early data is still emerging, but on the front-line we already see a significant impact:

- Our sites typically **see 30-50 patients a day and are full, resulting in patients being referred to alternative services**. This is especially true in regional areas, with unprecedented demand over the seasonal period.
- **~60% of patients state they would have gone to the ED⁶**; *Category 4 & 5 presentations appear to be lower (e.g. Logan -10%, Ipswich -25%⁷); and EDs tell us **YoY wait-times have fallen** (e.g. Rockhampton, Epping).*
- **9-out-of-10 patients in ForHealth Victorian clinics recommend** the service.

Policy extension

We welcome the additional commitment to UCCs following *National Cabinet* in Dec 2023 and believe three areas warrant consideration in the 2025-26 Budget:

- **Network: Expand network from 87 to 200 sites**, prioritised by Category 4 & 5 presentations and wait-times, network “gaps” and socio-economic status.
- **Capacity:** Add “peak capacity” by giving operators the option to add a **second GP and RN at “peak times”** (peak shifts and seasonal periods).
- **Regional Sustainability:** Regional funding is less than metro sites, however, it is more costly to operate due to workforce tightness. **Regional funding needs to be increased** for ongoing viability.

			Assumption	Cost p.a.
B1	Network	From 87 to ~200 sites covering ~85% of Australia	113 sites @ \$2.0m grant (excl. establishment), noting many sites are state conversions	~\$225m
B2	Capacity	Add 2nd GP and RN at “peak” times	~50 sites @ \$900k grant⁸	~\$45m
B3	Regional & Rural Funding Equity	Provide equivalence of funding to maintain service sustainability	~27 sites @ \$400k grant	~\$10m
				~\$280m

⁵ RNZCUC & Clearwater research

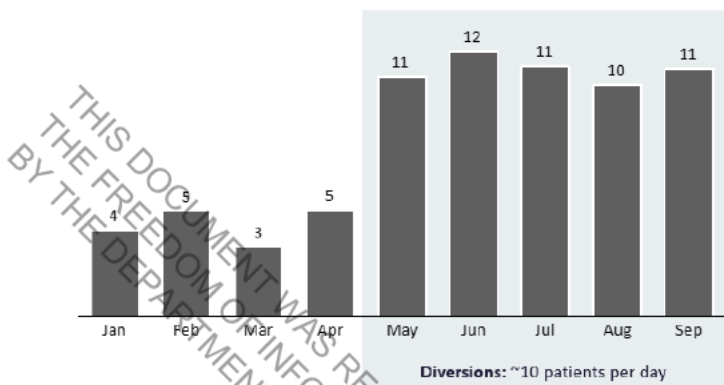
⁶ Data from ForHealth’s established Victorian Urgent Care Clinics

⁷ The Australian, 19th December 2023

⁸ Assumes 80% uptake of additional capacity grants for “peak” shifts and public and school holiday periods.

Data collected at site level indicates that approximately **50% of MUCCs are materially beyond capacity**. This results in patients being redirected, leading to poor patient experience, clinical outcomes and dissatisfied constituents. The ‘peak’ demand varies depending on clinic, and thus additional capacity funding should be provided, with the clinic able to exercise dynamic workforce allocation in line with community demand. In most cases, **a targeted 4-6hr Doctor & Nurse shift per day would remedy this shortfall**. In the case of Epping MUCC, it currently diverts 10-12 patients per day.

Demand exceeding capacity analysis (Epping MUCC example)



Northside (Kedron QLD) MUCC, in collaboration with Brisbane North PHN, successfully implemented a “12 + 4hr” workforce model, in response to high community demand. This effectively providing an additional 33% of capacity per day. This has resulted in a

- Proportionate (+30%) increase in patients treated per day,
- Reduction in patients ‘turned away’ despite growth in demand over the same period
- Increase in patient experience, reflected in a Google review score of 4.4 (from 2.6 prior to implementation).

Capacity expansion to address community demand (Northside MUCC case study)

