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Explanatory Version

To: The Treasurer
Email: ReformRoundtable@treasury.gov.au

Dear Treasurer,

Thank you for the opportunity to contribute to the national discussion on productivity. I make this submission to draw your attention to the importance of health as the foundation of our national prosperity and growth.

The relationship between economic prosperity and health outcomes at both the individual and population levels are well established. A healthy population is a productive population. Health care spending should be seen as an investment in a healthy and productive population - not as a cost burden. Ensuring that all Australians have access to clean air and water and quality housing is an investment in their health. Climate change, inadequate housing, poor nutrition - and poverty – all are health issues.

We need a robust health care system to meet the challenges of the future. Climate change is already impacting global health outcomes with poorer air quality, heat events, communicable diseases and water and food-borne disease on the rise, leading to increased hospitalisations and deaths according to World Health Organization data. Increased pressure on the healthcare system, combined with new and emerging risks to public health, necessitates a holistic approach to the allocation of every health dollar.

As the safeguard of population wellbeing, our healthcare system is a national asset. Additionally, the health care system - from hospitals to allied and primary health, capital investment, higher education, research and technical innovation and employment – represents a major segment of the economy.

Health spending represents 9.9% of GDP and accounts for 17% of Commonwealth government expenditure. In 2022-23, Commonwealth, State and Territory governments allocated $179 bn to healthcare, including $90 bn on hospital services and $50 bn on primary care - $82 bn of which was spent on chronic health conditions, a large proportion of which are preventable. The sector employs 690,000 registered professionals, and a total of 2.1 million people in the broader care economy.

As a major contributor to Australia's economic activity and population well-being, our health care system requires constant review to ensure it is efficient, equitable, and delivers great outcomes. Investment in primary care, preventive healthcare, and mental health services will ensure the better health and greater productivity of all Australians.

Acknowledging that the health sector is multi-faceted, I note here five priority areas where there is obvious potential for more effective spending of each health dollar, and significant opportunity for economic growth and increased productivity:

1. Medical research
2. Health sector regulation: medical workforce planning and regulation of health professionals
3. Practical placement support for students in healthcare disciplines
4. Private health insurance

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5. Preventive health measures.

1. Medical Research

Are we missing the opportunity to grow our medical research and medical technology sectors to ensure domestic capability and resilience against changes in global supply chains, with additional export potential?

Australia's medical research sector is world-class. Many of our research bodies collaborate globally in public health studies and clinical trials. The sector has untapped potential for growth and should be recognised as a net economic contributor which also contributes to population wellbeing and health security.

The percentage of GDP allocated to research and development funding in this country dropped from 2.3% in 2009 to 1.7% in 2022 - its lowest level in 20 years. The success rate of National Health and Medical Research Council grants is 10-15%; for some classes of Medical Research Future Fund grants, it's less than 4%. In early 2025 the Australian Association of Medical Research Institutes reported that, without more support, many of its members would no longer be financially viable in 5 years.

The Albanese government's 2023 decision to not engage with the EU's Horizon Europe initiative cost our researchers potential access to a massive funding pool and opportunities for international collaboration. Association with Horizon Europe would give Australian researchers access to a mega-fund and support international collaboration on key sectors, including health and the environment, at a time of increasing global geopolitical instability and uncertainty.

Additionally, over $368 million in research funding has been withdrawn from Australian research facilities this year due to executive decisions in the United States of America – at a time when our medical research institutes were already under pressure to meet ongoing overheads.

The Medical Research Future Fund (MRFF) was established for the purpose of providing an ongoing funding stream for medical research and medical innovation in perpetuity. Since 2015, the fund's investments have earned $6.4bn, but only $3.15bn has been disbursed; the Fund's balance has increased from its target of $20bn to over $24bn. The MRFF Advisory Board advised that there was $973 million available for disbursement in 2024-25; only 41% had been disbursed by end March 2025. In recent years, and in the forward estimates, the government has limited annual disbursements from the MRFF to $650 million. Those unspent MRFF funds represent $3 billion in opportunity costs.

The government has commissioned a National Health and Medical Research Strategy, but this important work won't be finalised until 2026 at the earliest. In the meanwhile, the government is sitting on hundreds of millions of dollars which could immediately be used to support a vital sector which is under acute financial strain. Australia sees a return of $3.90 for every $1 invested in health and medical research. By not using funds already available- funds which are literally in the bank already - we are throwing away the potential economic and social benefits of increased investment in this sector.

To that end, I encourage the government to:

1) ***immediately review its disbursements from the Medical Research Future Fund.***
2) ***reconsider its decision not to engage with the Horizon Europe research collaboration initiative.***

2. Health sector regulation

How can we better align the supply of healthcare professionals with geographical, and specialisation demands and remove duplication in the registration process?

a. Medical workforce planning

There is a significant gap in the national architecture around health care workforce strategy and reform. There is no channel or mechanism for identifying current or future workforce deficiencies, for setting policy direction and priorities around these, for coordinating actions required across the jurisdictional health systems at a national level and within the National Registration and Accreditation Scheme (NRAS), or for reporting on delivery of agreed priorities.

Despite the significance of our healthcare workforce to national wellbeing and to our economy - and despite a plethora of existing regulatory and advisory bodies - Australia lacks a single body to oversee medical workforce planning.

Australia's medical workforce is supplied through the domestic training of local and international students, and through immigration. The pathway to independent practice as a vocationally recognised specialist involves multiple jurisdictions, portfolios, regulators, public and private employers. The system lacks transparency and oversight regarding who ends up where, doing what work - and where the gaps are. This has obvious implications for health outcomes and, hence, sectoral productivity.

The existing Health Workforce Taskforce is not designed for, or tasked with, development of the national workforce strategic directions and priorities; nor is it accountable for the actions of the NRAS. Because health regulation operates at a state and territory level, new initiatives must be legislated in multiple jurisdictions.

This gap has been identified by multiple inquiries, including the Snowball Review, the 2017 Accreditation Systems Review, and, most recently, the 2021-31 *National Medical Workforce Strategy,* which called for creation of joint medical workforce planning and advisory structures with sufficient authority and expertise to make recommendations in relation to the size and structure of the national medical workforce.

Similar workforce reform is being contemplated in both the aged care and disability sectors following Royal Commissions into those sectors. The childcare sector also requires significant regulatory reform. There is an emerging patchwork of sector-specific workforce reform within the various care sectors. Consideration should be given at a national level to a consistent or single integrated model of regulation, applicable across all these sectors, to deliver more effective and efficient quality assurance and regulation of their workforces.

b. Regulation and oversight of health professionals

The National Registration and Accreditation Scheme (NRAS) registers 16 health professions in Australia. Each of these also has a national board which oversees professional registration, standards, codes, and guidelines.

The Australian Health Practitioner Regulatory Agency (Ahpra) administers the NRAS, manages registrations, and provides administrative support to the national boards. It is responsible for 960 000 health practitioners across the 16 professions.

There are significant flaws in the National Registration and Accreditation Scheme which result in increased bureaucracy, reduced transparency, and decreased productivity. In an interim report of a current review, the Complexity Inquiry by Ms. Sue Dawson, the deficiencies of the NRAS were described thus:

> *At the heart of complexity of the National Scheme is a lack of clarity and no shared agreement about what is most necessary and important in health professions regulation, at any point in time and over time. There is not an overarching framework for the regulation of health professions.*

Since Ahpra was established in 2010, it has been the subject of no fewer than 26 separate reviews and parliamentary enquiries highlighting inconsistencies, duplication and gaps in its services, including:

- Ahpra is not a federal agency. It was established by the Health Practitioner Regulation National Law as enacted under separate state and territory legislation as an independent statutory body. NSW and Qld operate as 'co-regulated' jurisdictions with Ahpra, remaining in the scheme only for the purpose of the

national register. Effectively, therefore, only 50% of Australia's doctors are covered by the 'national' health regulation agency.

- There is no single health minister or health department responsible for the scheme. Ahpra reports to nine different health ministers.

- The division of responsibilities between Ahpra and the Medical Board of Australia (and other national boards) is often unclear to medical professionals and to the public.

Reform of the NRAS should occur within a broader national health reform agenda. The federal government's ongoing attempts to streamline licensing and approvals for overseas trained professionals, and to increase the scope of practice of health professionals of varying disciplines, must be accompanied by effective measures for supervision, placement, regulation, support, and quality control.

I urge the government to:

1) ***Respond to the sector's call for an independent national health workforce planning agency.***
2) ***Expedite review and reform of Ahpra to reduce red tape and create a national overarching framework for regulation of health professions.***

3. Support for practical placements for students in healthcare disciplines

Are we failing to capitalize on investment in education by excluding students from the professional workforce due to barriers to practice placements.

The Commonwealth Prac Payment program which commenced on 1 July 2025, arose in response to a recommendation in the *Australian Universities Accord* to reduce the financial hardship and placement poverty caused by mandatory unpaid placements. That recommendation suggested that financial support should include funding by government for "*the nursing, care and teaching professions*", and funding by employers generally (public and private) for other fields.

As of 1.7.2025, the Albanese government has initiated the scheme for students of nursing, midwifery, teaching, and social work, without a clear rationale for excluding students in other care disciplines.

Practice placements can be very burdensome for students. Optometry and medical imaging students must undertake a full year of unpaid full-time training: physios, occupational therapists, podiatrists, speech pathologists and others are required to complete 1000 hours or more in unpaid placements. During these placements, the costs to students are both direct (e.g. travel, accommodation, uniforms, equipment, professional registration, and insurance) and indirect (e.g. loss of income, childcare costs, interest payable on debts to support placement). Those costs are often greater for students from rural and regional settings. They can be a significant obstacle to completion of training by those from First Nations and vulnerable backgrounds. They can be more challenging for women because women are more likely to have dependents and other care responsibilities.

The government should extend financial support for practice placements to students from all health care disciplines, on the basis of the existing workforce shortages in virtually all disciplines, (as identified in the Jobs and Skills Australia 2024 Occupation Shortage List), and given the impact of placement poverty on placement and degree completion and on the future workforce. This funding should align with the *National Allied Health Workforce Strategy,* which is currently under development, and with improvements to national medical workforce planning as outlined above.

It's a false economy to force students to defer studies or to go part-time to cover the cost of their practice placements - knowing that in many cases such decisions are followed by non-completion of studies - when we've already invested in those students' studies, and our nation needs the skillsets they're acquiring.

I urge the government to immediately extend financial support for practice placement to students from all healthcare disciplines, to address the significant workforce shortages across Australia and improve the rate and speed of completion of degrees and diplomas by students in the healthcare sector.

4. Private Health Insurance

Do we have the right settings on tax incentives and rebates for private health insurance?

The Commonwealth Government's contribution to the private health sector will approach $8 billion in the next year through rebates on private health insurance (PHI), which currently covers 15 million Australians. Government also intervenes in the sector through tax regulations designed to penalise medium and higher income earners for not taking out PHI, by application of the Medicare Surcharge Levy.

The rationale for continuous allocation of tax funds to private health insurance assumes two public benefits:

1) Increased access to health care products and services, leading to improved health standards across the population.
2) That additional capacity in the private sector relieves pressure on the public sector and reduces wait times for public patients.

There are serious questions about whether these benefits are being realised, including:

- Evidence that the government contribution derives less than $1 in value for every $1 spent on private insurance rebates – suggesting that those funds could be more efficiently allocated in direct delivery of health services through the public system, which would also be more equitable.
- Evidence that waitlists for elective surgery in the public system continue to grow year on year, with negligible impact from private health services.
- The fact that the private sector does not add capacity but rather competes with the public sector for a limited workforce, driving up costs.
- Private health services remain costly, with a proportion of consumers taking out PHI due to tax settings but electing not to use it because of persistently high out-of-pocket costs.

Given the size of this investment, the purpose of private sector subsidies requires a clearer statement of the objectives of private health insurance subsidies, and evaluation of their outcomes.

5. Preventive health - dental care

Are we fully realising opportunities to redirect spending to preventive health measures with downstream savings on chronic health, acute care and avoidable hospitalisations?

The National Preventive Health Strategy 2021-2030 sets out the benefits of preventive health measures. While the strategy primarily targets important aspects of public health, it can be expanded to identify those aspects of healthcare that demonstrate a high level of preventative value. In 2023, the Department of Health and Aged Care reported that every dollar spent on preventive care returned $14 in health care savings - and yet we spend less than 2% of our health budget on public health.

Oral health and dental care are obvious examples of this principle. The exclusion of dental care from our Medicare system is a historical anomaly which should be urgently addressed. Nearly one in five Australians are being forced to defer dental care due to its cost. This is a false economy: more advanced dental pathology often causes systemic health problems and ultimately necessitates more expensive, emergent care - including public hospital stays. In recent years government-funded dental programs have largely focused on high-cost services for acute conditions, rather than more cost-effective prevention strategies.

A recent study by the European Federation of Periodontology identified the economic benefit of preventative approaches to oral health. It noted that the global prevalence of dental caries and severe periodontitis

surpasses that of mental disorders, cardiovascular diseases, diabetes, and cancer. The Australian Institute of Health and Welfare reported that in 2022-23 about 87,400 hospitalisations for dental conditions could potentially have been prevented with earlier treatment.

There are two dimensions to be considered; the types of dental services that have a strong evidence base for prevention of complex treatments and avoidable hospitalisations, and the appropriate funding mechanism for these services.

An incremental approach to expansion of government-funded oral health services by demographic group and service type, with a focus on prevention, will provide both the evidence base for further expansion and an opportunity to immediately realise savings in acute care. This could be achieved in the first instance by facilitating access to private providers, similar to the CDBS, while building the dental workforce to accommodate additional demand.

Two obvious target groups would be those with the highest presentation of preventable treatments:

1) Pre-school and primary school aged children, for whom establishment of good oral health would have lifelong benefits, including decreased risk of stroke, cardiovascular diseases and diabetes in adult life.
2) Seniors, who face significant financial barriers due to the high cost of dental care and current limits on public dental services.

I urge the government to focus on the cost of preventable dental problems, and the benefits of preventive health measures for dental and oral health care, as a rationale for targeted expansion of publicly funded dental health care.

Thank you for considering this submission.

Dr Monique Ryan MP
Member for Kooyong