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Two Decades of Primary Care Funding in Australia: A Descriptive Time-Series and Distributional Analysis

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ABSTRACT

Objectives: To examine two decades of Australian expenditure trends across components of primary health and to assess whether recent expenditure changes have been equitably distributed.

Study Type: Descriptive modelling using standardised framework for classifying primary care expenditure.

Setting: Australian public and private health expenditure data (2002–03 to 2022–23) were disaggregated into: broad primary health care services (Tier A); direct primary care, predominantly funding general practice (Tier B); and funding for enhanced primary care for people with greater needs (Tier C). Distributional analysis was conducted across geographies.

Participants: No individual participants; analysis used aggregated health expenditure data across 327 Statistical Area Level 3 geographies.

Main Outcome Measures: Proportions of total and public expenditure allocated to each tier; equity in public Tier B and Tier C spending across areas, assessed using standardised slope indices.

Results: The share of total health spending allocated to primary care declined over the period. Tier A spending declined from 36.3% to 33.0% of total health spending; Tier B fell more sharply from 8.0% to 5.5%; and Tier C remained flat at 0.7%. Public spending trends were similar, but declines were more muted, with Tier C unchanged at 1.0%. Public spending on Tier B was 13% higher in the most disadvantaged areas than in the most advantaged areas in 2013–14; by 2023–24, this declined to 7%. Public Tier C spending remained progressive at 35% higher in the most disadvantaged areas, but decreased from 51% over the decade. Exploratory multivariate analyses suggested that Tier C spending was more redistributive than Tier B after accounting for need.

Conclusions: Data indicate that primary care has declined as a funding priority in relative terms in Australia, and investment in high-value care has remained stagnant and appears increasingly less redistributive. These patterns may have implications for health equity.

JEL Classification: General medicine, Health services administration

1 | Introduction

Strong primary care systems are the foundation of effective and equitable health systems [1]. International evidence shows that investment in primary care improves outcomes, promotes equity and enhances health system productivity by reducing hospitalisations and enabling a more efficient use of resources [2–4]. Reflecting this evidence, the direction of health reform in Australia and abroad has ostensibly aimed to shift healthcare from hospitals to primary and community settings, with the goals of improving health outcomes, strengthening prevention and ensuring the financial sustainability of health systems [5–9].

Plain Language Summary

The Known

Strong primary care systems improve outcomes and equity, but in Australia, despite repeated policy reviews and reform proposals, the fiscal priority given to general practice and enhanced primary care for complex and chronic conditions has remained unclear.

The New

Using a standardised model of primary care expenditure, we show that over two decades, the share of health spending on primary care has declined. Investment in enhanced care has remained stagnant at ~1%, and equity gains from redistributive spending have weakened.

The Implications

Without deliberate reallocation, Australia risks underfunding high-value primary care, limiting efficiency, worsening inequities and undermining system sustainability.

The focus on primary care is particularly important in a tax-funded, federated health system such as Australia's, where responsibilities and expenditure on health are shared across national and state governments, private insurers and individuals, making it difficult to understand how much is actually spent on specific components of care [10]. Australia's universal health insurance scheme, Medicare, funds free care in public hospitals for public patients and subsidises access to out-of-hospital medical care through the fee-for-service Medicare Benefits Schedule. For most Australians, general practice is the main provider of primary care, with nearly nine in ten people visiting a general practitioner each year at an average of approximately seven visits [11]. At the system level, about 90% of Commonwealth funding to general practices is generated via Medicare fee-for-service, with the rest generated mainly via block payments (Practice Incentives Program, PIP; and Workforce Incentive Program, WIP); practices also receive patient out-of-pocket payments [12].

Recent reforms to strengthen primary care in Australia have included the establishment of a network of urgent care clinics, increased Medicare funding to support bulk-billing (where providers bill Medicare only, with no gap payment), and changes to funding for chronic disease management and mental health services [12, 13]. Yet there is limited public evidence on how such reforms are reshaping the distribution of funding towards high-value care or simply reinforcing existing structures. To remedy this gap, this analysis examines long-term trends in primary care financing in Australia relative to total health expenditure, the priority given to enhanced primary care, and whether the funding distribution risks exacerbating socio-economic disadvantage.

2 | Methods

This was a descriptive modelling study using secondary analysis of routinely published, aggregated Australian health expenditure data, combining a national time-series by financial year (2002–03 to 2022–23) with repeated cross-sectional Statistical Area Level 3 (SA3) per capita expenditure comparisons (2013–14 and 2023–24) to assess equity gradients of different types of health spending, using financial years and geographic areas as units of analysis.

BOX 1 | Overview of the Primary Care Spend (PC Spend) Australia model.

Tier A: Broad primary healthcare services. Primary healthcare providers, public health, community health, including health promotion and prevention; diagnosis, treatment, cure and rehabilitation; treatment and management of acute illness, chronic illness and disability; palliative care; community health programmes.
Tier B: Direct primary care (subset of Tier A). All spending on services delivered by primary care professionals including activities of family physicians, general practitioners, primary care nurses, community-based physician assistants and community-based nurse practitioners.
Tier C: Enhanced primary care (subset of Tier B). All spending on primary care provided in the context of the four Cs (first contact, continuous, comprehensive, coordinated care), including physician-led health assessments, medication management reviews, creation and review of treatment plans and coordination of care for people living with complex health conditions who require multidisciplinary, team-based care from a general practitioner and at least two other providers.
*Adapted from Wright et al. 2025 [14].

We applied the recently developed Primary Care (PC) Spend (Australia) model, which adapts an international framework for the Australian context [14]. The model defines three tiers of care (described in Box 1).

Tier A represents the broadest primary health care expenditure, incorporating most care delivered in community settings beyond hospital and specialist referral. Tier B represents direct primary care expenditure, most of which relates to funding for Australia's 7000 general practices and Aboriginal Community Controlled Health Organisations [11].

Tier C represents enhanced primary care and the most advanced and potentially impactful form of primary care delivery. Such care is characterised by the 'four Cs' of high-quality primary care: first-contact access, continuity, comprehensiveness and coordination [15, 16]. These features are critical for managing chronic conditions, supporting preventive care and improving patient experience and outcomes (e.g., reduced hospitalisation, lower mortality and improved health equity [17, 18]). Unlike Tier B services, which often involve episodic or transactional encounters, Tier C funding targets patients with more complex care needs and incentivises long-term and team-based care. In the Australian context, this includes services such as GP management plans (now referred to as GP chronic condition management plans), team care arrangements, health assessments, medication management reviews and other Medicare-funded

activities designed to coordinate care for people with chronic or complex conditions.

We drew on multiple national data sources to construct a time-series of health expenditure in current dollars across the three tiers [14]. To assess patterns of fiscal priority over time, we calculated annual proportions of total and public health expenditure allocated to each tier. The national time-series comprised 21 financial years (2002–03 to 2022–23). The distributional analysis used SA3 per capita expenditure estimates for 327 SA3s in both 2013–14 and 2023–24; 9 SA3s were excluded across both years due to incomplete data. Aside from these exclusions, there were no missing values in the dataset.

Tier A data were derived from the Australian Institute of Health and Welfare's (AIHW) 'primary health care' expenditure category, published annually in the Health Expenditure Australia reports, typically featured in 'Table A3: Total health expenditure, current prices, by area of expenditure and source of funds, [year]' or in the corresponding data cube [19–21]. This category includes services provided in community and non-hospital settings, such as general practice, community health, dental services, pharmaceuticals and public health activities and excludes referred medical services such as specialists and pathology.

Tier B data, also from the same series of AIHW reports and the same table or data cube, were measured using the 'unreferred medical services' category. This mainly consists of general practitioner (GP) consultations, bulk-billing incentives and related activity. The category excludes referred specialist care, diagnostic imaging, pathology, the PIP [22] and other enabling or extended care components that fall within broader definitions of primary care services. We treat this tier as the core representation of funding for GP-led care.

Tier C data were derived from two Medicare Benefits Schedule-related datasets published by the AIHW [23, 24] using the 'enhanced primary care services' category, summing nationally for 'All persons'. This includes services such as care planning, health assessments, medication reviews and coordinated, team-based care for people with chronic or complex health conditions.

To examine distribution patterns of primary care investment for Tiers B and C, we used per capita expenditure data at the SA3 level from AIHW in 2013–14 and 2023–24 [23, 24]. SA3s are geographic units defined by the Australian Bureau of Statistics, representing regions with populations typically ranging from 30,000 to 130,000 people. These units are designed to reflect functional communities and are widely used in health and social data reporting.

Due to data availability at the area level, the distributional analysis for Tier B is proxied by the category 'GP attendances (total)', which includes standard, after-hours and telehealth consultations. Using a proxy is a weakness in the analysis, but while narrower than the full national definition of Tier B for unreferred medical services, the measure provides consistent and geographically disaggregated estimates over time. Access to expenditure data on PIP would improve the analysis as the programme provides public incentives to general practices to support quality of care improvements, particularly in areas such as chronic disease management, data reporting and preventive health.

To assess equity, we linked 327 available SA3 expenditure estimates to the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD), which is a measure of socio-economic status (SES), published by the Australian Bureau of Statistics. IRSAD scores were converted to population-weighted relative ranks from 0 (most disadvantaged) to 1 (most advantaged). To account for changes in area-level socio-economic status over time, the relative socio-economic ranks were assigned based on 2016 IRSAD scores—with 2016 being the midpoint year between comparison periods, as suggested in the literature [25].

The Slope Index of Inequality (SII) was then calculated for each tier and year, representing the modelled difference in per capita spending between the most disadvantaged and most advantaged SA3s, standardised by the national average programme expenditure [26]. This enabled consistent comparisons of progressivity—the extent to which spending is disproportionately concentrated in areas of different SES levels—over time and across tiers.

Although health need is a critical consideration in equity analysis, more direct measures such as age-standardised expenditure and chronic illness prevalence were either unavailable or limited in temporal coverage for this analysis. Such measures may also understate unmet need in disadvantaged areas. We therefore used SES as the primary equity axis, consistent with established frameworks that view social position as a fundamental driver of both health need and structural access to care [27, 28]. Assessing progressivity by SES complements need-based approaches and reflects the broader goal of health systems to reduce avoidable inequality.

As an exploratory sensitivity analysis, we fitted cross-sectional linear regression models for the most recent period (2023–24) to examine whether the observed SES gradient persisted after adjustment for selected demographic and need-related area characteristics. Separate models assessed the association between SA3 standardised public Tier B proxy and Tier C per capita expenditure and 2021 IRSAD relative rank, remoteness, census-derived chronic illness prevalence and the proportion of the population older than 65 years.

Analysis was conducted in Microsoft Excel Version 2601 Build 16.0.19628.20132 and R studio 2024.12.1 Build 563. The study is reported in accordance with the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology).

3 | Results

Analysis of 20-year trends shows a persistent decline in primary healthcare's share of total health expenditure (Tier A), a decline in GPs and other direct primary health services' share (Tier B) and a stagnant share for enhanced primary care services (Tier C) (Figure 1). Although Tier A expenditure grew in nominal terms over the period (Table 1), its share of total

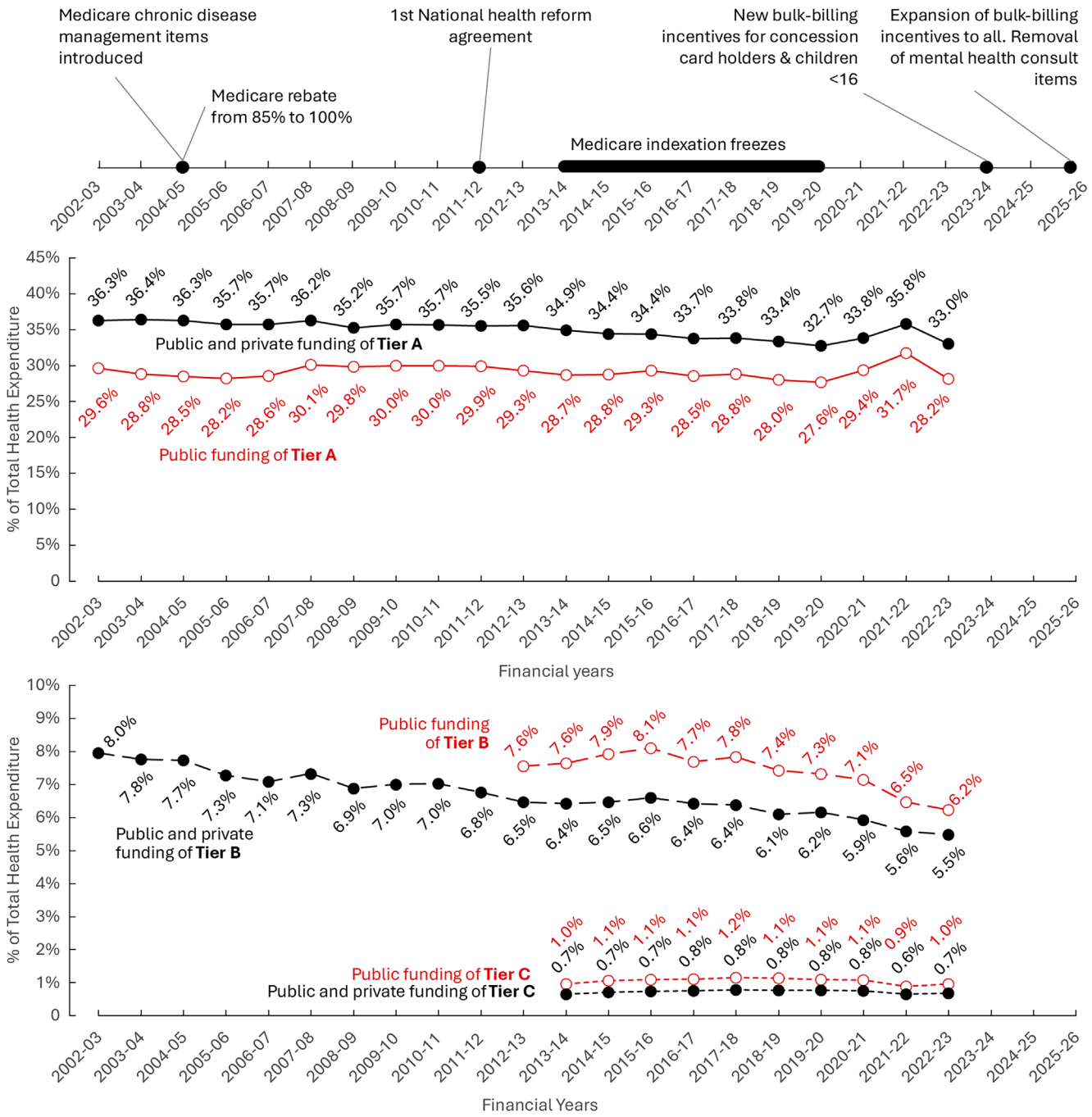

FIGURE 1 | Proportion of total health expenditure on tiers of primary care, by broad source, 2002–03 to 2022–23 and policy timeline. *Source:* Authors' analysis of Table 1. Medicare indexation freeze ran from November 2013 to July 2018, with staged reinstatement from 2017 (bulk-billing incentives), 2018 (standard general practitioner/specialist attendances), 2019 (allied health) and 2020 (diagnostic imaging and remaining items). Bulk-billing incentives (extra payments to general practitioners for bulk-billed patients) were expanded in 2023 to concession card holders (low-income, pensioner and welfare recipients) and children under 16 years.

health spending fell from 36.3% in 2002–03 to 33.0% in 2022–23, temporarily surging during the COVID-19 pandemic to 35.8% in 2020–21. The *relative* declines reflect faster growth in other parts of the health system, particularly hospital and acute care expenditure, including during the COVID-19 period.

The decline is more pronounced in Tier B (direct primary care services, based on AIHW's unreferred medical services data), which fell from 8.0% of total health expenditure in 2002–03 to 5.5% in 2022–23. As a proportion of Tier A, Tier B also declined from 22% to 17% of expenditure, suggesting that even within the primary health care budget, GP-type services are being de-emphasised.

Tier C (enhanced primary care), first identifiable in expenditure in 2013–14 data, has remained consistently low, between 0.7% and 0.8% of total health spending, in contrast to recent reform intention to expand coordinated and comprehensive care.

TABLE 1 | Health expenditure totals (current dollars, millions).

	Financial years																					
	2001–02	**2002–03**	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**	**2010–11**	**2011–12**	**2012–13**	**2013–14**	**2014–15**	**2015–16**	**2016–17**	**2017–18**	**2018–19**	**2019–20**	**2020–21**	**2021–22**	**2022–23**
Public + private																						
Total health care expenditure	64,046	65,455	69,847	76,584	83,028	91,148	100,727	112,052	120,461	130,452	141,532	146,376	153,956	160,766	169,252	179,723	185,090	195,907	203,330	222,196	243,116	252,515
Total recurrent health care expenditure		62,013	66,672	72,765	78,766	86,164	95,725	106,205	114,985	123,302	132,939	137,769	144,842	151,200	159,047	167,055	175,812	185,460	192,185	210,463	231,392	237,689
Tier A		23,755	25,440	27,784	29,673	32,544	36,500	39,497	43,023	46,513	50,242	52,040	53,697	55,303	58,207	60,638	62,594	65,355	66,534	75,127	86,993	83,322
Tier B		5206	5426	5921	6041	6458	7383	7713	8439	9162	9577	9472	9886	10,391	11,179	11,542	11,816	11,943	12,527	13,179	13,576	13,842
Tier C													1004	1131	1243	1356	1465	1524	1569	1702	1592	1756
Public only																						
Total health care expenditure	44,089	47,892	50,459	56,109	60,046	65,603	72,369	79,652	85,717	91,725	99,607	100,058	104,452	107,533	114,323	123,923	126,298	133,199	142,654	155,987	176,001	178,706
Total recurrent health care expenditure	42,413	46,785	49,382	54,918	58,981	64,358	71,152	78,563	84,847	90,064	92,476	94,887	99,620	103,327	110,466	116,467	122,333	128,634	137,896	150,505	170,848	171,833
Tier A		14,185	14,528	15,985	16,952	18,749	21,773	23,742	25,696	27,493	29,757	29,334	29,993	30,928	33,517	35,342	36,404	37,279	39,430	45,801	55,860	50,343
Tier B												7563	7983	8520	9261	9524	9895	9900	10,456	11,151	11,377	11,129
Tier C													1012	1140	1254	1367	1452	1510	1554	1685	1572	1724

When examining public expenditure alone, the trends are more muted but still point to a sustained decline in fiscal prioritisation of the delivery of primary care. Tier A public spending remained steadier as a share of total public health expenditure, declining only slightly from 29.6% in 2002–03 to 28.2% in 2022–23. In contrast, Tier B public spending declined more clearly, from 7.6% to 6.2% over the same period, highlighting a gradual shift away from direct GP-type services within public funding. Tier C saw a modest nominal increase but remained flat in proportional terms, comprising only 1.0% of public health expenditure in 2022–23, as it did a decade earlier. Despite policy commitments to enhance coordinated care, public investment has not shifted meaningfully towards these higher-value care models.

Our distributional analysis provides additional insights into the socio-economic gradient of spending by source, tier and time. Figure 2 shows how public expenditure on Tier B is more progressive than total (public and private) expenditure, Tier C public expenditure is more progressive than Tier B public expenditure and Tier C public expenditure was more progressive in 2013–14 than in 2023–24. In other words, public spending on primary care—particularly on complex care—is typically more concentrated in poorer areas, potentially partially offsetting the regressive distribution of private spending on primary care specifically and health spending more broadly. Yet evidence here shows that the magnitude of this redistributive pattern has weakened over time.

These socio-economic gradients in spending were quantified (see Table 2) using 2016 IRSAD ranks. In 2023–24, the most socioeconomically disadvantaged areas received about 35% more public Tier C spending per capita than the most advantaged areas, down from 51% more in 2013–14. Public Tier B spending declined from 13% higher in areas with most disadvantage in 2013–14 to around 7% higher in 2023–24, and the latter was no longer statistically distinguishable from zero. Total Tier B spending showed little socioeconomic gradient in 2013–14 but was regressive in 2023–24, with around 7% higher expenditure in the most advantaged areas, a difference that was statistically distinguishable from zero. The findings suggest that the weakening redistributive effect of public primary care spending is no longer offsetting the regressive nature of private expenditure to the same extent, contributing to a more regressive overall distribution of direct primary care spending. These shifts may reflect a combination of structural design and behavioural factors in healthcare use, including service availability, claiming incentives and out-of-pocket affordability. Such a result could also occur due to declining health inequalities by SES, but evidence suggests that the opposite trend is true [29].

To assess whether these distributional patterns simply reflected underlying need, exploratory supplementary multivariate regressions were further conducted, but only for public expenditure in 2023–24. The supplementary results suggest that public expenditure remains modestly higher in more disadvantaged areas, with Tier C appearing more redistributive than Tier B. Expenditure was higher in areas with a larger proportion of older residents, while no clear relationship was observed with chronic illness prevalence, possibly due to collinearity with demographic and SES variables. After accounting for these factors, more remote areas continued to see less per capita funding—consistently so for Tier B, and more modestly for Tier C, where only some remoteness categories differed from metropolitan areas (see Table S1). Although exploratory, these results suggest that further investment in Tier C may promote a more equitable distribution of primary care spending.

4 | Discussion

Despite more than a decade of policy debate about strengthening primary care [7, 30], Australia has seen a steady decline in the priority given to primary care within overall health spending. Although nominal investment has risen, the share directed to general practice and other direct services has fallen, while spending on enhanced primary care has remained stagnant at around 1% of public health expenditure.

With an accelerating level of policy attention on primary care [12, 31], it is important to continue to monitor the spending impact of reforms. This will include, for example, tracking how recent changes to Medicare items related to chronic disease management and dedicated mental health consultations affect fiscal resource allocation to high-value, enhanced primary care services.

The distributional findings highlight the potential for equity gains from health spending. Public expenditure on primary care, particularly enhanced care models, tends to be more concentrated in disadvantaged areas, although this redistributive effect has weakened over time, which may be due to increased access and affordability barriers over the decade to 2024. Areas with lower SES continue to receive more public funding for enhanced primary care, but the gradient is flatter than a decade ago, and remote communities continue to receive less per capita investment. Without deliberate reallocation and continued focus on access and affordability, these equity gains may be difficult to sustain.

In the context of an ageing population, strengthening primary care is not only a matter of equity but of sustainability, with previous evidence showing that it can reduce avoidable hospitalisations and contain costs while improving chronic disease outcomes [1, 32, 33].

International comparisons suggest that Australia is behind. Australia spends a smaller share on primary care than the Organisation for Economic Cooperation and Development average and lags in continuity and financial protection [34]. One remedy could involve setting targets [14]. Several US states have adopted primary care expenditure targets to anchor health investment decisions [35].

Emerging reforms, such as MyMedicare and enrolment-linked incentives [36], offer a pathway towards models that emphasise continuity, coordination and comprehensive care. However, any funding reforms risk further underfunding the existing high-value models of care if policy rhetoric is disconnected from actual spending patterns.

This analysis is constrained by the lack of detailed and disaggregated expenditure data. The categorisation of services into specific tiers relies on item definitions that have evolved over time, meaning that some observed trends may partly reflect changes in programme design or classification rather than shifts in fiscal priority.

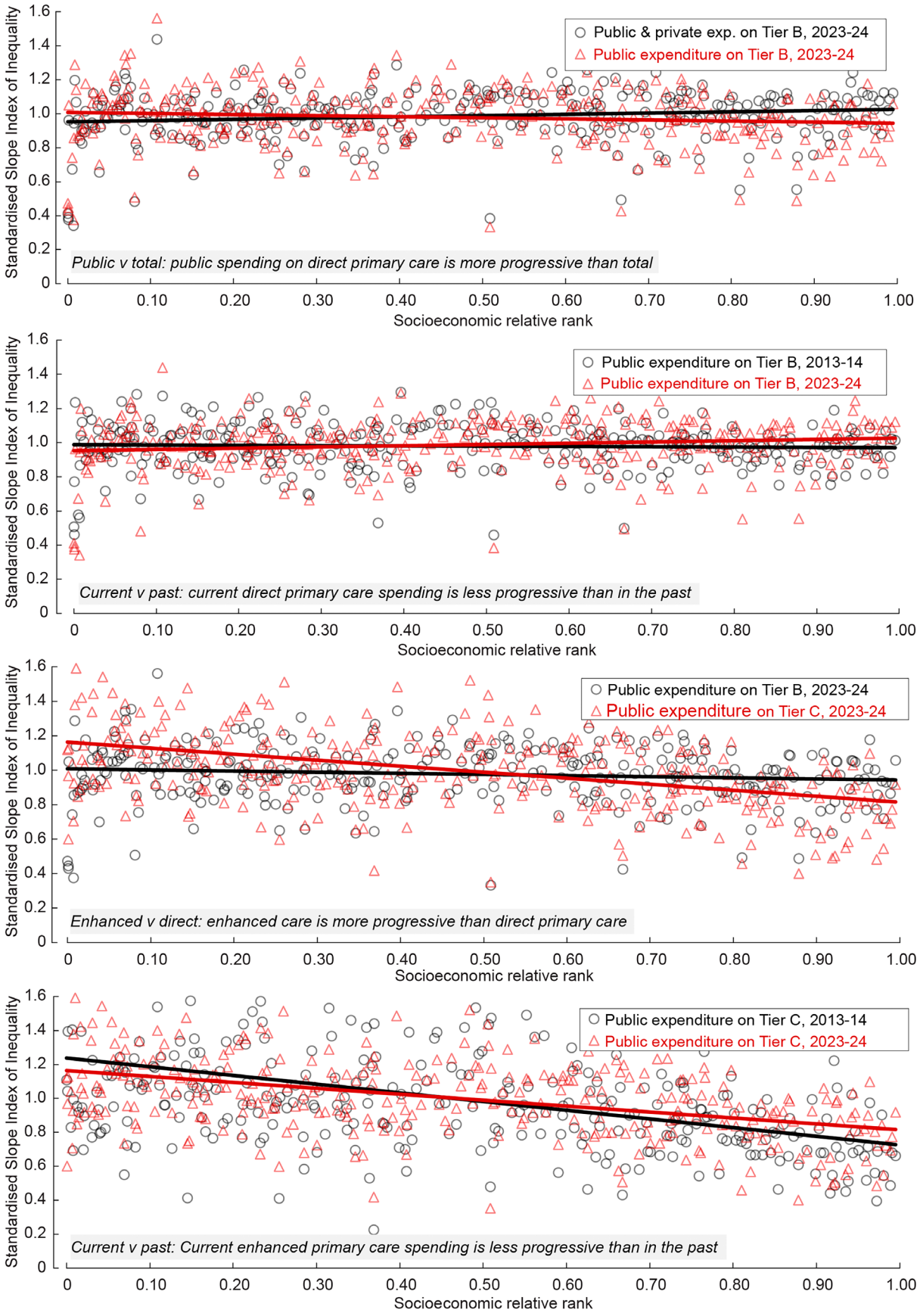

FIGURE 2 | Legend on next page.

FIGURE 2 | Selected slopes of inequality of expenditure by source, tier and time. Standardised Slope Index of Inequality shows the absolute difference in per capita expenditure between the lowest (left) and highest (right) socio-economic status areas, adjusted for average program cost. Socio-economic relative rank is the rank of Statistical Area Level 3 geographies from low to high (0 to 1), adjusted for population size and based on 2016 Index of Relative Advantage and Disadvantage. As operationalised in the present analysis, a downward slope denotes greater spending in areas with more disadvantage compared to areas with more advantage.

TABLE 2 | Estimated % difference in per capita spending (most disadvantaged compared to most advantaged areas).

	2013–14	2023–24	Change in progressivity
Total Tier B	**Neutral: 2%** more in most disadvantaged areas (not significant) compared to most advantaged	**Regressive: 7%** more in most advantaged areas ($p < 0.05$) compared to most disadvantaged	More regressive
Public Tier B	**Progressive: 13%** more in most disadvantaged areas ($p < 0.001$) compared to most advantaged	**Neutral: 7%** more in most disadvantaged areas (not significant) compared to most advantaged	Less progressive
Total Tier C	**Strongly progressive: 50%** more in most disadvantaged areas ($p < 0.001$) compared to most advantaged	**Progressive: 31%** more in most disadvantaged areas ($p < 0.001$) compared to most advantaged	Less progressive
Public Tier C	**Strongly progressive: 51%** more in most disadvantaged areas ($p < 0.001$) compared to most advantaged	**Progressive: 35%** more in most disadvantaged areas ($p < 0.001$) compared to most advantaged	Less progressive

Note: Based on the estimated Slope Index of Inequality (SSI), standardised for average programme cost.

Trends are presented as shares of total health expenditure to capture the relative importance of primary care spending; however, proportional declines do not imply nominal reductions in spending but rather slower growth relative to other sectors, particularly hospitals. Small differences are observed between the estimates reported here for 2020–21 and those previously reported by Wright and colleagues [14]. These arise primarily because the earlier analysis focused on total expenditure, whereas the present analysis distinguishes between total and public expenditure, and because the AIHW has revised historical estimates in more recent multi-year data cube releases, which are more amenable to trend analysis [14]. The possibility of such discrepancies highlights the importance of transparent and consistent reporting of primary care spending across tiers. The potential for such differences underscores the message of this article, that government and data custodians must do more to transparently report primary care spending for different tiers to facilitate adequate monitoring. The supplementary multivariable analyses should be interpreted as exploratory sensitivity checks rather than definitive causal estimates. Future work should incorporate age-standardised spending and include incentive programmes and capital investments to capture the full picture. More broadly, routine public reporting aligned with standardised primary health care categories would enable consistent monitoring of both investment levels and equity impacts.

5 | Conclusion

In applying a standardised primary care spending model, we examined two decades of Australian primary healthcare expenditure and assessed whether recent changes have been equitably distributed. We highlighted a long-term decline in the relative prioritisation of primary care within Australia's health system and particularly low, stagnant investment in enhanced models of care. Although funding for high-value primary care services, such as care planning, is more equitably distributed than funding for general primary care, its reach remains limited and its redistributive impact has weakened over time. As policy attention intensifies, systematic monitoring of resource allocation will be critical to ensure that primary care receives the investment needed to deliver on its promise.

Author Contributions

Rafal Chomik: conceptualisation, data curation, formal analysis, investigation, methodology, visualisation, writing – original draft, writing – review and editing. Shona M. Bates: conceptualisation, methodology, project administration, writing – original draft, writing – review and editing. Michael Wright: conceptualisation, methodology, project administration, writing – original draft, writing – review and editing.

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Disclosure

Not commissioned; externally peer reviewed.

Conflicts of Interest

At the time of writing, the authors were employed by the University of New South Wales International Centre for Future Health Systems, which receives funding from the Ian Potter Foundation. At the time of writing, Michael Wright was appointed as the President of the Royal Australian College of General Practitioners.

Data Availability Statement

This study used publicly available, aggregated data from published sources; no new individual-level dataset was created. All authors had full access to all data (including statistical reports and tables) related to the study. Source extracts used for analysis can be provided by the corresponding author on request. doi:10.5694/mja25.01161.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** mja270210-sup-0001-supinfo.pdf.