



**Aboriginal  
Health Council  
of Western Australia**

# **Inquiry into Rural, Regional and Remote Medicare Access and Funding**

## **Submission**

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## Introduction

The Aboriginal Health Council of Western Australia (AHCWA) welcomes the opportunity to provide feedback to the Inquiry into Rural, Regional and Remote Medicare Access and Funding (the Inquiry).

AHCWA is the peak body for 24 Aboriginal Community Controlled Health Services (ACCHS) in Western Australia (WA). Our Member Services are located across geographically diverse metropolitan, regional and remote locations, delivering a model of comprehensive primary health care that is uniquely positioned to identify and respond to the cultural and health needs of Aboriginal people.

AHCWA Member Services in rural, regional and remote WA utilise the Medicare Benefits Schedule (MBS) alongside essential core funding through the Indigenous Australians' Health Programme (IAHP) to deliver their comprehensive model of care. All of our ACCHS were completely bulk-billing services prior to the 1 November 2025 changes, as access to free health services is central to our model of care.

## Term of Reference (a): Impact of 1 November 2025 Medicare changes

**Positive Incremental Steps:** The introduction of the Bulk Billing Practice Incentive Program (BBPIP) and expanded eligibility for Bulk Billing Incentives are welcome steps toward better support for sustainable primary care services. Early feedback from AHCWA's Member Services indicates increased Medicare payment following the 1 November 2025 changes, which was expected as our services have always been completely bulk-billed. However, we are unable to quantify the full impact of this across WA ACCHS, noting that implementing MBS changes is resource-intensive and takes time and many services have workforce fluctuations which also impact MBS billing.

**The Salaried GP Incentive Conflict:** The 50/50 split for the BBPIP has caused significant confusion, and at times, conflict for ACCHS. Because many ACCHS typically employ General Practitioners (GPs) on a salary (rather than a percentage of their billings alone), and ACCHS are by nature bulk-billing in WA, clear and official guidance from the Commonwealth is required to advise that practices can negotiate for 100% of the incentive to be directed to the service. Additionally, support for ACCHS GPs within this negotiation process is also required.

## Term of Reference (b): Financial sustainability of rural general practices

**The Expenditure Gap:** Aboriginal people experience a disease burden 2.3 times the rate of non-Aboriginal Australians, yet there remains a \$2.6 billion shortfall in Commonwealth health expenditure relative to this need<sup>1</sup>. MBS funding typically accounts for 10 to 15 per cent of revenue for large ACCHS, and significant practice resources are required to facilitate high-quality and compliant billing practices. In the context of current funding settings, MBS

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<sup>1</sup> Measuring the Gap in Health Expenditure: Aboriginal and Torres Strait Islander Australians. May 2022. [https://static1.squarespace.com/static/61b14c4abbc81a1543f55180/t/62789d5f490b3b08b26635d0/1765316316027/NACCHO-and-Equity-Economics-Report-Measuring-the-Gap-in-Health-Expenditure\\_FINAL.pdf](https://static1.squarespace.com/static/61b14c4abbc81a1543f55180/t/62789d5f490b3b08b26635d0/1765316316027/NACCHO-and-Equity-Economics-Report-Measuring-the-Gap-in-Health-Expenditure_FINAL.pdf). (accessed 26 March 2026).



income is an essential component of ACCHS funding, and provides an avenue for ACCHS to increase their service provision to the community in line with the community's priorities. The ACCHS sector's 19(2) exemption, which enables MBS billing in our services, is highly valued.

**The Way Forward:** Block funding of ACCHS through the Indigenous Australians' Health Programme (IAHP) is absolutely essential to enable ACCHS to operate. For ACCHS to overcome workforce instability, support high patient complexity, and continue to increasingly move toward a preventive care approach (which prioritises improved health outcomes and promotes health and wellbeing), increased IAHP investment is urgently required. Many ACCHS have been under-funded through the IAHP for years, limiting the range of services that can be provided and adding further strain to the workforce.

Ultimately, the fee-for-service model which underpins the Medicare system, will never be able to enable the health system to move from a system which treats disease to a system that effectively promotes health and prevents disease. Optimising IAHP funding for ACCHS would demonstrate that block-funding primary care services at sufficient levels to deliver effective comprehensive primary care will effectively prevent disease and promote health.

### Term of Reference (c): Avoidable emergency and hospital admissions

**Chronic Condition Support:** A key strategy for reducing emergency department presentations and hospital admissions (including avoidable readmissions) is improving the management of chronic conditions. This requires a systematic, population-based approach to chronic disease care. ACCHS are already leaders in delivering care through this model. However, recent changes to the MBS, while intended to support such an approach, appear to be primarily focused on encouraging adoption within mainstream general practice, rather than facilitating and strengthening this established model of care within the ACCHS sector.

### Term of Reference (d): Adequacy of Medicare support for mixed-team models

**Team-based Care in ACCHS:** The ACCHS Model of Care is built on team-based, holistic care. This is enabled through IAHP funding, and other sources of block funding, including philanthropic support, and would not be possible through MBS funding alone. The MBS does assist our ACCHS holistic Model of Care by enabling certain team-based care items such as 10987 and 10997 for follow-up services provided by nurses and Aboriginal Health Practitioners (AHPs). Increased remuneration for these types of items can better facilitate sustainable team-based care in ACCHS. A welcome reform would be to enable ACCHS staff, including nurses and AHPs, to access Medicare claimable items within their scope of practice (e.g. cervical screening tests, Implanon insertion etc).

Allied Health services are often embedded within ACCHS clinics, however, under current Medicare rules, a formal written referral from a GP is required for patients to access these practitioners. A more efficient system for ACCHS would enable GPs to refer their patients to Allied Health practitioners that work in their organisation via internal systems. As Allied Health practitioners within an ACCHS can access the Patient Management System, the referral could be brief and collegiate, or could even be facilitated through multi-disciplinary



team meetings within the service. This would avoid an unnecessary administrative burden, which often contributes to delays in care provision and reduced service efficiency. AHCWA recommends introducing an exemption for ACCHS to enable direct access to Allied Health services without the need for a formal written referral.

### Term of Reference (e): Impacts on large corporates vs. community-embedded clinics

**The Throughput Disadvantage:** The current Medicare rules often favour large corporate providers focused on short consultations and rapid patient turnover. In contrast, ACCHS routinely manage intergenerational trauma and complex multimorbidity, requiring longer, more resource-intensive consultations that are not well supported by time-tiered MBS rates. Additionally, small community-embedded practices, including ACCHS, face higher costs for recruitment, travel, housing and locum cover for medical staff.

### Term of Reference (f): Reforms needed to ensure Medicare is fair, workable and sustainably funded

**Renal Dialysis:** Aboriginal people experience an increased burden of kidney disease, particularly in regional and remote areas including end-stage kidney disease requiring renal replacement therapy.<sup>2</sup> To address this crucial need, Pilbara ACCHS are expanding their renal service delivery to ensure culturally safe, on-country renal haemodialysis (Newman is currently in operation, with haemodialysis units under construction at Jigalong and Tom Price). To ensure these clinics operate effectively, there is a need to increase the amount that can be claimed through MBS item 13105. Item 13105 provides a rebate for managing haemodialysis for people with end-stage kidney disease in very remote areas classified as Modified Monash Model 7.<sup>3</sup> This supports patients to stay on-country for treatment which ensures better treatment adherence rates, fewer hospital admissions and a greater life expectancy.

Currently, there is a significant disparity between the rebate and the actual operational costs for dialysis. At present, Medicare provides \$690 per session, whereas the real cost of delivering these vital services stands at approximately \$1,100 per session. According to WA ACCHS, this substantial gap creates ongoing challenges in maintaining sustainable dialysis treatment for communities.

### Term of Reference (g): Any other related matters

**MyMedicare:** The current MyMedicare model disadvantages Aboriginal patients who are mobile between different communities, as a patient can maintain only one MyMedicare registration. This could be overcome by enabling registration at multiple GP providers, including ACCHS.

Additionally, the requirement to nominate a single preferred GP when registering with MyMedicare does not support the ACCHS model of care, which is built upon shared and

<sup>2</sup> Schwartzkopff K.M., Kelly, J., Potter, C. (2020). Review of kidney health among Aboriginal and Torres Strait Islander people. Australian Indigenous Health Bulletin 20(4).

<sup>3</sup> <https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=13105&q=13105>. (accessed 1 April 2026).





team-based care within an ACCHS. This requirement should be removed for ACCHS, with the patient nominating the service as their preferred provider (rather than a named GP).

**COAG Section 19(2) Exemptions and Transparency:** AHCWA is deeply concerned by the granting of COAG 19(2) exemptions to WA public hospital sites without genuine consultation with local ACCHS (contrary to COAG Section 19(2) Exemption guidance<sup>4</sup> and the National Agreement on Closing the Gap Priority Reforms).<sup>5</sup> Furthermore, AHCWA's Member Services report a lack of transparency regarding the Commonwealth requirement for state sites to reinvest 70% of MBS revenue into local primary care. The granting of 19(2) exemptions without appropriate community consultation (including with local ACCHS) risks fragmenting care and undermining the viability of existing ACCHS.

**Assignment of Benefit Modernisation:** The implementation of the modernisation of the Assignment of Benefit process is a source of concern and stress for ACCHS across WA. We continue to wait for information from Patient Information Management Systems providers on how this can be integrated into current workflows. At this stage it seems unlikely that new Assignment of Benefit processes will be ready for implementation on 1 July 2026.

**Patient End Support Services:** New MBS patient end support items, introduced 1 March 2026, are welcome to enable GPs and Nurse Practitioners to claim for face-to-face clinical support during video consultations with specialists, supplementing item 10983 which was already available. However, the requirement for the specialist to also bill a relevant MBS video item restricts utilisation of this support for those who would most benefit. Where patients are referred to public outpatient services (the majority of specialist referrals in ACCHS), the specialist does not bill the MBS and therefore ACCHS are unable to utilise these new items.

## Key recommendations

This Inquiry presents a key opportunity to review rural, regional and remote Medicare access and funding and address key issues regarding Medicare to ensure equitable access to healthcare for rural, regional and remote patients, and particularly for Aboriginal people in line with the Priority Reforms of the National Agreement on Closing the Gap.

As such, AHCWA recommends:

1. Providing clear guidance on BBPIP splits for salaried GPs to support practice sustainability.
2. Increasing block funding of ACCHS via the IAHP to reflect the actual cost of providing complex, culturally safe care and health promotion.
3. Granting ACCHS exemptions from referral requirements to enable direct access to Allied Health services within ACCHS clinics.
4. Increasing the MBS Item 13105 rebate so that it matches the actual cost of dialysis treatment provided to remote patients.

<sup>4</sup> Guide to the COAG Section 19(2) Exemptions Initiative. <https://www.health.gov.au/sites/default/files/2023-10/guide-to-the-coag-section-19-2-exemptions-initiative.pdf>. (accessed 1 April 2026).

<sup>5</sup> National Agreement on Closing the Gap Priority Reform: <https://www.closingthegap.gov.au/national-agreement/priority-reforms>. (accessed 1 April 2026).



5. Reforming MyMedicare to support mobile patients by enabling multiple ACCHS registrations and the removal of the preferred GP nomination.
6. Strengthening COAG 19(2) oversight; ensuring no exemptions are granted without local ACCHS support and inclusion that reinvestment of MBS revenue is transparently reported.
7. Addressing specialist telehealth barriers for rural patients, specifically by revising items that require a specialist to bill Medicare, which prevents access to patient end support items for patients in public outpatient settings.