



A submission from the Sydney School of Public Health, University of Sydney to the Rural and Regional Affairs and Transport References Committee Parliamentary Inquiry: “**Rural, regional and remote Medicare access and funding**”.

From a public health perspective, funding support that improves access to and provision of primary healthcare through Medicare for rural, regional, and remote (RRR) communities is welcome and supported. While general practitioners have a clear role in public health (preventive and primary care), quality care is multi-disciplinary. Good health and wellbeing is possible when residents get the timely and appropriate care they need, from the right healthcare provider, and as close to home as possible.

A number of vital mechanisms and funding initiatives currently support RRR healthcare providers and the provision of primary care. This initiative cannot be at the cost of available and effective funding resources or a reduction of the RRR health workforce.

The changes associated with “Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians” appear to be part of ongoing changes that on 1 November 2025, included increasing bulk-billing incentives, streamlining mental health plans, the greatest permissible gap payment, and contraceptive items.

This initiative has the potential to improve access by addressing barriers associated with *affordability*. Bulk-billing incentives can minimise cost barriers and facilitate RRR residents with personal candidacy to approach appropriate healthcare providers when they need help. Too many RRR residents delay or avoid healthcare because of the financial cost, particularly when there are additional costs they must consider, including travel and time. Additional funding through Medicare that encourages bulk-billing will undoubtedly assist RRR residents (particularly those with a lower socioeconomic status), but uptake is actually subject to practice structures. While some remote communities and private healthcare providers bulk-bill 100% of their services, the November 1 changes may not be sufficient for uptake by other healthcare providers in RRR communities because it may not cover existing costs or income expectations for contracting clinicians. Practices across Australia have contracting clinicians, and bulk-billing is dependent upon full practice support. This complication, in addition to the ongoing Payroll Tax requirements, has created a complex system between RRR practices and the contracting clinicians. The mechanisms for using the Medicare initiatives must not be too difficult to navigate or manage. Financial incentives that support RRR primary healthcare are valuable and necessary, but there may be other health or funding systems-level changes that could have a greater impact on improving access to needed primary healthcare providers and services for residents of RRR communities.

The expressed position of the November 1 initiative within the reference list to acknowledge multi-disciplinary care teams and to incorporate telehealth addresses barriers associated with *availability*. RRR communities are areas of high primary healthcare need that already struggle with the recruitment and retention of an appropriate health workforce. Availability of the healthcare workforce is also affected because more health providers are seeking a sustainable ‘work-life-balance’ that often results in working part-time, increasing the number of practitioners required to meet the workforce need. When RRR residents cannot afford to go to the local general practitioner (or appropriate provider), who may not have an available appointment for weeks or months, they turn to the nearest hospital emergency service. It is unlikely this Medicare initiative will improve practitioner availability, or encourage new practitioners to take up RRR practice, to a degree that would impact avoidable hospital presentations or admissions.



The November 1 initiative also purports to include telehealth services; potentially addressing *affordability* and *availability*. Mental health is a stand-out discipline that has embraced various telehealth models for delivering care, but there are still challenges within the Medicare structure that limit the adequacy and acceptability of Medicare initiatives for telehealth services. Providing a billing structure for telehealth acknowledges the impact of this mode within RRR healthcare but it may not be appropriately addressing practical or contextual delivery modes or models. Support for hybrid models of care, particularly for the more remote regions, may be worth exploring, however, it is important to note that alternative models cannot always replace local in-person healthcare. While many RRR communities acknowledge the value of hybrid and virtual models of care, their already poorer health and greater need is in the balance.

It is necessary to assess the impact of “Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians”.

1. One question is of sustainability. From the consideration of those using the Medicare initiative (the healthcare providers), sustainability may be determined by *affordability* – a two-pronged consideration of whether the financial incentive from Medicare is sufficient to cover existing costs of the clinician and whether it can provide benefit to the practice. Healthcare providers must be able to make a minimum fee for their services to make any incentive worthwhile. If a greater incentive is needed for uptake, it may not be sustainable.
2. A second question is whether the changes can be deemed a success. Presuming use is a signal for access (and the delivery of care), one consideration for determining success of this Medicare initiative is a function of the number of *available* and eligible practitioners, across disciplines, who are using the Medicare incentive in RRR areas since its launch, particularly by providers, and in the practices and communities, where bulk-billing activity was already low. (Noting that it may be too soon to determine success.)
3. Third, is the question of its effectiveness for improving access to services across RRR settings. This involves examining the *adequacy*, *acceptability*, and *awareness* of the incentives from the health professionals and services involved. Details of the Medicare changes are not readily available and the users (eg. practitioners, practices) must be aware of the changes, understand their eligibility and what the initiatives are addressing, how to implement the initiatives, and why using the initiatives will be beneficial. Initiatives that improve access to timely and appropriate healthcare, from the right provider, as close to home as possible, while also enabling candidacy among vulnerable patients, can support good health and wellbeing.