

SUBMISSION

Subject	Submission to the Senate Inquiry into Rural, Regional and Remote Medicare Access and Funding		
Recipient	Rural and Regional Affairs and Transport References Committee		
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1. Introduction: A region losing confidence in the system

Western Queensland Primary Health Network (WQPHN) welcomes the opportunity to contribute to this inquiry.

However, we do so with a growing concern shared across our region: confidence is slipping that the Australian Government will ever implement the structural reforms that rural and very remote communities urgently require.

For two decades, successive inquiries, evaluations, parliamentary reports and Commonwealth reviews have delivered a consistent message:

Medicare, in its current form, does not and cannot meet the needs of rural, regional and remote Australians. That the system fails to deliver access, equity and continuity of services in the bush.

The most recent Medicare changes, while well-intended, have again demonstrated a pattern of metro-centric policy design, insufficient rural stress-testing, and an over-reliance on fee-for-service mechanisms that simply do not work in thin and non-existent markets.

WQPHN urges the Committee to ensure that this Inquiry results in actionable recommendations, not another cycle of diagnosis without implementation.

2. WQPHN regional context: The most at-risk population in the nation

The WQPHN region covers some of the largest, most sparsely populated areas in Australia, with communities classified as MMM 6 and MMM 7. The region spans 954,340 km², representing 55% of Queensland's total land area. Our residents experience:

- The lowest life expectancy in the country
- High burden of chronic disease, preventable conditions and complex mental health needs
- Limited access to general practice, ACCHOs and essential primary care
- Heavy reliance on visiting, locum and fly-in-fly-out (FIFO)/drive-in-drive-out (DIDO) workforce
- Fragmented funding streams that inhibit continuity, coordination, and long-term place-based planning.

Medicare in these communities is no longer a universally accessible system—it is a gap in the system.

3. Response to Terms of Reference

a. Impact of the 1 November 2025 Medicare changes

The changes have had minimal positive impact in WQPHN communities because:

- Fee-for-service relies on patient throughput that is not achievable in remote settings
- Telehealth changes were applied uniformly, without accounting for the trust, literacy and digital inclusion barriers and the lack of connectivity faced by remote and very remote residents. Many very remote areas lack adequate digital technology infrastructure, with a significant proportion reliant on costly solutions just to enable basic communication
- Voluntary Patient Registration (VPR) with MyMedicare remains unworkable where practices lack stable workforces and business models.
- Medicare's complexity has increased, not decreased, for rural and remote providers.

Outcome: The reforms have not materially improved access, continuity or equity.

b. Financial sustainability of rural general practices

Independently owned rural and remote practices, particularly in MMM 6–7 towns, are barely viable under current Medicare and government incentive structures. Key issues:

- Small patient volumes and high complexity make viability unworkable.
- Rising costs of staffing, locums, and regulatory burden.
- No mechanism for block or pooled payments to stabilise services.
- High workforce turnover due to geographical isolation and less support services disrupts care continuity and impacts accreditation and quality systems.

Without structural reform, further closures will occur, worsening already critical access challenges.

c. Medicare settings and avoidable hospital use

Current Medicare rules contribute directly to:

- Avoidable Emergency Department presentations for conditions that would normally be treated in primary care.
- Preventable hospital admissions, particularly for diabetes, respiratory conditions and cardiac issues.
- Over-dependence on hospital-based virtual care because local capacity is insufficient.
- Fragmentation that prevents early intervention and continuity of care.

The lack of resourcing for multidisciplinary team-based care further increases hospital dependence.

d. Adequacy of Medicare support for mixed-team models

Medicare continues to privilege GP-centric, throughput-driven models unsuitable for remote communities.

Medicare is not designed for multidisciplinary care in thin markets.

The current Medicare system fails to fund:

- Nurse-led models
- Allied health-led chronic disease pathways
- Team-based case management
- Place-Based community co-designed multidisciplinary approaches
- Virtual-plus-local hybrid care models that our region depends on.

This is a fundamental structural flaw.

e. Impacts on large corporate providers vs. small rural clinics

Current Medicare settings advantage large corporate providers, who can:

- Leverage scale
- Recruit nationally
- Maximise MBS throughput
- Invest in compliance, reporting and digital systems.

In contrast, rural community-embedded practices operate:

- With higher overheads
- With variable workforce
- In thin markets that prevent economies of scale
- With limited capacity for large-scale digital investment.

Medicare inadvertently accelerates consolidation, undermining community co-designed models that are essential to remote primary care.

f. Reforms needed for a fair and workable Medicare

WQPHN strongly supports reforms that move beyond fee-for-service and build place-based, pooled, flexible funding envelopes for rural and remote communities.

Key recommendations:

1. Introduce pooled or block-funded primary care for MMM 6–7 communities
 - Consolidate Commonwealth program streams
 - Cash out a portion of un-accessed MBS
 - Tier the cash out portion depending on the complexity of the patient
 - Tier payment for preventive healthcare to reduce chronic condition occurring
 - Tie to outcomes, not throughput.
2. Mandate rural stress-testing for all Medicare changes
 - No change should be implemented nationally until modelled and evaluated in at-risk regions.
3. Enable multidisciplinary, mixed-team care with bundled payments
 - Adopt Health Care Homes–style risk-stratified payments
 - Allow nurse practitioners and allied health to be funded appropriately, and work to their entire scope of practice.

4. Expand the use of virtual-plus-local hybrid care models
 - Ensure virtual care supplements—not replaces—face-to-face care
 - Require integration with local care coordinators.
5. Establish regional commissioning trials
 - WQPHN proposes a 5-year Pooled Planning and Commissioning Approach (PPCA)
 - One pooled Commonwealth investment
 - One line of accountability
 - Outcomes aligned to national frameworks.

The evidence already exists. The question is whether the political will does.

g. Other related matters

1. Aged care, disability and mental health must be integrated

Medicare cannot be examined in isolation. Remote residents experience the system as one ecosystem, not as separate programs. Fragmentation reduces effectiveness and increases administrative burden.

2. Workforce redesign is urgent

Remote communities require flexible, community-based, Certificate II–IV enablement roles, supported by virtual clinicians and stronger local capacity building.

3. Community trust must be rebuilt

Policy instability and ongoing churn in program rules contribute to declining confidence in the system.

4. A call to action

This Inquiry must break the cycle of reports that restate long-known problems without delivering meaningful solutions.

The Senate Committee has the opportunity, and responsibility, to:

- Insist on implementation-ready recommendations that change the status quo
- Mandate Commonwealth reforms that enable pooled, flexible funding
- Prioritise outcomes over throughput, particularly for MMM 6–7 communities
- Embed rural stress-testing for all future Medicare changes.

Rural and very remote Australians cannot wait another decade for the system to adjust to their needs.

If the reforms recommended by this Inquiry are not bold, structural and actionable, the consequences will be clear:

- services will close,
 - health outcomes will worsen, and
 - communities already at a disadvantage will be left further behind.
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WQPHN stands ready to work with the Committee and the Australian Government to deliver the reforms our region urgently needs.
