AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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AMA Submission to the Inquiry into rural, regional and remote Medicare access and funding

Senate Rural and Regional Affairs and Transport References Committee

Executive Summary

The Australian Medical Association (AMA) calls for government action on the following priority issues to improve access for rural, regional and remote Australians.

1. *Modernise Medicare to support longer GP consultations for complex care*

The AMA urges reform of the Medicare Benefits Schedule GP consultation structure so that patient rebates reflect consultation length and clinical complexity, remove current disincentives for longer consultations, and enable patients with chronic and complex needs to spend adequate time with their GP without higher out-of-pocket costs.

2. *Expand and properly index the Workforce Incentive Program (WIP)*

The AMA recommends expanding and indexing the WIP so practices can employ nurses, allied health professionals and other team members essential to access, continuity and quality care in rural areas.

3. *Strengthen continuity of care through Medicare-funded after-hours services*

Enhancing after-hours care delivered through general practice will improve patient access and reduce avoidable emergency department presentations. The AMA recommends aligning Medicare after-hours definitions with deputising services, resourcing care delivered by a patient's usual practice to improve continuity, safety and access, as well as better integration of Urgent Care Clinics (UCCs) and 1800Medicare with general practice.

4. *Embed a formal rural impact assessment for all Medicare reforms*

The AMA supports a mandatory rural impact assessment (rural-stress test) for all Medicare reforms, modelled across Modified Monash Model (MMM) classifications, co-designed with rural clinicians and communities, and reported transparently to Parliament.

The impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians

The AMA welcomed the $8.5 billion investment in Medicare and workforce initiatives promised by both parties in the 2025 election and its confirmation in the subsequent Federal Budget. The AMA has consistently acknowledged the investment would help address affordability issues for many who didn't qualify for the bulk billing incentives. However, the issue of structural reform of Medicare rebates remains. This requires modernising the MBS GP consultation structure with a seven-tier model that better reflects the realities of clinical complexity and enable patients to spend the time necessary with their GP to receive the care they deserve. The AMA calls on all parties to focus their efforts on structural reforms that improve patient access to GP-led multidisciplinary care that is affordable and enables them to sustain a long-term, trusted relationship with a doctor who knows their health history.

The Medicare changes commencing 1 November 2025 expanded bulk-billing incentives and introduced the Bulk Billing Practice Incentive Program (BBPIP). By 30 November 2025, the Department of Health, Disability and Ageing (DOHDA) reported 2,902 practices had registered in the program and 3.8 million additional bulk-billed services from October to November 2025, with an overall bulk-billing rate of 81 per cent. One month of data is insufficient to assess impacts in rural, regional and remote communities. The AMA recommends routine reporting of BBPIP participation and payment flows by MMM classification to determine whether reforms are improving access and affordability where need is greatest.

Telehealth changes from 1 November 2025 strengthen continuity by linking eligibility to MyMedicare and usual GP arrangements. The AMA supports the extension of established-relationship requirements to nurse practitioner telehealth to strengthen patient safety through continuity. In thin rural markets where face-to-face contact every twelve months can be difficult, established-relationship requirements may inadvertently tighten access. Co-designed telehealth with rural clinicians and Aboriginal Community Controlled Health Organisations (ACCHOs) is therefore essential to ensure it enhances GP-led primary care - not fragment it.

Australia has a strong healthcare system compared to the rest of the world. In the most recent Commonwealth Fund Report, Australia's health system ranked first overall among the countries considered by the board, and first in terms of equity and health outcomes. The AMA cautions against adopting bulk billing rates as the primary metric by which the strength and success of Australia's primary care system is measured. High-performing primary care rests on Barbara Starfield's four Cs: first contact, continuity, coordination and comprehensiveness, and must be supported to achieve these aims.

The financial sustainability of independently owned rural general practices under current Medicare funding and incentive structures

The AMA supports practices setting fees that reflect the cost of delivering comprehensive, quality care. Rising practice costs means some clinics cannot sustainably extend bulk billing to more patients. The AMA urges reforms to secure rural practice viability through funding that provides adequate indexation, the option for practices to adopt blended/MMM-weighted revenue streams, and tailoring incentives through co-designed rural pathways that safeguard access. Decades of inadequate indexation have eroded practice viability[1]. Fee-for-service revenue streams alone are brittle in smaller rural communities due to higher unit costs, limited scale, and unfunded administration work and travel time. The AMA supports blended funding, underpinned by MMM-weighted modelling, that combines fee-for-service and cohort-based block payments (e.g., aged care outreach, chronic disease cohorts) to stabilise cashflow, encourage team-base care and enhance practice viability. The BBPIP, combined with expanded incentives, may help in some settings; however, as previously noted full bulk-billing is not viable for practices in all locations.

The extent to which current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas

The Australian Institute of Health and Welfare reports persistent rural inequity, with Remote/Very Remote residents experiencing substantially higher potentially preventable hospitalisations and low-urgency ED presentation rates compared to metropolitan areas. A strong general practice sector is essential for a high-quality, equitable, and sustainable primary care health system. National and international evidence shows when general practice is well-funded and well-supported, it leads to better health outcomes, more efficient care, and reduced pressure on the hospital system. Further investment in a digitally enabled health system is also essential to support secure, real-time data sharing to reduce duplication and support continuity of GP-led care.

[1] AMA analysis shows the MBS freeze stripped $3.8 billion from primary care, with losses forecast to $8.3 billion by 2027–28 without structural correction. The under-indexation of the Level B GP item alone has "saved" both Labor and Liberal governments $8.6 billion since 1993 – a cost that has shifted to practices and patients in thin rural markets.

Properly funded general practice measurably reduces avoidable admissions and costly re-admissions. NSW Health's Lumos health data program showed that seeing a GP within 2 days of hospital discharge is followed by 32 per cent fewer readmissions in the first week. A GP visit within 7 days is followed by 7 per cent fewer 28-day readmissions, with benefits persisting at 1-3 months. The AMA's Medical Home position and Modernise Medicare reforms prioritise longer consults and GP-led multidisciplinary teams that provide continuity after discharge, proactive chronic disease management, and relational care in general practice prevent deterioration and keep patients out of hospital. In aged-care settings, GP-led teams also reduce hospital pressure by preventing avoidable transfers and treating deterioration early.

Current Medicare definitions and item settings for after-hours care create barriers to after-hours general practice care by defining 'after-hours' too narrowly and creating financial barriers for practices to open beyond 8pm. In many rural and remote communities, the GP who works in the clinic during the day is the same clinician who provides after-hours, on-call emergency care at the local hospital reflecting poor Commonwealth/State funding alignment.

The AMA recommends aligning the definition of after-hours care with that used for Approved Medical Deputising Services (AMDS): weekdays after 6pm, Saturdays after 12pm, and all day on Sundays and public holidays. This alignment would enable more patients to access care from their usual GP or practice team when and where they need it, reducing unnecessary hospital presentations and improving patient safety. Enabling more GPs to work after-hours in their usual practice settings will reduce unnecessary presentations to emergency departments and Urgent Care Clinics (UCC), where continuity of care is often lost.

Member feedback suggests that UCC expansion has a mixed impact on emergency department volumes and may divert attention from longer, relational primary care that prevents deterioration. Unless tightly integrated into GP-led primary care and evaluated against clear outcomes, UCCs risk fragmenting care, diverting workforce from general practice and duplicating services. To ensure UCCs work for rural, regional, and remote communities, the AMA recommends they must use existing general practice infrastructure, require GP leadership, be commissioned according to demonstrated gaps, mandate clinical GP handovers and be evaluated according to emergency diversion, continuity of care, patient safety and cost-effectiveness.

The adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities, including the roles of general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists

The AMA supports the appropriate resourcing of multidisciplinary care in primary care where GPs lead coordinated care with a team reflecting the health needs and patient demographics of their community. However, current funding is insufficient to attain and sustain team-based care at the level rural communities need. The Workforce Incentive Program - Practice Stream (WIP-PS) caps support at $32,500 per quarter (before rural loadings), with indexation having commenced 2024–25. This is helpful, but insufficient where clinics must attract, retain and sustain nurses, nurse practitioners and key allied health professionals. The AMA's Modernise Medicare calls for expanding the WIP (an additional $401.4 million over four years) so practices can employ the right mix of staff and coordinate digitally enabled, whole-patient workflows that lift access and continuity.

The AMA supports top-of-scope practice for nurses, nurse practitioners, and allied health professionals within GP-led clinical governance structures that safeguard safety, medication stewardship and diagnostic accountability. This will improve access to nursing and allied health services in general practice ensuring patients have all their health needs addressed under one roof as part of a GP-led, multi-disciplinary care team.

The AMA also calls on the Commonwealth to:

- Provide flexible and blended payments to support innovation and access, while maintaining fee-for-service as the bedrock of primary care funding.
- Resource practice nurse pathways into general practice and support practices in change management.
- Resource after-hours care delivered by the patient's usual practice team, to protect patient safety and reduce unnecessary emergency department demand.

Reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians, including the requirement for rural stress-testing of future changes

AMA rural members were asked to outlined their priorities through the AMA's Rural Health Issues Survey in February 2025. The key priorities included rural health professionals and communities being involved in policy making decisions at all levels, increase incentives such as the WIP to recruit/retain doctors in rural areas and enhance rural access to specialist outreach services. A formal rural impact assessment ("rural stress-test") modelled across MMM categories and co-designed with rural clinicians and communities would ensure reforms improve access, continuity, affordability and patient safety for rural patients and communities. Rural-weighted incentives, simplified compliance and up-front practice-linked payments to fund GP-led multidisciplinary teams in thin markets, along with patient-reported access and continuity, would be consistent with the AMA's Rural Plan for localised, flexible solutions.

Any other related matters: Growing the rural health workforce

Access for rural patients and communities, Medicare-funded or otherwise, cannot be sustained without a stable rural workforce. The AMA welcomes the additional Australian General Practice Training and rural generalist training places, noting the current momentum must be maintained through the expansion of training places and pathways in rural areas. This is especially true of rural end-to-end training encompassing training from medical school to specialist vocational training. The AMA supports continued Commonwealth investment in Single Employer Model (SEM) trials for GP training as a means of delivering stability, parity of conditions, and long-term attachment to rural communities. The AMA supports the establishment of an Independent National Medical Workforce Planning Agency and the development of a National Rural Health & Workforce Strategy to align supply, training and incentives across rural, remote and regional areas.

International Medical Graduates (IMGs) underpin Medicare-funded care delivery in many rural communities. AMA analysis indicates IMGs comprise 53 per cent of Australia's rural medical workforce. Yet, AMA research highlighted persistent structural, professional and social barriers faced by IMGs, particularly in rural and remote communities. These included complex and opaque registration processes, limited access to supervision and mentoring, and inadequate family and settlement supports. The AMA urges funding for high-quality flexible and remote supervision and teaching for doctors in training and IMGs across medical Colleges that are co-designed with rural, regional and remote services.

Contact

president@ama.com.au