RDN submission to the Australian Parliament's inquiry into rural, regional and remote Medicare access and funding

RDN – The Charity for Health Access

RDN is a health and social care access charity group that develops and manages social enterprises centred on achieving the vision of "*health and social care access for all*".

RDN administers services, builds capacity and mobilises knowledge for communities. It works collaboratively within wide networks of stakeholders, including health professionals, service agencies, educational institutions, professional associations, corporate and philanthropic partners, Aboriginal and Torres Strait Islander health organisations, Local Health Districts (LHDs) and Primary Health Networks (PHNs), policy-makers and all tiers of government.

"RDN supports the World Health Organisation's goal of achieving a world in which all people have access to the full range of quality health services they need, when and where they need them, without financial hardship." - RDN Strategic Plan 2025-2028.

Summary

RDN welcomes this inquiry and the opportunity to contribute on behalf of the millions of people living in remote, rural and regional Australia. We would welcome the opportunity to further discuss the views presented in this submission.

Inequities in rural health outcomes and access remain persistent and significant.

The financial sustainability of rural general practice is shaped by multiple pressures: the legacy of the MBS freeze, the decline in VMO income, acute GP shortages, an ageing workforce, and the increasing complexity of practice ownership and operations. Rural practice owners face shifting funding rules, expanding regulatory obligations, complex billing requirements, and substantial volumes of non-clinical work that current funding models do not resource.

To support sustainable primary care in rural areas, primary care reform momentum must continue. Funding models should reflect the higher costs faced by rural practices and adequately resource essential non-clinical functions. Strengthened telehealth, reliable business support and training, and coordinated regional planning across health services, local communities, and all health stakeholders are critical. Without stable settings and targeted support, independently owned rural practices will remain vulnerable putting rural access to primary care at risk.

a. Impact of 1 Nov changes to rural general practices

The introduction of the Bulk Billing Practice Incentive Program (BBPIP) is too recent for its impact to be fully realised or quantified, although early data is promising. RDN has received early feedback on the factors influencing practice level and individual billing.

Communication about the incentive has been highly effective, resulting in strong awareness among rural GPs and practices. This suggests that decisions around participation are well-informed. Feedback indicates that both GPs and practices are carefully weighing multiple considerations, not solely financial, when determining whether to shift to a bulk-billing model.

RDN is aware, from engagements directly with the sector, that some GPs have already relocated, or plan to relocate, due to differing views between themselves and their employers on the shift to bulk-billing. Workforce changes of this kind have a disproportionately high impact in rural areas, where even small movements can destabilise service continuity and undermine community access to care.

Practice-level decision-making is varied. Some practices having identified clear operational or financial advantages in adopting universal bulkbilling, whilst others have not. These decisions extend beyond financial modelling to include factors such as patient demographics, local socioeconomic characteristics and the organisation's broader service strategy. Several multi-site organisations are conducting internal pilots - transitioning a single practice to BBPIP before determining whether to expand or reverse the decision. These pilots are expected to influence further BBPIP uptake over time as lessons emerge.

Competition appears to be a limited driver of BBPIP adoption in many rural settings, where restricted service capacity and limited consumer choice constrain market dynamics. However, some larger corporate providers have indicated plans to expand into locations with minimal bulk-billing availability, which may introduce stronger competitive pressures in certain regions. In areas of adequate supply, competition, supported by the increased visibility of bulk-billing practices through BBPIP promotion and required signage, may play a larger role in influencing practice decisions.

A consistent concern raised with RDN through direct engagement with GPs relates to the stability of the BBPIP's design. Some practices are hesitant to shift to 100% bulk-billing without confidence that the 12.5% loading will remain in place for a reasonable period of time. This caution reflects of previous policy changes, particularly the freeze on MBS indexation, which eroded trust in funding stability and forced many rural practices away from bulk-billing. This shift away from bulk-billing as a result of the freeze required significant patient education, generated considerable frustration and abuse towards practice staff, and caused moral injury for GPs who needed to charge gap fees to financially vulnerable patients. Consequently, practices now report preparing for potential patient backlash irrespective of their BBPIP decision, either due to perceived inconsistency between bulk-billing claims and procedure fees, or disappointment that a practice has not opted into the program.

Despite these concerns, it is important to note that all rural practices, regardless of whether they adopt the BBPIP, will benefit from the strengthened bulk-billing incentives that apply across Medicare. These broader payments will provide additional support to the sustainability of rural general practice irrespective of their billing model.

In addition to BBPIP changes on 1 November 2025, RDN notes that the redesign of the Better Access program and increase in MBS rebates for long-acting reversible contraception (LARC), also implemented from 1 November 2025. These changes will each have specific implications for rural communities.

RDN welcomes the increase in rebates for LARC services as supporting access. Enhanced financial support is particularly beneficial for rural communities, where socioeconomic disadvantage is more prevalent and affordability remains a key barrier to accessing comprehensive reproductive healthcare.

Conversely, any reduction in access to telehealth services (such as those implemented as part of the Better Access redesign) will disproportionately affect rural and regional populations, who rely heavily on remote modalities due to distance, workforce shortages and limited local specialist availability. While the Government's intention to expand access to a scarce mental health workforce across a broader patient group is commendable, its effectiveness for rural areas will depend on ensuring that telehealth accessibility is not compromised.

b. Ongoing financial sustainability of independently owned rural general practices

Financial viability in independently owned rural general practices is challenged by multiple interrelated pressures. Without system-level policy redesign, the instability of rural general practice will continue to put accessible primary care at risk for rural communities.

A useful indicator of the current state of rural primary care is the extent to which rural local governments are becoming involved in supporting access to services. A recent survey[1] conducted in November 2025, involving 71 of the 91 rural local governments in NSW, found that 39% reported undertaking activities to enhance access to health services in their communities. These activities include owning or managing health facilities and providing accommodation or transport for members of the primary care workforce. These results suggest that health access activities are being supported by local government even though they are not funded to do this.

Another indicator of rural primary care access concerns is the increasing number of applications for COAG 19(2) exemptions, which allow state run health services to claim MBS rebates when providing eligible primary care services in areas with limited access to private providers. RDN notes, however, that the use of this exemption requires careful consideration. It is important that all relevant stakeholders within the community are appropriately engaged and that potential impacts on the local service market are thoroughly assessed before an exemption is implemented. To ensure this assessment is impartial and effective, the evaluation could be completed by an independent party rather than the service who will be receiving the benefit of the decision.

The freeze on MBS rebates between 2013 and 2020 significantly reduced profitability and viability of all services, putting increased pressure on smaller rural practices who often operate at lower profit margins due to lower economies of scale and higher operating costs. AMA analysis from 2023 indicated that the freeze reduced primary care funding by $3.8 billion over a 30 year period, resulting in decreases in practice viability and bulk-billing. Although recent incentive reforms (BBI expansion and BBPIP) should improve financial dynamics, practice owners remain cautious due to the lingering effects of the freeze.

A decline in Visiting Medical Officer (VMO) arrangements with regional hospitals has also undermined income structures for rural practices. Outdated on-call expectations and inadequate remuneration have prompted GPs with VMO capabilities to forgo contracts. In response, rural hospitals are increasingly reliant on locum doctors, bypassing local practices entirely, which further reduces rural practice revenue and destabilises community relationships. Whilst locums are an essential part of filling temporary rural workforce gaps, they should not become a permanent solution.

Persistent GP workforce shortages in rural and remote areas are both a cause and effect of the issues mentioned above, creating a positive feedback loop and driving the system further away from the desired state. Overworked staff are more likely to leave rural practice, while the increasing age profile of rural GPs results in both more part-time clinicians and a higher rate of retirements. Some practice principals cannot find buyers and are forced to close, with closures particularly disastrous in smaller towns where service capacity is already fragile.

Ownership and operation of a general practice are becoming increasingly complex. Regulatory requirements continue to expand, funding streams and program rules shift regularly, clinical practice grows more specialised, digital systems become essential to day-to-day operations, and profit margins tighten. In this environment the traditional rural practice model, typically a solo GP supported by a practice manager, can no longer maintain the breadth of expertise required to manage modern administrative, legal, financial, ICT, accreditation, governance, and care-coordination responsibilities.

[1] Health Access Survey, conducted November 2025 by RDN and the Country Mayors Association of NSW. Unpublished.

For example, optimising practice billing and incentive income has become a highly technical task requiring up-to-date knowledge of MBS item numbers, billing rules, incentive programs and software systems. Optimisation of these tasks depends on timely, accurate data, which is usually only available through integrated software applications. RDN engagement with rural practices indicates that they may face knowledge gaps due to variable staff expertise, frequent turnover and limited access to high-quality training. Where training does exist, it may be prohibitively expensive, unavailable in-person in rural locations or based on outdated or incorrect information.

Sustainable funding for general practice, must therefore adequately resource the essential non-clinical activities that underpin quality care. These activities include patient care coordination, clinical and business operations education, clinical governance activities, ICT and infrastructure management, legal and accounting management. Support for these activities should be designed for the different practice environments, particularly small (lacking economies of scale) and rural (care costs more to deliver) practices.

These activities are foundational to safe and effective practice, but are not support by current funding mechanisms. Primary care funding and pricing policy could be informed by Independent Health and Aged Care Pricing Authority's approaches to pricing and costing health care provision in rural locations and smaller organisations and also of training activities. Under these models, rural and small organisations have a higher price/cost per unit of care delivered and are most often block-funded to account for the minimum viable cost of delivering certain levels of care, whilst teaching, training and research activities are also block-funded, for similar reasons.

c. How current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas

RDN does not have a response on this clause.

d. Adequacy of Medicare support for MDTs

Current state

What a multidisciplinary team (MDT) is, within the context of primary care, is still being defined by the Department of Health, Disability and Ageing (DHDA). In this section, we focus on primary care MDT's as a general practice that has non-medical clinicians practicing within the business or that the general practice collaborates with non-medical clinicians via care plan arrangements. We acknowledge that this is a limited definition, but make it for the purpose of providing comment on the current Medicare supports, which, by their design, guide the system towards these service models.

The WIP Practice Stream payment provides financial incentives to general practices to employ non-medical clinicians, i.e. nurses, midwives, allied health professionals and Aboriginal and Torres Strait Islander health workers and practitioners. In recent years, Medicare Benefits Scheme (MBS) billings have also been enabled for more non-medical primary care clinicians, including nurses and midwives. Despite these shifts, the sector has not seen a large increase in the number of non-medical clinicians being employed within general practices.

General practice accreditation is a prerequisite for these payments. Achieving accreditation may be less viable (from a financial, capacity or capability perspective) for small, solo practices, common in rural and remote areas.

Within the current funding structure exist numerous, nuanced barriers to primary care businesses operating MDT service models. Some are listed below:

- General practice accreditation, a prerequisite for WIP Practice Stream payments, is less viable for the smaller and solo practices common in rural and remote areas.
- Consultation rooms are not made available for non-medical clinicians as practices will generally make the most money by having a GP in every consult room.
- GPs still need to see the patient for many services that nurses can bill Medicare for, but the GP can only bill for their time, so it often more convenient from administrative, patient flow and time management perspectives for the GP to conduct the whole consult.
- There are not enough nurse practitioners within the workforce so it is challenging for rural locations to recruit them, whilst the Medicare items they are eligible for are insufficient to justify the amount the practice would need to pay them.
- Allied health clinicians may not generate enough income in a practice if they are only bulk-billing patients on care plans.

Future state

A desired future state was first delineated in the Strengthening Medicare Taskforce Report, which called for providing investment to support MDTs that reflect local needs.

Due to the complexity of the current suite of primary care incentives and funding streams, any changes are likely to create unintended effects. A system design approach is needed to create targeted, lasting change within such a system. RDN refers the Committee to the GP Incentives Review Report, which detailed why this approach was necessary and and designed their recommendations using this approach.

Clarity is also required from DHDA, as system stewards, on what constitutes an MDT in primary care and what doesn't, their desired future state for MDTs within primary care, and how the sector will be incentivised and supported to achieve milestones along this change journey (policy, legislation and funding).

This definition should:

- be designed with unbiased/balanced clinical and system design expertise;
- reference best available evidence (whilst being aware that evidence may not be available for all aspects of such a multifactorial situation);
- be able to be applied across all relevant policies, programs and grants, and be consistently applied across all these.

Adequacy of Medicare funding is only one of the enablers for this system change. This change should therefore progress with a view to the maturity of the other key enablers such as: widespread data sharing and machine-readable clinical data, expanded scopes of practice (refer to the Scope of Practice Review Report); and flexible funding programs. These system characteristics will not just enable MDTs to deliver on the IHI Quintuple Aim, but will also enable the sector to move through process of change.

Evidence, and the fact that health care access is so multifactoral, strongly suggest that MDTs must be able to be designed and applied locally, with support for the design and change process, as well as funding streams that are flexible enough to sustain a multitude of MDT designs.

Small businesses that, although decreasing, still make up a critical proportion of rural primary care providers, may need more expert advice and support (than larger practices) if they are to shift their service model in the direction of more MDT care. DHDA has already invested in innovative primary care service and care models, e.g. the PRIMM and IMOC grant programs. The learnings from these programs should be shared more widely. For example, a platform and support service could be created for the sharing of expertise in relation to MDT service models, change management processes, and change management supports.

Finally, it should not be assumed that skills in MDT and collaborative processes and operations exist within the primary care clinical and practice management workforce. Training and skills development supports must therefore be provided. When designing these supports, accessibility for rural clinicians and practice management should be considered. This should include financial support for travel, accommodation, training course costs and any requirements for staff backfill.

e. Impact of current Medicare rules and incentives on large corporates versus small rural independents

The primary focus of the Government should be on whether the services delivered by any providers (regardless of size) are within the bounds of what the Government deems acceptable to pay for in relation to quality, timeliness, cost, availability, appropriateness, etc. Development of a system which delivers on these aspects of quality care is made more complex due to primary care being delivered under a quasi-market model, meaning aspects of market health that need to be considered and designed for. In primary health, these may include: competition; low barriers to entry; price transparency; sustainable and stable pricing; fair profitability; diversity of choice; and local provision of services. These aspects may be influenced by, or influence the, size of provider within this market, however in order to achieve success in relation to the whole market, the Government should maintain focus on overall system design and stewardship, rather than on any particular aspects in isolation.

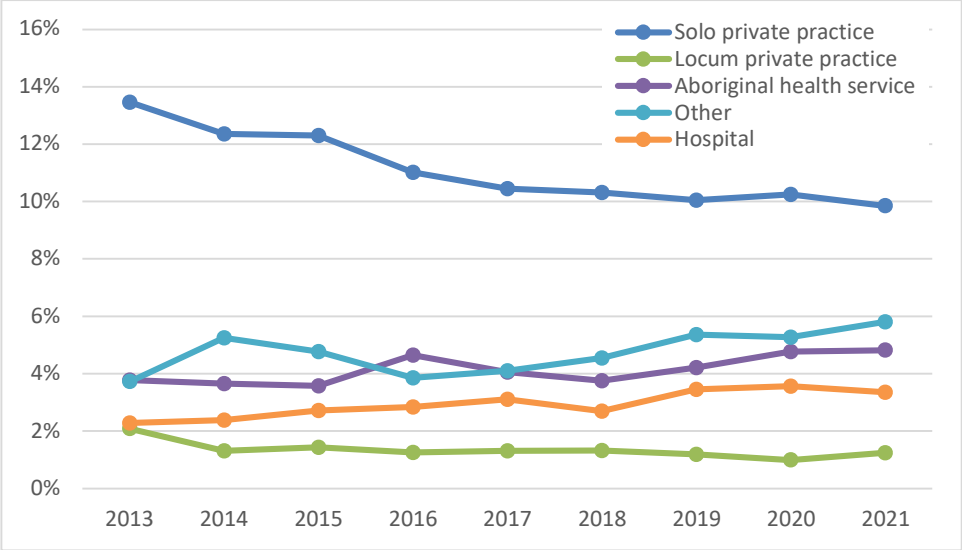
An example of this is increasing regulations (e.g. clinical governance, digital interoperability and sharing) in order to improve clinical care outcomes will shift the market in favour of larger corporates, who will receive economies of scale by designing once and applying to many. This should only be of concern for the Government if this pressure shifted the market so much that consumers are losing out in relation to the characteristics of interest, i.e. quality, timeliness, cost, etc.

In highly-regulated markets such as health care, large corporate providers benefit significantly from economies of scale, not only in financial terms but also through structured employment and billing practices, comprehensive in-house policies, and the ability to systematically learn from experiences (their own and others). This structure allows for proactive business optimisation, such as the implementation of vaccine wastage reduction programs, and the continual implementation of best practice, which collectively leads to substantial efficiency gains.

In contrast, independent practices are generally less structured, operating with fewer staff and resources to support education, review, or change initiatives. These practices tend to learn mainly from their own experiences rather than benefiting from broader sector insights, which can result in missed opportunities for optimisation and efficiency improvements, leading to greater inefficiencies.

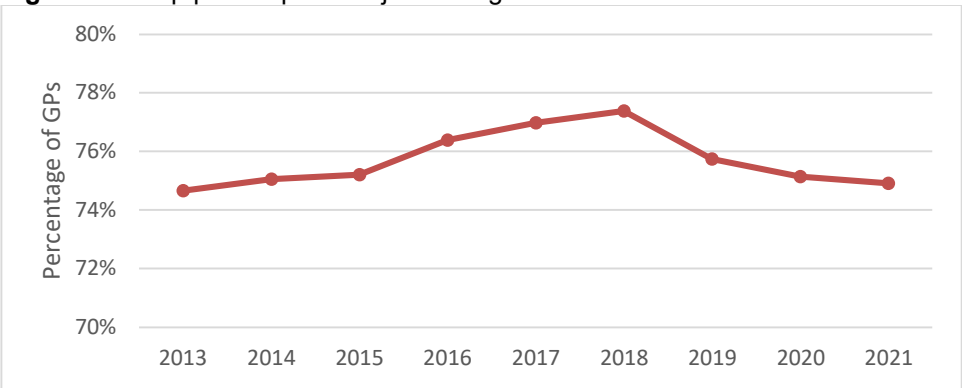
With regards to what is occurring within the market, data from the Health Workforce Data Tool indicates that the number of GPs working in solo private practice in rural NSW is decreasing. In the last nine years the proportion of GPs working in solo private practice has gone from 13.5% to 9.9%. This has been accompanied by an increase in GPs working in other areas, including Aboriginal health services and hospitals (Figure 1). Interestingly the proportion of GPs in rural NSW working in group private practice peaked in 2018 (77.4%) and returned to 2013 levels in 2021 (74.9%), perhaps due to closure of some larger practices (Figure 2).

Figure 1 Job setting for GPs in MMM2-7 areas of NSW



Source: Health Workforce Data Tool. Department of Health, Disability and Aging.

Figure 2 Group private practice job setting for GPs in MMM2-7 areas of NSW



Source: Health Workforce Data Tool. Department of Health, Disability and Aging.

From our work in supporting the rural primary care workforce, we understand that factors other than Medicare rebates and incentives are potentially more influential in this change. Most notably in the case of solo private practice may be the increasing age of this workforce. Younger GPs tend to want to work in an environment that is more supported, in terms of both GP colleagues and practice administration, and are therefore not selecting business ownership as a career path.

f. Reforms needed for sustainable rural general practice, including requirement for rural stress-testing

Every system is perfectly designed to get the results it gets -W. Edwards Deming

Attempts to improve sustainability for rural health access must also take a system-level approach. Rural general practices benefit greatly from integration with the rest of the local health system in relation to economies of scale, sharing workforces, patient care coordination and developing multidisciplinary team based services and care models.

System-level reforms must also be designed specifically for the rural context. The challenge of delivering services in small remote and rural communities is well known, and it is clear that a one-size-fits-all approach does not work at a national level. RDN suggests a 'rural for rural' approach to design and spending, rather than rural stress-testing a metro-centric program.

Given that, detailed below are specific aspects of rural health service sustainability RDN recommends greater efforts be committed to.

Stakeholder collaboration

Fragmentation and siloing is particularly damaging to health access in rural areas. Support must be available for all stakeholders to collaborate in planning integrated, tailored rural health systems for their region, and maintaining ongoing, cross-system governance of same.

Sub-regional collaborative planning and governance approaches can build on the specific strengths of the region to create an integrated system of health services that have the necessary critical mass to be sustainable. Approaches could include partnered or pooled workforces, funding streams, linked systems and coordinated patient-centred care.

Involved stakeholders must be comprehensive, covering state and federally-funded health agencies (e.g. LHDs, PHNs, Rural Workforce Agencies), Aboriginal health organisations, local governments and local health businesses and individual health professionals. State government services must be incentivised to engage with local primary care providers (e.g. via the NHRA). State government services are the big fish in rural areas – they need to be incentivised to engage with collaborative efforts, as their participation is often the lynchpin to integrated care projects succeeding or failing.

Rural funding solutions

RDN note that, despite existing remote-specific incentives and remoteness loadings in various incentive programs, remoteness still has an impact on the financial sustainability of rural primary care providers.

Funding structures designed specifically for rural primary care services, graduated for remoteness (and perhaps size of parent company), should be considered by Government. Insights from IHACPA's work on rural hospital funding could help inform considerations.

Appropriate funding structures should be designed to level the playing field with metropolitan-based primary care services by providing adequate support for adherence to regulations, collaborative and clinical governance, cross-organisational clinical management, staff training, and business administration.

Funding solutions must consider human factors and behavioural economic concepts in relation to collaborative and intra-business operations, and economic forces in relation to the wider market, to ensure funding and incentive design achieves what it aims to and minimises perverse incentives. This will be complex to get right, but it is essential for equitable rural health access.

Workforce planning

Workforce planning is a critical issue in rural health, as the new generation of clinicians generally do not accept the heavy workloads that characterised the previous workforce. To address this, innovative service models are needed that not only make rural practice more appealing but also support flexible working arrangements.

Another key challenge observed by RDN is retaining clinicians in rural areas once government-supported training and return or service obligations conclude. While financial incentives are often emphasised, evidence suggests that money alone is rarely sufficient to influence personal decisions about relocating to or remaining in rural communities. Government simply cannot afford the level of funding that would be required to shift workforce preferences at scale. Instead, a greater focus should be placed on personal motivations, lifestyle benefits, and fostering a strong sense of community, as these factors are more influential in encouraging clinicians to stay in rural practice.

An example solution to these challenges are the single employer models. Whilst too early to make claims of success, they aim to provide general practice and rural generalist registrars with competitive remuneration, whilst also taking lifestyle preferences into account.

Business supports

The sector requires enhanced supports to drive uplifts across all key aspects of the IHI Quintuple Aim. It is essential to provide tailored business administration assistance that strengthens financial management and governance, recognising that smaller practices will have different needs compared to larger operations.

Additionally, continuing professional development (CPD) opportunities must be designed to address both community need and business priorities, ensuring they are accessible to clinical, as well as administrative, staff. This includes practical supports such as time off, backfill, and assistance with travel and accommodation.

Furthermore, accreditation standards should reflect the current requirements of the health system, with appropriate support mechanisms in place to help practices of all sizes achieve and maintain these standards.

Change management support

The Government has already invested in innovation within primary care - the Primary Care Rural Innovative Multidisciplinary Models (PRIMM) and Innovative Models of Care (IMOC) grant programs being two recent examples.

Further investment is now required to support diffusion and application of the evidence base that has been produced to effect improvements across the system, including in rural areas. This investment should include support for sub-regions to assess their current needs and options, based on available funding streams, service models and workforce available to them, including learning from the PRIMM and IMOC grants and workforce planning resources that can be used at the state and local health district level.

Primary care services must be supported in this process with accessible change management expertise and funding. Learnings from the Health Care Homes trial indicate that change management supports must be mature, expertly designed and delivered, and sufficiently accessible to all practices if this change is going to be successful.