07/02/26

Committee Secretary
Senate Standing Committees on Rural and Regional Affairs and Transport
PO Box 6100
Parliament House Canberra ACT 2600

Re: Inquiry into Rural, Regional and Remote Medicare Access and Funding

Submission from:
Dr Manjit Sekhon
Chief Executive Officer & Chief Medical Officer
Gidgee Healing
Aboriginal Community Controlled Health Organisation

Thank you for the opportunity to provide a submission to the inquiry into the Government's changes to rural, regional and remote Medicare access and funding.

I welcome scrutiny of these changes and wish to place on record my serious concerns about the real-world impacts on rural and remote service providers and the communities I support.

Lack of consultation with affected rural services

Gidgee Healing is the fifth largest ACCHO in Australia and provides care to ATSI people spread over geographical regions of 640,000 KM square, covering Mount Isa and Lower Gulf communities in Far North QLD.

I have been serving in the position of Chief Medical officer at GH since Aug 2024 and for over a year in CEO position.

At no stage was I consulted directly regarding the design or implementation of the Medicare changes that came into effect on 1 November 2025. There was no attempt to understand how these changes would affect the Gidgee Healing service model, workforce constraints, or the realities of delivering comprehensive primary health care in a rural and remote settings. This absence of consultation has resulted in policy settings that are poorly aligned with on-the-ground conditions and that actively undermine access to care for communities who access Gidgee Healing, an Aboriginal Community Controlled Health Organisation.

Impact on access to primary health care and telehealth

Telehealth is not an optional adjunct for our service; it is essential. After more than twelve months of sustained effort, we were able to secure a highly suitable general practitioner based in South Australia who provides services exclusively via telehealth and meets the specific needs of our community. Under the current Medicare changes, this clinician can no longer bill under MHP or similar arrangements solely because they are not physically present on site.

This has effectively dismantled a functioning and carefully developed care arrangement, despite no reduction in quality, safety, or continuity of care. The policy fails to recognise the necessity of telehealth-only models in communities where resident GPs cannot be recruited.

What's more challenging is that the introduction of a change which demands we desist a certain service delivery model also gives us no alternative solutions. So, whilst Services Australia can write to us saying you can not bill xyz from 01 Nov 2025, I am hardly in a position to tell the patients from these regions that you can no longer see the GP from 01 Nov 2025 as we can not bill for the services of the GP. Medicare billings are not essential for our doors to open but it does play significant role in our staffing and administrative support levels as it is treated as discretionary income and comes into play. Infact one of the measures we report against to our Federal and State funding bodies is exactly how much we are able to generate as Medicare income as it plays significant contributory role in how funds are distributed.

Workforce shortages and sustainability of rural general practice

Despite offering competitive salary packages and making sustained recruitment efforts, we have been unable to attract a GP willing to relocate and live in the area (Mount Isa, Queensland) for over 18 months. This experience is not unique and reflects broader workforce shortages across rural and remote Australia.

Even when telehealth clinicians are available, they are increasingly reluctant to work in rural contexts due to fear of inadvertent non-compliance with complex and frequently changing Medicare rules.

There is widespread uncertainty about acceptable platforms, billing requirements, and compliance risks. In our case, we rely on Microsoft Teams with many times experiencing unreliable connectivity and network coverage, yet clinicians remain concerned about potential repercussions for factors entirely outside their control.

Financial sustainability and structural bias in Medicare settings

Current Medicare rules and incentive structures disproportionately favour large corporate providers that are resourced to maximise billing opportunities and absorb compliance risk.

Small, independently owned, community-embedded rural clinics do not have the administrative capacity, IT infrastructure, or legal support to navigate this complexity.

Rather than supporting locally embedded services that are accountable to their communities, Medicare settings are increasingly pushing rural care into models that prioritise scale over continuity, relationships, and place-based care.

Lack of support for telehealth delivery in rural and remote areas

While telehealth is heavily relied upon in rural and remote Australia, there is effectively no Medicare support for establishing, maintaining, or delivering telehealth services. This includes:

- no recognition of the additional time required to manage telehealth consultations;
- no allowance for poor connectivity, network dropouts, or severe IT issues that are beyond local control;
- no funding for infrastructure, troubleshooting, or staff support; and
- no flexibility in platform requirements despite variable regional capacity.

These realities are ignored in current policy settings, placing both providers and clinicians at risk and reducing access for patients.

Need for reform and rural stress-testing

We strongly support reforms to ensure Medicare is fair, workable, and sustainably funded for rural, regional and remote Australians. Future Medicare changes must be subject to mandatory rural stress-testing to assess their impact on workforce availability, service viability, telehealth reliance, and patient access before implementation.

Policies designed around metropolitan assumptions will continue to fail rural communities unless rural realities are embedded at every stage of decision-making.

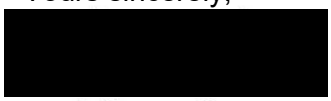
Conclusion

In summary, the current Medicare changes risk reducing access to care, destabilising already fragile rural services, and further entrenching inequity between metropolitan and rural Australians.

Without meaningful consultation, flexibility, and recognition of the realities of rural healthcare delivery, these reforms will do harm rather than achieve their stated objectives.

I urge the Committee to consider the lived experiences of rural service providers and communities and to recommend reforms that genuinely support accessible, sustainable, and locally appropriate primary health care.

Yours sincerely,



Dr Manjit Sekhon
FRACGP
Chief Executive Officer &
Chief Medical Officer
GP Portfolio: RHD, Connected Beginnings, Headspace
Gidgee Healing, Mount Isa Aboriginal Community Controlled Health Service
Mount Isa and Lower Gulf Communities
E: [redacted]

T: [redacted]