



**Submission: Rural, regional and remote Medicare
access and funding**

Rural and Regional Affairs and Transport References Committee

March 2026

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Acknowledgements

The National Rural Women's Coalition (NRWC) acknowledges the Traditional Owners of the land on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and future. We value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We extend our respect to Aboriginal and Torres Strait Islander women who for thousands of years have preserved the culture and practices of their communities on Country. This land was never surrendered, and we acknowledge that it always was and always will be Aboriginal land. We acknowledge that Australian governments have been complicit in the entrenched disadvantage, intergenerational trauma and ongoing institutional racism faced by Aboriginal and Torres Strait Islander people. We recognise that Aboriginal and Torres Strait Islander people must lead the design and delivery of services that affect them for better life outcomes to be achieved.

About NRWC

The National Rural Women's Coalition (NRWC) is a grass roots organisation, established in 2002, that provides a collaborative, powerful national voice for women living in rural, regional, and remote Australia. We are a coalition of five peak rural alliances comprising the Australian Local Government Women's Association, Australian Women in Agriculture, National Rural Health Alliance, Women in Seafood Australasia and Transport Women Australia Limited. For over 20 years, we have worked to ensure better social, economic, and environmental outcomes for women in rural townships, in rural communities and in primary production throughout Australia.

Summary

The National Rural Women's Coalition supports the November 1 changes to Medicare which have expanded bulk billing to increase affordability of primary health care for all Australians, including rural, regional and remote women across Australia. However, NRWC believes further systemic reforms are needed to ensure improved access to the right services, at the right cost, and in the right location, for rural women and their families. Key gaps include serious failures in provision of essential reproductive health care services and sustained lack of access to GPs and other critical allied health services in rural areas. To address these gaps, the NRWC advocates for the following policy changes to strengthen the existing Medicare changes:

1. Remove the need for a face-to-face consultation to access mental health care via telehealth and ensure midwives can access incentives for LARC consultations.
2. Introduce rural generalist Medicare incentives that properly remunerate the breadth and depth of services provided by rural GPs
3. Commit to an ongoing increased allocation of rural generalist training pathways
4. Continue to fund and extend trials of community-led multidisciplinary health care clinics that align with the PRIM HS model.
5. Review reproductive health care (including maternity and termination services) provision across rural Australia and develop a strategy to address identified gaps.
6. Nationalise patient travel and accommodation subsidies to be administered under Medicare, ensuring equality and improved coverage for rural patients.

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

The NRWC has little direct information about the real-world impact of the November 1 changes from its stakeholders due to the short time frame since their introduction. However, NRWC notes that while there is evidence that bulk billing rates have increased¹ since the introduction of these changes, changes to bulk billing alone do not address the wider problems in healthcare, especially in rural and regional areas.

Firstly, the rebate does not cover the actual cost of delivering services,² and with the cost of providing those services (for example non-patient facing time), not all doctors or clinics will be able to bulk bill. Financial sustainability challenges are much more pronounced in rural areas, and in some cases, special models are needed to enable adequate service provision.

Secondly, bulk billing incentives do not address the number of GPs available to access in rural Australia. Australia is facing a GP shortage and that shortage is more pronounced in rural Australia. Modelling done for the Commonwealth predicts a shortfall of 7,700 GPs by 2033, growing to more than 12,400 more needed by 2048.³ Areas classified as MM5-7 (small rural towns, remote and very remote

communities) have a lower than average number of doctors per 100,000 people and MM6 has the lowest rate (40% per cent below the national rate).⁴ About half a million Australians live in GP deserts. These are communities in the bottom 5% for GP services per person. Most GP deserts are in remote Queensland, Western Australia and the Northern Territory, and some are in Canberra. People in GP deserts receive 40% fewer GP services than the national average.⁵

Lack of availability of health services, including GPs, and the associated greater cost and difficulty in accessing appropriate care, leads to worse health outcomes for people living in rural, regional and remote areas of Australia. The lack of rural services equates to a total annual rural health spending deficit of \$8.35 billion.⁶

This is more pronounced for rural women, who suffer the compounding effects of gender and geographic disadvantage. Women are more likely to suffer chronic illnesses, have multiple health conditions, and require specific reproductive health care.⁷ There is strong evidence that women pay more to access healthcare and are more likely to delay accessing that care.⁸

Thirdly, bulk billing, while lowering the cost to the patient for that appointment, does not address other gaps in health care provision. Bulk billing incentivises doctors to see more patients quickly, rather than supporting an integrated health care approach (nurses, allied health, pharmacists, psychologists) where costs to the patient can be very high. It does not support holistic care for people with multiple chronic conditions.⁹ This is especially relevant for women, who also require access to allied and other supporting health care services (such as termination services, midwifery, post and antenatal care, domestic or sexual violence services).

NRWC notes the 1 November 2025 MBS changes which introduced new MBS items for Nurse Practitioners for LARC services, however, recommend that this should be extended to midwives to ensure greater access for rural, regional and remote women. It is well known that LARC uptake is comparatively low in Australia. Expanding the availability of LARC services in rural Australia would support better health outcomes for rural and remote women, who experience higher rates of unintended pregnancies.¹⁰

Finally, the NRWC is aware that there are concerns about the change in requirement to see a GP in person, in order to access mental health care via telehealth.¹¹ This rule change disproportionately affects rural people who face longer wait and travel times to see a GP in person and many of whom have been accessing GP consultations online for many years. While in person assessment is often necessary, for mental health consultations and referrals this rule change seems unnecessary and likely to disadvantage rural patients. Similar concerns have been expressed for nurse practitioners, who are also now required to see patients face to face in the past 12 months to access MBS benefits and who disproportionately work in regional and remote areas.¹²

Without additional policy interventions to address the number and spread of GPs (and other critical services) across underserved rural, regional and remote areas, changes to bulk billing incentives will only address part of the problem. These changes do not address the number of GPs available, the true costs of operating a medical clinic in rural areas and other critical services including women's reproductive health care.

b) the financial sustainability of independently owned rural general practices under current Medicare funding and incentive structures;

The financial sustainability of rural GP clinics is not supported by current Medicare or wider health funding structures.

The current system rewards a caseload built on a high volume of patients with single health issues. According to the National Rural Health Alliance, it does not provide appropriate remuneration to sustain smaller rural general practices without a critical volume of patients and whose patients have multiple comorbidities; or who cannot make a co-payment due to their socioeconomic circumstances.¹³ People living in regional, rural and remote Australia overall have lower incomes¹⁴ and therefore less ability to pay out of pocket costs. Rural people also experience more complex health issues including higher burden of disease¹⁵, which means care is often more complex and requires longer appointments that are not necessarily reflected in MBS item numbers.

This also applies to other primary health care professionals including allied health, dentistry, nursing and midwifery, as there are very few MBS items that patients can claim and the rebates are often very limited. This reduces the financial viability of non-medical private primary healthcare practices in rural areas. This issue is complicated by the fact that rates of private health insurance coverage reduce with geographic remoteness.¹⁶

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

Difficulty accessing timely and appropriate primary health care is associated with higher, avoidable hospital admissions and emergency presentations in rural, regional and remote Australia. There is a higher rate of potentially preventable hospitalisations in all areas outside Major Cities. This is 2-3 times higher in Remote and Very Remote areas.¹⁷ Additionally, people in rural areas face a higher burden of disease and elevated mortality rates, compared to those in Major Cities.¹⁸

Long travel times and delays to access services mean people put off essential health care, which then over time becomes more urgent. This is more pronounced in remote areas of Australia. As noted above, there are fewer doctors in rural areas, and Across Remote and Very Remote areas, there are still more than 18,000 people living with no access to a GP within an hour's drive from their home.¹⁹ And,

inequitable access also extends to other essential medical services. National Rural Health Alliance data shows disparity of access to other health professionals including pharmacists, dentists and medical specialists. People living in Very Remote areas use Medicare almost 50% less than those in metropolitan areas.²⁰

GPs and primary health care are the core entry point to Australia's health care system and a cornerstone of high-quality health care provision. If rural people cannot access a timely appointment with a GP (who knows them and their medical history), and other required wrap-around services, it is highly unlikely we will see improved health outcomes for rural patients.

d) 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;

Women are more likely to suffer multiple and chronic illnesses and require specialist reproductive care throughout their lives. These services are essential and require access to appropriate supporting primary care and allied health services. Poor access to some of these services is well established, especially maternity and pregnancy termination services.

Large parts of rural, regional and remote Australia are underserved when it comes to termination services. In Queensland, there are nine listed surgical abortion providers, none further west than Longreach.²¹ Access to surgical abortion in regional Western Australia, which has only decriminalised abortion in 2024, is unclear.²² Of the 24 high disadvantage regional and rural LGAs in Victoria, 67% did not have any listed surgical abortion providers, 45% did not have any listed medication abortion providers and 60% did not have any listed medication abortion dispensing pharmacies. In NSW, large areas of the state are abortion care 'deserts'. The only public hospitals in NSW openly providing abortion outside of a medical emergency are in Broken Hill, Newcastle and the Royal Women's Hospital in Sydney.²³ Given that an estimated one in four women²⁴ will have an abortion in their lifetime, termination services should be considered essential frontline service, not a specialist, optional service that women should have to travel to access.

Poor access to maternity services is also well documented, especially for women living in remote areas of Australia. Between 1992–2011, there was a 41% reduction in the total number of maternity units in Australia which are associated with rurality.²⁵ Women in rural areas lack birthing services, as well as antenatal and postnatal care close to home. They also experience challenges when their local rural hospital does not offer a maternity service and they must travel long distances to give birth. This is at odds with best practice including midwifery continuity of care and Birthing on Country/Birthing in our Community models recommended by the Australian College of Midwives.²⁶

Rural mothers face different health outcomes due to lower access to services. More rural mothers smoke during pregnancy, more babies are born prematurely, and there are lower rates of exclusive breastfeeding. Rural and remote women are also more likely to experience domestic and family violence (people living in rural areas are 24 times more likely to be hospitalised due to domestic violence than those in Major Cities)²⁷. They also have higher rates of unplanned pregnancies, infant mortalities, low birthweights and preterm babies.²⁸ This is an unacceptable failure in basic health service provision for rural women.

In addition to reproductive health care gaps, there is also a clear need for multidisciplinary care in rural areas. 2025 data shows only 57 percent of GPs work in a multi-disciplinary team and two in three GPs want to do more multidisciplinary team care. Lack of funding, time to collaborate and access to other health professionals are the barriers to achieving this.²⁹ This lack of multidisciplinary care is likely to be more pronounced in rural areas.

The National Rural Health Alliance advocates for the implementation of a new model of health care provision in rural areas to overcome some of the barriers to rural workforce attraction and retention. These barriers are professional (lack of opportunities), financial (viability of practice businesses) and social (isolation and access to education and other services).

The model they propose (PRIM HS) are not-for-profit organisations funded by the government, designed and established by local communities. These models operate on dedicated, ongoing funding models and employ a range of primary healthcare professionals – including general practitioners, nurses and midwives, dentists, allied health professionals.³⁰ PRIM HS provides secure, ongoing employment with a single or primary employer, with attractive conditions including leave provisions and certainty of employment and income. This model relieves practitioners from the commitment of establishing their own practices and operating a financially viable, standalone business. While examples of this model are currently being trialled, more should be done to embed new approaches to deliver holistic health services to underserved communities.

e) the impacts of current Medicare rules and incentive arrangements on large corporate providers compared with small, community-embedded rural clinics;

Currently, close to one in four practising GPs (24%) are practice owners. Interest in becoming a practice owner continues to fall, with 82% of non-owner GPs saying they are not interested in owning a practice in the future.³¹ This demonstrates that across the board there is low interest in running a practice, and this is likely to be much more pronounced in rural or remote areas where challenges such as recruitment and financial viability are likely to be much more stark. The number of GPs who are practice owners is also declining over time, due to factors such as financial and administrative burden.³² At the same time commercial ownership models have emerged and over time, the number of commercial operators has

shrunk, reducing competition in the market and increasing control of those few companies. This is likely to negatively affect access for rural communities, due to multiple smaller services being consolidated in larger practices in larger areas.³³

f) 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; and

While 'Rural Generalist' has recently been approved as a new field of specialty practice within General Practice, and Medicare incentives already increase according to remoteness, there have also been calls for the introduction of rural generalist MBS item numbers. Appropriate remuneration for RGs through Medicare will enable rural generalists to deliver both broad and advanced specialised services within their rural, remote, and First Nations communities.³⁴

The Royal Australasian College of General Practitioners State of the Nation report points to the increasing volume and complexity of patient presentations in general practice without a corresponding increase in consultation time, support, or remuneration. Mental health, chronic disease, and aged care needs are rising sharply, often requiring extended management and follow-up.³⁵

In this context, additional Medicare reforms supported by the NRWC include incentives that acknowledge the true cost and nature of providing care - including medication renewals, ordering tests and making specialist referrals and a move towards a 'blended' model of payments, that combines a flexible payment based on each patient's needs with a fee for each visit. This model can better account for patient disadvantage and ability to pay, which is no longer considered in universal bulk billing.³⁶

g) any other related matters.

Need for more general practitioners in rural areas

As noted above, many rural areas are underserved when it comes to GPs. To help address that gap, the Rural Doctors Association of Australia is calling for 200 FTE new generalist training places and the current 'one off' quota to be converted to permanent training positions. This will enable the relevant Colleges to develop and sustain their training capacity at the required level, as well as give junior doctors and students confidence in their training and career.³⁷

According to the Rural Doctors Association of Australia, general practice training has been declining in popularity as a choice for junior doctors due to complexity of employment arrangements, contract negotiations and loss of entitlements gained while working in the hospital sector. Because the vast majority of medical services in rural and remote areas are provided by GPs and rural generalists, the lower rates of doctors completing GP training is again, disproportionately felt in these areas.³⁸ RDAA and

other rural health bodies advocate for implementation of a Single Employer Model (SEM) where a central employer employs a GP throughout their different placements. RDAA also advocates for this model for GP fellows, to enhance the attractiveness of pursuing a career as a GP, allowing them to work across hospital and community-based programs.

Accessible health care for rural women and girls

Women and girls face barriers accessing the right medical treatment, which can lead to poorer health results like delayed diagnosis and treatment, over prescribing and dismissal of pain.³⁹ Women pay more and are more likely to delay their treatment. In fact, women are nearly twice as likely to delay seeing a GP, with 1 in 25 women delaying care in the past 12 months, compared to 1 in 40 men.⁴⁰ Women are often more likely to prioritise the care of others around them, often at the expense of their own health.⁴¹ Rural women in particular, who are known to be stoic and used to adversity, may be at risk of delaying medical care and prioritising the wellbeing of their family members.⁴²

To effectively improve access to primary and allied health care in rural regional and remote areas, NRWC supports the implementation of tailored to community, needs-based multidisciplinary health care services in rural areas. By integrating services in one location, better holistic care can be provided and some of the financial sustainability barriers faced by health services operating in rural areas can be overcome, though sharing resources. Alongside GPs, these types of service offerings should consider women's health needs including midwifery, reproductive health services, mental health, specialist domestic and sexual violence and relevant allied health services.

Travel costs

If a rural woman gets a specialist referral from her GP, she is likely to face additional barriers accessing those specialist services which often do not exist in rural areas. Australia's various patient transport schemes add another layer of difficulty for these women, by failing to properly cover travel costs for women to access the specialist services they need.

Not only are the schemes inconsistent and therefore inequitable, but the payment rates are inadequate, particularly the accommodation rates. Most of the accommodation subsidy rates are between \$45 and \$70 per night, leaving patients paying a very high out of pocket cost per night.⁴³ The combination of out-of-pocket costs for both travel and accommodation, as well as other associated costs like meals or childcare, create an unreasonable cost burden for rural regional and remote patients. This means that rural patients either pay more, or they delay or choose not to receive treatment.

Recommendations

The NRWC advocates for the following policy changes to strengthen the existing Medicare changes:

1. Remove the need for a face-to-face consultation to access mental health care via telehealth and ensure midwives can access incentives for LARC consultations.
2. Introduce rural generalist Medicare incentives that properly remunerate the breadth and depth of services provided by rural GPs
3. Commit to an ongoing increased allocation of rural generalist training pathways
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5. Review reproductive health care (including maternity and termination services) provision across rural Australia and develop a strategy to address gaps
6. Nationalise patient travel and accommodation subsidies to be administered under Medicare, ensuring equality and improved coverage for rural patients.

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