Consumers Health Forum of Australia

SUBMISSION

Senate Inquiry: Rural, Regional and Remote Medicare Access and Funding

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Consumers Health Forum of Australia (2026)
Submission to the Senate Inquiry on Rural, Regional and Remote Medicare Access and Funding

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CHF deeply respect the lived and living experiences of health consumers, carers, families, and communities across Australia and recognise the right of every person to equitable access to healthcare, regardless of their background or circumstances. We particularly recognise all of the health consumers who generously contributed their stories and experiences to this document.

CHF acknowledges Naomi Thomson, Senior Policy Analyst, as the lead author of this submission and extends its appreciation to all team members who reviewed and contributed to this document.

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Rural, regional and remote Australians continue to experience deep and persistent health inequities driven by chronic underinvestment, limited service availability and Medicare settings that do not reflect or respond to the realities of rural life. Consumers consistently report long waiting times, limited provider choice, lack of continuity of care, high out-of-pocket costs and the need to travel significant distances for basic care, all issues that sit at the heart of this Inquiry's focus on primary care access and affordability.

Meaningful, ongoing engagement with rural and remote consumers and communities is essential to achieving sustainable change and should be central to this Inquiry. Embedding consumer voices, including those of First Nations peoples, in all stages of policy development and service design is critical to ensure reforms are fit for purpose.

Locally led, place-based models of care are the most effective way to deliver safe, accessible and culturally responsive healthcare. These models recognise the diversity of regional, rural and remote communities, leverage local strengths, and embed multidisciplinary approaches that work in areas with limited workforce and infrastructure. However, current Medicare settings, funding arrangements and workforce constraints limit the viability of such models. Without flexible funding models, modernised scopes of practice, and long-term rural workforce development through coordinated approaches, rural services cannot deliver the continuity and coordination required for equitable care.

To drive progress, Australia needs a National Rural Health Strategy, co-designed with regional, rural and remote consumers, consumer organisations, First Nations communities, healthcare providers, and other rural stakeholders, that defines what equitable access looks like in rural and remote settings and aligns Commonwealth, State and Territory investment. A national strategy would provide the structure, accountability and long-term commitment required to address rural health inequities and ensure that consumer voices are embedded at every stage of reform. This Inquiry has a critical opportunity to support a coordinated, community-driven approach that delivers a fairer, stronger and more effective Medicare and wider health system for all regional rural and remote Australians.

Consumers Health Forum of Australia's (CHF) recommendations are as follows:

Consumer Engagement

1. Establish formal, embedded consumer engagement mechanisms in all regional, rural and remote health reform processes, including dedicated engagement with First Nations communities.

2. Support locally led models of care that reflect community-identified needs and priorities.

3. Hold Inquiry hearings in rural and remote locations, specifically Modified Monash Model (MMM) 3-7 regions, to ensure lived experience meaningfully informs this Inquiry.

A National Rural Health Strategy

4. Develop and fully fund a National Rural Health Strategy, co-designed with regional, rural and remote consumers and communities.

5. Support the National Rural Health Alliance's work to define optimal levels of access and align funding with the true cost of rural service delivery.

Affordable and accessible primary care

6. Support blended funding models combining fee-for-service with block funding to ensure equitable, place-based care in regional, rural and remote communities.

7. Remove in-person attendance requirements for telehealth rebates and MyMedicare registration.

8. Expand Medicare rebates to support longer and multidisciplinary telehealth consultations.

9. Invest in reliable digital infrastructure as a healthcare access enabler, including broadband, mobile coverage, 000 access and telehealth hubs.

10. Strengthen telehealth readiness through community digital health literacy programs and provider training and equipment.

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11. Improve urgent and after-hours care through rural and remote specific models co-designed with local communities and providers.

Workforce development

12. Prioritise long-term regional, rural and remote workforce development through coordinated recruitment, training and retention strategies and supports.

13. Enable advanced, multidisciplinary service models that blend in-person and telehealth care, supported by flexible cross-setting work arrangements.

14. Implement reforms recommended in the 'Unleashing the Potential of our Health Workforce – Scope of Practice Review' Final Report to enable rural and remote health professionals to work to their full scope.

Travel support

15. Establish a more equitable and responsive Patient Assisted Travel Scheme with harmonised national elements, expanded eligibility and subsidies that reflect real costs.

Community education

16. Fund community-based Medicare education programs for rural and remote communities.

Inclusive care

17. Strengthen cultural, language and identity-specific support through translated materials, interpreter engagement and training, multicultural liaison roles, inclusive, affirming care for groups with specific needs, and community led First Nations models of care.

Data improvement

18. Enhance Medicare data transparency and usefulness by requiring full geographic disaggregation of service use, bulk billing rates and out-of-pocket costs.

Introduction and background

The Consumers Health Forum of Australia (CHF) welcomes the opportunity to provide a submission to the Senate Inquiry into Rural, Regional and Remote Medicare Access and Funding. As the national peak body representing the interests of Australian health consumers, CHF works to achieve safe, quality, timely, inclusive, affordable healthcare for all Australians, supported by accessible health information and systems. Our submission centres the consumer perspective, ensuring that the voices, experiences, and priorities of health consumers are amplified and embedded at the heart of health reform.

Regional, rural and remote communities continue to experience persistent health inequities. People living outside of major cities often have poorer health outcomes, higher rates of hospitalisation, chronic disease, and premature and preventable death. They also have less access to, and lower use of, primary health care services.[1]

Despite the clear need, recent research demonstrates that government continues to spend significantly less on rural and remote consumers than their metropolitan counterparts.[2] In 2023-24 the annual expenditure deficit was $1,090 per rural person (age-standardised), amounting to an $8.35 billion annual rural health funding deficit compared to funding for metropolitan areas. Equivalent health spending, however, does not necessarily result in equal health outcomes. Rural and remote Australians face a triple healthcare disadvantage: higher costs of accessing and delivering care, poorer service availability, and greater health needs driven by worse social determinants and higher disease prevalence.[3] People in these areas are often sicker and require longer health consults, while basic preventative measures, such as access to fresh food, are often more difficult and more expensive. CHF's 2025 National Consumer Sentiment Survey also found that rural and remote residents reported lower satisfaction with healthcare quality, greater difficulty navigating the system, and more challenges accessing after-hours care than metropolitan residents.[4]

CHF supports urgent action to improve access to health care in regional, rural and remote locations. We recognise that this Inquiry is focused on Medicare access and funding in these regions. However, Medicare is only one component of a broader policy landscape that has contributed to the historical and ongoing disadvantages experienced by consumers living in rural Australia. Further, not everyone living in regional, rural and remote Australia is eligible for Medicare. Achieving meaningful, sustainable improvements in regional, rural and remote health requires a comprehensive, integrated approach that considers the full range of factors influencing healthcare delivery and outcomes, including prevention, and a broader, long-term commitment to strategic investment in regional, rural and remote Australia. This must extend beyond health to include industry, housing, transport, education and childcare, creating the foundations for sustainable growth and, in turn, supporting a strong and stable healthcare workforce.

In January-February 2026, CHF invited regional, rural and remote consumers across Australia to respond to an online survey or attend an online discussion to share their experiences with the health system. In total, 28 consumers responded, with participants from most states and territories, as well as a mix of regional, rural and remote locations. We also drew upon insights consumers and consumer organisations have shared with us in

recent years through other consultations, CHF's National Consumer Sentiment Surveys, and recent discussions with key stakeholders. Consumers' experiences and perspectives are reflected throughout this submission, including in the form of direct quotes. Where requested, respondent's names have been changed to protect their privacy.

Regional, rural and remote consumer feedback highlights a deep challenge in the way national health policy settings are designed. Many existing frameworks implicitly assume metropolitan conditions. These include stable workforces, dense populations, and ready access to services. Such assumptions do not hold in rural and remote communities.

There are two broad options in responding to this misalignment. One is to design policy settings specifically for rural contexts. The other is to invest in the infrastructure, workforce, transport systems, and community capacity required to make existing policies workable in rural environments. Our submission makes recommendations that contribute to both approaches. These recommendations are grounded in what consumers are telling us and signal the need for a more deliberate and equitable redesign of national health policy, so that it genuinely works for regional, rural and remote Australia.

Engaging rural healthcare consumers

Regional, rural and remote communities are diverse, each with distinct contexts, challenges and priorities. To be effective, health reforms that impact on these areas must be designed, implemented and evaluated in partnership with these communities.

Consumers repeatedly tell us they want to be active partners in shaping local solutions, yet many feel excluded, unheard and disempowered, which fuels frustration, stress and anxiety.

> *"There is extreme stress and anxiety within the community regarding local health service redevelopment. There appears to be no influence on the board, CEO or government departments from the healthcare workers and general public they serve." – Therese, Regional NSW*

> *"[I have lived here] 13-14 years, but I've never seen any genuine consultations among the local community and the health and the government officials." – Saba, Regional NSW*

The government's recently released National Consumer Engagement Strategy highlights the importance of enabling and supporting consumer participation across all stages of health policy-making and decision making, including policy development, implementation and evaluation activities.[5] It provides a framework for how to do this in a purposeful, inclusive, respectful, collaborative and transparent way and how to partner with consumer organisations and networks to achieve this.

In the regional, rural and remote healthcare context, we would emphasise the particular importance of engagement with First Nations communities. The lack of recognition of this is a gap in this Inquiry's Terms of Reference.

> *"Listen to the consumer, it's their story" – Aunty Maureen, Remote QLD*

Locally led planning, design and reform ensures consideration of the specific needs of First Nations and geographically isolated populations, and the great diversity between regional, rural and remote communities. The National Rural Health Alliance has consistently demonstrated the success that locally owned and led models of care can have in rural and remote communities.[6] Any future healthcare reform in these regions must involve formal, embedded consumer representation and engagement, including within governance mechanisms, to adequately understand and respond to the needs of healthcare consumers in each region. Importantly, existing consumer organisations and networks (including CHF) play a critical role as enablers and partners in ensuring rural and remote health reforms genuinely reflect local needs.

> *"There really needs to be some sort of mechanism for community participation through regular consultation with community groups… that's really important if you want to know the needs and challenges of the local community."*
> *– Saba, Regional NSW*

While CHF supports the principle of formal 'rural stress-testing' of all proposed Medicare Benefits Schedule (MBS) reforms, this mechanism on its own will not resolve the deeper issue that national policy settings often assume metropolitan conditions that simply do not apply in rural and remote communities. Rural testing is an essential safeguard to identify unintended consequences and assess impacts on access; however, technical testing cannot substitute for direct, ongoing engagement with regional, rural and remote consumers themselves. Only by pairing structured rural impact assessments with lived-experience input can policymakers ensure that MBS changes are not only analysed for rural feasibility but genuinely shaped by the realities of the communities they are intended to serve.

In line with this, this Inquiry should demonstrate its commitment to genuine engagement with consumers by holding hearings in rural and remote Australia, particularly in Modified Monash Model (MMM) 3-7 regions, where the burden of poor access and system failures is felt most acutely. Convening hearings in MMM3+ regions would allow the Committee to hear firsthand experiences from a wide range of local stakeholders and ensure that rural realities meaningfully shape the Inquiry's findings and recommendations.

Recommendation 1: Establish formal, embedded and sustainable consumer engagement mechanisms in all regional, rural and remote health reform processes, including dedicated engagement with First Nations communities.

Recommendation 2: Support locally led models of care that reflect community-identified needs and priorities.

Recommendation 3: Hold Inquiry hearings in rural and remote locations, specifically Modified Monash Model (MMM) 3-7 regions, to ensure lived experience meaningfully informs this Inquiry.

A National Rural Health Strategy

Achieving meaningful, sustainable improvements in regional, rural and remote health will require a comprehensive, integrated approach that considers the full range of factors influencing healthcare delivery and outcomes. A National Rural Health Strategy, co-designed with healthcare consumers, consumer organisations and local communities, providers and stakeholders, and supported by dedicated funding would provide the structure, accountability and investment needed to achieve sustained change. By coordinating Commonwealth, State, and Territory investment in health for regional, rural and remote Australia, it would help to ensure that services in these regions are not expected to deliver metropolitan-level care on metropolitan-designed budgets. It will also provide a mechanism for ongoing, structured and funded consumer engagement processes and locally led planning processes.

The National Rural Health Alliance's work on defining optimal levels of access to primary healthcare highlights the need for a clear, evidence-based formula for determining what equitable care looks like in regional, rural and remote areas. Their framework argues that equity requires parity of access, not identical service models, and calls for funding that reflects the higher cost of delivering care in these settings, the need for multidisciplinary teams, and the importance of culturally safe, community-led models. Supporting this work would help government define what "optimal access" means in practice and ensure funding models are aligned with real need.[7]

Recommendation 4: Develop and fully fund a National Rural Health Strategy, co-designed with regional, rural and remote consumers and communities.

Recommendation 5: Support the National Rural Health Alliance's work to define optimal levels of access and align funding with the true cost of rural service delivery.

Responses to Terms of Reference

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

For regional, rural and remote Australians, the most significant barrier to equitable healthcare is access itself. When essential services are limited, distant, or entirely absent, communities are left navigating a system that cannot meet them where they live, entrenching poorer health outcomes and widening existing disparities.

> *"In my experience if you're trying to get help under the public system then it's just the expectation that you'll have to wait a long time and that it may not be available in your area." – Brendan, Regional VIC*

Long waiting times and limited provider availability shape almost every aspect of rural and remote healthcare experiences. Many consumers report experiencing long waits for basic healthcare, sometimes so long that they become significantly more unwell while waiting, resulting in a need for acute care. Consumers particularly struggle to access timely specialist care, often waiting months to years to see someone, regardless of urgency. Meanwhile, even consumers who have a regular GP find appointments are often booked out for weeks.

> *"It took me 6 months to access a rheumatologist and 9 months to access a psychiatrist… In that waiting time I had to give up my job because I couldn't access help and our family income almost halved." – Kate, Regional TAS*

> *"If I am lucky, it takes six weeks to gain a "next appointment" with my preferred GP. It is longer for my husband, and he has more complex medical needs." – Therese, Regional NSW*

Consumers consistently tell CHF that living in a regional, rural or remote area significantly limits their choice and control when it comes to healthcare. With limited services and providers available, consumers often feel forced to accept whatever they can get, regardless of cost, wait times, or personal preference.

> *"It's more that you get what you're given, so choice or control would be something I'd value. I don't feel I have that, I doubt that many do." – Brendan, Regional VIC*

Where healthcare is available, affordability is another major barrier to consumers in these areas accessing the care that they need. Consumers consistently report struggling to access affordable primary care services, with growing out-of-pocket fees becoming an increasing problem. Even short appointments for routine items, such as new prescriptions, can be a significant cost burden for many.

> *"The standard appointment time is so short, and costs approx. $60 out of pocket. Paying that when I simply need a new script is a significant cost burden in my budget, and I make good money." – Alex, Regional TAS*

The 1 November 2025 Medicare changes introduced expanded bulk billing incentives, a new Bulk Billing Practice Incentive Program, strengthened continuity requirements through MyMedicare, and aligned telehealth incentives with face-to-face care.[8] While these reforms were intended to improve affordability, stabilise general practice viability, and embed continuity of care, their impact in rural, regional and remote communities is varied and uneven. Notably, it has only been just over four months since the changes were implemented and it is simply too early to provide a comprehensive, evidence-based assessment of their impact. However, what CHF has heard recently from consumers on the ground is that they are not yet experiencing any significant change to cost.

Some rural and regional consumers report having greater access to bulk-billed appointments. However, many report seeing no local benefit from recent changes, and note that many practices continue to choose not to offer bulk billing.

> *"I was hopeful that there may be more opportunities to get bulk billed appointments after the recent announcement of that being expanded, but all I've seen anywhere I've looked is notices saying the practice won't be offering it." – Alex, Regional TAS*

Where bulk billing is available, many consumers report challenges accessing these clinics due to popularity and note that for many consumers it is still challenging to pay out of pocket expenses, even if they are recuperated later.

> *"There is one GP who will bulk bill via Medicare. That service shut their books many years ago and only intermittently allow "new" patients on the books when a prior patient is no longer accessing the service. Pensioners and the surrounding communities are required to pay the GP and then have the Medicare benefit recouped. Many pensioners cannot afford the cost and are presenting to the Health Service Emergency Department." – Sharyn, Rural NSW*

Families continue to report significant financial strain when seeking care, and some have had to change to private health cover or delay appointments due to cost and scheduling barriers.

> *"My GP used to sometimes bulk bill me if it was a quick visit, but now every visit is charged, even if it's just to pick up a repeat script. I have to try and manage my appointments so that I get all my needs met in one visit rather than keep going back." – Lee, Regional NSW*

Certain healthcare appointments have been particularly highlighted by consumers as expensive, including non-GP specialists, mental health, and perinatal care.

> *"Having a baby in this community is very expensive- with no bulk billing options." – Meredith, Remote WA*

Community members also express concern about unstable clinic management, rising fees, and uncertainty about the future of local services.

> *"It's scary how many practices are closing in Tasmania, and how dependent the rural and regional areas are on GP practices owned by private capital that may pull out." – Kate, Regional TAS*

Addressing the affordability issues in regional, rural and remote communities is complex. Many government funding sources include regional loadings to offset the higher costs of delivering care in these areas. While such loadings are vital, they rarely bridge the full gap. As a result, providers are often forced to balance affordability for patients with the financial viability of providing services. This is particularly evident in MMM7 (very remote) regions, where the highest bulk billing rates coexist with the highest average out-of-pocket costs for GP appointments.[9] Small and dispersed populations simply cannot absorb these inflated costs, making long-term service sustainability increasingly difficult. When local services become unaffordable or unavailable, consumers face even greater financial strain through travel, accommodation, and lost income (see p 20 for more on this issue).

As highlighted by the NRHA, addressing equity of access and improving health outcomes for rural Australians requires recognising that market-based fee for service models cannot deliver for small populations spread across large distances. The *Unleashing the Potential of our Health Workforce: Scope of Practice Review* reported that fee-for-service models consistently limit scope of practice and teamwork, restricting access to optimal, multidisciplinary care, whereas blended, bundled, block-funded and salaried payment models enable greater teamwork, scope of practice and sustainability.[10]

Regional, rural and remote health services therefore need blended funding models, with block funding provided to supplement fee-for-service. Such funding models should be designed to deliver place-based solutions based on local population health needs while also acknowledging and addressing workforce realities.[11]

Recommendation 6: Support blended funding models combining fee-for-service with block funding to ensure equitable, place-based care in regional, rural and remote communities.

The 1 November 2025 Medicare changes also impacted telehealth. Telehealth is a vital enabler of healthcare access in regional, rural and remote Australia, particularly where local service availability is limited. However, telehealth services cannot be viewed as a substitute for in-person services or seen as the primary solution to rural workforce shortages. Equitable healthcare must always include the ability to access face-to-face care when needed. Telehealth does, however, have an important role in alleviating the burden of travel costs and providing care pathways in rural and remote areas. Many consumers living in these communities refer to telehealth as a helpful and valuable aspect of their care.

> *"Telehealth has been amazing and some pharmacies will take telehealth scripts and deliver them to town with a few other people's so we don't have to drive the one hour each way." – Remy, Rural NSW*

Government could do more to make telehealth a reliable, affordable, and genuinely accessible part of healthcare in rural and remote Australia. Consumers consistently tell us that while they would like to use telehealth more often, it is not always offered as an option and not supported as much as it should be.

> *"Many clinicians are not using telehealth and if they are, only using phone. Telehealth is not being supported or promoted as it should" – Marianne, Outer Regional NT*

Currently, there is a requirement for consumers to have attended an in-person GP consultation at least once in the past 12 months to be eligible for a Medicare telehealth rebate. This disproportionately disadvantages people who live a significant distance from their GP clinic. The 1 November 2025 changes also extended this requirement to nurse practitioner appointments. In a survey conducted by the Australian College of Nurse Practitioners, 82.9% of nurse practitioners surveyed believed their patients would struggle to meet this face-to-face requirement.[12] Being registered with MyMedicare at a practice can remove the 12-month rule, however this initiative relies on the idea of a "regular" GP. In many rural and remote areas, high GP turnover, locum reliance, and chronic workforce shortages make establishing this very challenging. Furthermore, to be eligible to register with MyMedicare, a consumer must have had two face-to-face appointments with the same practice in the previous 24 months (or one visit for remote locations) and their chosen practice must be registered with MyMedicare.[13] Additionally, there is a lack of awareness of MyMedicare, with only 32.5% of rural and regional respondents to CHF's recent NCCS survey aware of this program.[14] MyMedicare's relevance and benefit in rural and remote areas is highly questionable, as its design assumptions simply do not align with the realities of life in these communities.

Similarly, changes related to telehealth appointments for mental health could also negatively impact rural and remote consumers, as access to mental health care is now tied to having a regular GP, which, as outlined above, many do not (and simply cannot) have.

Recommendation 7: Remove in-person attendance requirements for telehealth rebates and MyMedicare registration.

Expanding Medicare rebates for longer and multidisciplinary telehealth consultations allows more equitable care in regional, rural and remote areas. Longer telehealth items would enable clinicians to undertake comprehensive assessments, care planning and chronic disease management, while multidisciplinary telehealth rebates would facilitate coordinated input across general practice, nursing, allied health and specialist services. This is an essential mechanism for regions where local workforces are thin, fragmented or absent.

Recommendation 8: Expand Medicare rebates to support longer and multidisciplinary telehealth consultations.

Importantly, access to telehealth relies on a number of enabling conditions, including digital infrastructure, digital literacy and access to technology. The digital infrastructure needed for telehealth in rural and remote areas is often patchy and unreliable, which makes it hard for people to use telehealth consistently. Virtual care can exacerbate health inequities by excluding people who do not have internet access, access to digital devices or who cannot

afford mobile data. Reliable digital infrastructure is essential for accessing telehealth and other remote care options. Improving broadband and mobile coverage in rural and remote areas would help to ensure virtual care is genuinely usable and reliable. Establishing local telehealth 'hubs', for example in local libraries, can also help to provide access to technology and the internet for individuals who lack these resources at home. Alongside this, investment in digital health literacy, delivered through local community groups, would help residents feel more confident to access video consultations, online triage and specialist care.

Finally, supporting rural and remote health providers with necessary training and equipment, is essential to ensure telehealth becomes an integrated and dependable part of rural and remote healthcare.

Recommendation 9: Invest in reliable digital infrastructure as a healthcare access enabler, including broadband, mobile coverage, 000 access and telehealth hubs.

R**ecommendation 10:** Strengthen telehealth readiness through community digital health literacy programs and provider training and equipment.

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

The access and affordability issues outlined above directly impact on avoidable emergency presentations in regional, rural and remote areas. As GP books fill and new patients are turned away, many residents rely on hospitals for timely and affordable care.

> *"There are currently several weeks waiting list to see a doctor in a clinic- often the hospital is the place people go to get medical help- because you will be seen that day- even if you have to wait 5 hours - and you don't have to pay." – Meredith, Remote WA*

The lack of timely access to primary care services can result in conditions getting significantly worse during long waiting periods, eventually leading to a consumer's condition worsening to the point that they require urgent care.

Similarly, the lack of after-hours support available in many rural, remote and regional locations means consumers have no choice but to attend hospital emergency departments for care.

> *"We need more out of hours clinics to take the pressure off emergency departments." – Lee, Regional NSW*

> *"[For urgent or after-hours care] you go to hospital or call the local ambulance- if the latter is unavailable as he is on a more urgent call, you need to get yourself to the hospital." – Sarah, Remote QLD*

Furthermore, rural and remote Australians face significant barriers even accessing hospitals for urgent and emergency care due to distance, limited service availability, and reliance on volunteer-based transport Many communities have no local hospital or only small facilities unable to manage emergencies, forcing residents to travel long distances to access care.

> *"There is no established hospital or go to service in my location. If I call an ambulance. I am escorted by ambulance to the nearest hospital which is 60kms away. The hospital that is closer, roughly 15kms away is not well equipped for emergencies." – Natasha, Remote WA*

Ambulance response times vary, with some remote areas dependent on single-officer or volunteer crews who may be unavailable, leaving patients to arrange their own transport in critical situations. These experiences highlight the need for strengthened emergency capacity, improved staffing models, and more reliable, locally accessible urgent care pathways in rural and remote communities.

> *"The only issue is if there is a medical emergency as we rely on volunteer medical transport and there is oftentimes a wait to get them to your place and then there's the 1.5 hour drive to the [hospital]. You would not be wanting to have a heart attack or be bitten by a snake - let's say." – Tess, Regional TAS*

Urgent care clinics (UCC) are a recent Medicare-funded initiative that aim to reduce pressure on hospital emergency departments by providing fast, free, and accessible treatment for urgent but non-life-threatening health issues.[15] Consumers who can access these clinics have reported positive experiences.

> *"When I had to access urgent care when in Townsville for my mother - that was very different. We attended an Urgent Care clinic and it was just excellent, very impressive." – Hannah, Remote QLD*

However, of the 123 existing clinics, only approx. 14% are in regional areas (MMM2), 11% in rural areas (MMM3-5) and 7% in remote areas (MMM6-7).[16] Similarly, of the 50 Medicare Mental Health centres around the country, approx. 52% are in metropolitan areas, 8% in regional areas (MMM2), 36% in rural areas (MMM3-5) and only 4% in remote areas (MMM6-7).[17]

Even where urgent care clinics exist, long waits, lack of onsite diagnostics, limitations around prescriptions and the need to travel between multiple locations for imaging or follow-up can contribute to delayed treatment and poorer outcomes.

> *"A GP at the urgent care clinic refused to provide a script of antibiotics for a condition and [she] was sent to ED. She did not get the script for antibiotics for over 28 hours and suffered more pain unnecessarily." – Marianne, Outer Regional NT*

Moreover, the recent second interim evaluation of UCCs has highlighted that workforce shortages and attrition impact significantly on the effectiveness of these clinics in rural and remote locations.[18] UCCs are a clear example of a service designed for metropolitan areas that are simply not as effective or viable in a rural or remote context. There is a need to explore after-hours and urgent care options and models of care that are responsive to rural and remote contexts and their related challenges. For example, this could involve expanding the after-hours capacity of existing GP clinics, as has been recommended previously by the Rural Doctors Association of Australia.[19]

Beyond this, there is a clear need to address workforce constraints in these regions to support new models of urgent and after-hours care. See the following section for more on this issue.

Recommendation 11: Improve urgent and after-hours care through rural and remote specific models co-designed with local communities and providers.

d) The adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities

Mixed-team models of care are widely recognised as best practice in regional, rural and remote communities because they bring together the right mix of clinical, allied health, and other expertise needed to address the high burden of chronic and complex illness in these communities. Such teams may include GPs, rural generalists, nurses, nurse practitioners, allied health, midwives, and Aboriginal health workers.

When these multidisciplinary teams are supported by strong wrap-around services, such as care coordination, social and emotional wellbeing supports, transport, outreach and links to housing, disability and aged-care systems, people can receive genuinely integrated care that reflects the realities of living rurally. Embedding consumer choice within this model is essential, it ensures care is person-centred, culturally responsive and flexible, which allows individuals to choose providers and modes of care that align with their needs, preferences and community context. As recognised in the current National Health Reform Agreement, "*For people living in rural and remote communities, where possible, service delivery models should focus on the needs and preferences of the person receiving care*."[20] Together, mixed-team care, wrap-around supports and consumer choice can create a sustainable, responsive and equitable model that improves access and delivers better outcomes for rural and remote populations. However, the ability to deliver this model at scale is severely constrained by persistent workforce shortages that limit service availability, continuity and community reach.

Workforce shortages are one of the most significant barriers to timely, reliable and quality healthcare in rural and remote Australia. Small towns often rely on only a handful of doctors and nurses who are not available full-time, leaving patients waiting weeks or months for appointments. For example, rural communities located in MMM5 areas (small rural towns) have been shown to have 55% fewer health professionals per capita than metropolitan (MMM1) communities.[21]

> *"We have 3 doctors, but they don't always work 5 days a week. Our nurses are taking a much more active role, but they also don't work 5 days per week." - Kathryn, Remote TAS*

These issues are exacerbated when a person is referred to a specialist. The waiting time between receiving a referral for a specialist and actually seeing one is consistently highlighted by consumers as a significant issue, with potentially harmful consequences.

> *"I just wish that the time gaps between getting a specialist referral and an appointment to see that specialist were much shorter. We weren't told that there was any urgency or of any symptoms to be aware of for escalation. We might have tried to find a private practitioner if we were fully informed and my partner might still be with me if he hadn't had to wait over 6 months for an appointment." – Julie, Rural VIC*

> *"[My husband's] quality of life has been diminished because it is difficult to get timely care." – Therese, Regional NSW*

Workforce constraints shape the quality and consistency of care people receive. While regional, rural and remote consumers deeply value the dedication and compassion of local clinicians, they report that limited staffing, fragmented service models, and high turnover undermine continuity and long-term monitoring. They also recognise the strain on local providers and the potential for exhaustion and burnout.

> *"I feel like it's impossible to have a doctor that knows me as a patient anymore, so the quality of care is definitely less than when I had a long term GP." – Alex, Regional TAS*

> *"I'm lucky to have found a good GP - but, she's hard to get into, and to be honest, looks exhausted. Whilst she gives me the time I need, I do see her energy diminishing." – Nardia, Rural VIC*

Of the consumers we surveyed for this submission, the vast majority felt that building the workforce and ensuring the retention of more experienced, long-term providers in rural and remote areas was the change that would most significantly impact their healthcare experience. Locum and fly-in fly-out staff fill workforce gaps, but they also disrupt continuity of care. Consumers also feel that some visiting clinicians can misunderstand the realities of remote or rural life. Communities want more locally based practitioners who understand their context, supported by multidisciplinary teams that blend in-person and telehealth care in ways that actually work for rural and remote communities.

> *"[We need] more country people being country doctors. City or overseas doctors don't understand that there are differences." – Remy, Rural NSW*

Building a stable local workforce, rather than relying on locum or fly-in fly-out models, must remain the priority in rural Australia. Locally based staff reduce discontinuity of care, curb the cycle of workforce turnover, and foster trust and stronger relationships through their understanding of local culture, circumstances and services.[22]

To achieve this, there needs to be sustained investment in attracting, training, mentoring and ultimately retaining regional, rural and remote health professionals. This is complex, as there are broader systemic issues that undermine attempts at this, including limited medical student and healthcare provider accommodation, lack of schooling options for healthcare provider's children and limited employment opportunities for their partners.

> *"I know there are a lot of fancy stuff to attract health professionals in a rural and regional areas, but there isn't any mechanism to retain them because I always keep on telling it's easy to attract, it's really hard to retain the health professionals." – Saba, Regional NSW*

Strengthening and boosting the sustainability of the rural workforce should involve consideration of coordinated recruitment, training and retention strategies, bonded pathways, rural generalist programs, mentoring programs, housing and relocation support, and measures addressing partner employment and schooling.

Flexible workforce models that enable clinicians to work across public and private settings are also needed. Joint regional training and supervision arrangements would expand professional development opportunities, strengthen supervision for extended scopes of practice, and help build a stable local workforce.

Multidisciplinary care could be further supported through advanced service delivery models that blend in-person and telehealth care. These hybrid models allow clinicians from different providers to collaborate without being co-located, thereby improving continuity of care and reducing reliance on short-term or fly-in fly-out clinicians. By building on existing arrangements that already allow staff to work across services delivered by different providers, this approach enhances the collective capacity of services to provide services and share expertise.

Recommendation 12: Prioritise long-term regional, rural and remote workforce development through coordinated joint recruitment, training, supervision and retention strategies and supports.

Recommendation 13: Enable advanced, multidisciplinary service models that blend in person and telehealth care, supported by flexible cross setting work arrangements.

Strengthening and modernising scopes of practice has the potential to improve access to care, including multidisciplinary care in regional, rural and remote Australia by enabling a broader range of health professionals to work to the full extent of their skills and contribute to delivering comprehensive, team-based care in their communities.

Allowing nurse practitioners, nurses, pharmacists, allied health professionals and other clinicians to take on expanded roles that are supported by clearer pathways, reduced regulatory barriers and better team-based models would ease the pressure on an already overstretched local GPs, shorten wait times, and make multidisciplinary care genuinely achievable. Implementing scope of practice reforms recommended in the Unleashing the Potential of our Health Workforce – Scope of Practice Review[23], as well as the current National Health Reform Agreement[24], would not replace the need for more clinicians, but would unlock capacity, improve continuity, and help ensure people can access timely and coordinated care closer to home.

> *"Access to health care will be much easier when doctors accept the changes we as patients need to allow other kind of practitioners to work to their full scope of practice, for which they are trained and qualified!" – Kate, Regional TAS*

For example, midwives are trusted local healthcare providers who are well-positioned to deliver long-acting reversible contraception within their communities. However, current regulations do not allow them to provide these services. Additionally, there is a need to support the growing reliance on community pharmacists to provide care in rural areas.[25]

Recommendation 14: Implement reforms recommended in the 'Unleashing the Potential of our Health Workforce – Scope of Practice Review' Final Report to enable rural and remote health professionals to work to their full scope.

f) Reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians

i. Travel support

Access to healthcare, including Medicare-funded healthcare is shaped not only by the availability of services, but by the cost of reaching them. This is an issue that disproportionately affects people in rural and remote communities. Consumers in these locations consistently tell CHF that one of the major barriers they face to accessing care, including GP, allied health, and particularly specialist care, is having to travel outside of their community and incur associated costs. For many consumers the lack of local services in their community can mean these travel times are significant, even for minor or recurring matters.

> *"I have to travel 60 kms each way to the GP. There are closer GPs but none of them were accepting new patients when I came here 25 years ago." – Julie, Rural VIC*

People in rural and remote areas face a wide range of costs when travelling for healthcare. Beyond the basic expenses such as fuel, transport and accommodation, consumers often incur additional nights of accommodation for multi-day trips, parking fees at health facilities, loss of income from time away from work, and childcare costs. Many consumers also need to travel with a support person for medical, cultural or safety reasons, potentially doubling the cost of travel, accommodation and lost wages. These combined direct and/or indirect expenses create a significant financial barrier to accessing essential care for rural and remote Australians.

> *"[I have to travel] one thousand kilometres to a specialist. Travel and accommodation, meals and time away from work, plus if you need a carer. Took 7 years to get my knee done, then I got an infection, had to go back and forward to major hospital for treatment. PTS [Patient Transport Scheme] doesn't give you enough money to cover costs. Also, not everyone has a carer or someone to take them to city appointments." – Aunty Maureen, Remote QLD*

> *"The time required to access specialist medical care away from home is so much greater than those in metro areas could ever imagine, so the impact of poor health is much greater as I can no longer work due to how frequently I have to travel for care." – Hannah, Remote QLD*

Cost is not the only prohibitive factor when it comes to travel. For many consumers, particularly those that are very unwell or have support needs that are difficult to meet when away from home, travel can be significantly detrimental to their health and wellbeing. For example, one consumer in rural Tasmania shared their experience of needing to travel for care, but being so negatively impacted by the travel that they were non-verbal upon arrival at their specialist appointment. This significantly impacted how helpful and effective the appointment could be in those circumstances.

For some consumers, the lack of accessible care in their region and the challenges associated with travel are so extreme that they have decided to move closer to areas that do have the services they need.

> *"I now live part-time with my son in a Queensland regional town because my closest rural township from our farm does not offer the level of healthcare and support I require for my chronic health condition…at the farm I am quite isolated from community connections, with no public transport available to access medical care."*
> *– Carolyn, Rural QLD*

> *"I am coming to the realisation if I want to be proactive in my health and ensure I maintain my independence I may have to relocate, which is very difficult given my current circumstances. It says something that I have gone from championing rural services to feeling so hopeless and feeling there is just no way forward for me."*
> *– Hannah, Remote QLD*

Despite the availability of patient assisted transport schemes, there is a widespread lack of awareness of these programs, their eligibility, what they cover, and how to access them. The schemes are coordinated at a jurisdictional level, and their eligibility requirements and benefits vary significantly across States and Territories. For instance, a person in NSW travelling over 100km one way for specialised medical treatment will be subsidised 40 cents per kilometre for travel in a private vehicle and $75 per night for commercial accommodation. In contrast, a person in Victoria travelling the same distance will receive 21 cents per km for private vehicle travel and only up to $49.50 per night for commercial accommodation.[26] Consumers who access these subsidies consistently report that they simply don't cover costs. Most of the schemes are focused on travel for non-GP specialist care and don't provide support for access to other healthcare. The administration required to claim patient travel subsidies is also described by many as onerous and challenging.

> *"Patient Travel should be managed in a very different way as currently it is a gruelling system that wears me down and I'm often in tears thinking about it. The onus is on the person with a disability to coordinate everything… It is humiliating, overly bureaucratic, and I have not one good thing to say about it." – Hannah, Remote QLD*

A more consistent national approach to patient travel schemes could help to create a fairer and more transparent system, while still allowing flexibility to reflect the realities of different jurisdictions, including population size, travel distances, and availability of public transport. CHF support the National Rural Health Alliance's calls for stronger support for travel costs, regular review of distance thresholds for eligibility, and a simplified, timely reimbursement process that reduces administrative burden.[27] The NRHA also calls for appropriate expansion of scheme eligibility to include essential non-medical specialist services such as allied health and dentistry. Finally, reimbursement rates must accurately reflect real accommodation and transport costs and be regularly adjusted for inflation.

Recommendation 15: Establish a more equitable and responsive Patient Assisted Travel Scheme with harmonised national elements, expanded eligibility and subsidies that reflect real costs.

ii. Community education

A recurring concern raised by consumers is confusion around how they can successfully navigate the healthcare system. There is a notable lack of public awareness regarding many of the available care pathways and support schemes and what is and isn't covered by Medicare. Consumers report finding the health system and its various services and processes complex and difficult to navigate, particularly when they are very unwell.

> *"Services are there, but the people are not aware of those services. So, maybe better exposure of them in the local community through various events…you know, the community events, the festivals, that's such a good opportunity for them to engage." – Saba, Regional NSW*

CHF's 2026-27 budget submission calls for a national Medicare community education program, noting that it is a cost-effective way to strengthen the health system by improving public understanding of how Medicare works, supporting uptake of reforms such as MyMedicare, and helping existing investments deliver their full value. Importantly, there is a need for such a program to be community-based and tailored for each location. Such a program should prioritise core content and resources that are co-designed with consumers and their communities. This should be supported by 'train-the-trainer' approaches that enable trusted local organisations to deliver education in appropriate settings, and local delivery grants to support community-led outreach through trusted channels.

Recommendation 16: Fund community-based Medicare education programs for rural and remote communities.

iii. Inclusive care

Many rural and regional areas are key settlement locations for newly arrived migrants, yet people from culturally and linguistically diverse (CALD) backgrounds in these communities face significant barriers to accessing and navigating healthcare. Key issues include the lack of translated materials, visa exclusion from Medicare, limited interpreter use, and the absence of multicultural liaison officers to support communication and coordination between services.

> *"My place is a settlement area… There are limited translated materials anywhere in my local hospital and in the clinics. What I find is there is limited coordination between the clinics and the hospital because again, with the settlement area, there is no multicultural liaison officer or dedicated multicultural department at the hospital and the entire local health district." – Saba, Regional NSW*

Many CALD community members are unaware of supports such as travel subsidies because information is only available in English and often filled with jargon. While there are targeted support services available to refugees and asylum seekers, many new migrants, including international students and skilled migrants, report receiving little to no support in understanding Medicare, out-of-pocket costs, or how the Australian health system works. Cultural inappropriateness in health programs further limits engagement and access.

> *"For me, you know, I came as an international student, then I became a skilled migrant, then I became a citizen. For me, there wasn't a single support for us… And so even though you get a Medicare card, you don't know the purpose… it's really hard to navigate Australian healthcare system if you're unsure." – Saba, Regional NSW*

Additionally, targeted training for healthcare providers on how to provider culturally appropriate and culturally safe care, including use of interpreters, could make a significant difference to the experience of these communities.

The Australian Multicultural Health Collaborative (AMHC) has recently called for additional funding to embed cultural safety and training into core health system infrastructure to improve patient and workforce outcomes. They have highlighted that MBS items should recognise the extra time required to deliver culturally appropriate care, noting that culturally and linguistically diverse patients may need additional support due to language barriers, lower health literacy or settlement-related challenges.[28]Similar barriers affect other groups who require culturally responsive, identity-affirming, or tailored communication to navigate healthcare confidently. This includes LGBTQIA+ communities, people with disability, and others whose needs are not well met by mainstream models of care.

First Nations peoples experience unique and well-documented barriers to culturally safe care. These challenges require standalone, community-led solutions grounded in self-determination, cultural authority, and the leadership of First Nations People.

Recommendation 17: Strengthen cultural, language and identity-specific support through translated materials, interpreter engagement and training, multicultural liaison roles, inclusive, affirming care for groups with specific needs, and community led First Nations models of care.

iv. Data improvement

Geographic breakdowns of Medicare data are limited, meaning policymakers cannot fully understand how uptake varies between metropolitan, regional, rural, and remote communities. This masks inequities in access, hides the extent of unmet need in rural areas, and prevents targeted planning or investment to address gaps in service availability, workforce distribution, and affordability.

Current Medicare reporting provides only partial remoteness-based breakdowns, which limits the ability to clearly identify where access is constrained, where bulk billing is declining, and where unmet need is highest. A comprehensive, publicly available dataset disaggregated by MMM region and including service type, provider type, bulk billing status, and patient costs—would enable governments and communities to accurately assess rural and remote access gaps, plan workforce and funding responses, and ensure Medicare investment aligns with population need.

Recommendation 18: Enhance Medicare data transparency and usefulness by requiring full geographic disaggregation of service use, bulk billing rates, and out-of-pocket costs across all remoteness categories.

Conclusion

Rural, regional and remote Australians have waited too long for a health system that recognises and responds to their realities. Without targeted, consumer-led reform, inequities will continue to widen, and communities will remain underserved and overburdened. Meaningful progress requires more than incremental adjustments to Medicare settings, it needs sustained investment, locally led models of care, a strengthened workforce, fairer funding structures and genuine partnership with the people whose lives are most affected.

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