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RACP Submission – Rural, Regional and Remote Medicare Access and Funding Inquiry

March 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 23,200 physicians and 9,000 trainee physicians, across Australia and Aotearoa New Zealand.

The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine.

Beyond the drive for medical excellence, the RACP is committed to developing healthcare policies which bring vital improvements to the wellbeing of patients, the medical profession and the community, with a strong focus on ensuring equitable access to high-quality physician care for people living in rural, regional and remote areas.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

RACP Submission to the Inquiry into Rural, Regional and Remote Medicare Access and Funding

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the Inquiry into Regional and Remote Medicare Access and Funding ('the Inquiry').

People living in rural, regional and remote areas experience ongoing inequity in access to comprehensive, timely and coordinated specialist healthcare. Access decreases with remoteness. These inequities reflect a persistent mismatch between patients' higher disease burden and clinical complexity in rural, regional and remote areas, and limitations in scope, continuity and coordination of specialist services currently available across healthcare settings.

This inequity is particularly acute for Aboriginal and Torres Strait Islander communities, who live with a higher burden of disease and face an additional cultural load when engaging with health systems, including the need to navigate culturally unsafe environments, advocate for family and community, and manage the impacts of systemic racism.

The unique challenges that culturally and linguistically diverse communities can face in accessing healthcare can also be amplified in rural, regional and remote settings.

The RACP welcomes initiatives aiming to address the significant unmet clinical needs that distinguish our rural health landscape from metropolitan areas, particularly the many physicians and trainees with a broad, generalist focus across a range of specialties who make a significant contribution to rural and remote medicine through the skills and expertise they offer.

Targeted reform of Medicare settings is required to improve access to physician and other specialist healthcare in rural, regional and remote areas. When specialist care is poorly aligned or inaccessible, primary care is left to manage complex conditions beyond its scope, contributing to delayed escalation, fragmented care and avoidable deterioration.

The RACP calls for Medicare settings and items to better reflect the time, complexity and coordination inherent in specialist care, through appropriate rebates, rural loadings, telehealth parity, and support for multidisciplinary care, including evolving models of care. **These reforms can facilitate earlier specialist input, shared management and continuity of care.**

This submission outlines the RACP's response to relevant terms of reference of the Inquiry.

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.

Reinstatement of specialist telehealth items is a positive step

The reinstatement of physician telehealth phone consultation items from 1 November 2025 is a welcome and necessary step to improve access to specialist care for people living in rural, regional and remote communities. However, it is still too early to assess the full impact of these changes on access, continuity of care and patient outcomes in these settings.

Formal evaluation of the reinstated items is required through a rural, regional and remote lens, with findings used to inform ongoing item design and implementation in consultation with the RACP and relevant specialty societies, including release of data collected by Services Australia on item use. This formal evaluation must also seek and incorporate Aboriginal and Torres Strait Islander leadership and knowledge about what is working for Aboriginal and Torres Strait Islander communities.

The second phase reforms, which commenced on 1 March 2026, proposes the introduction of new patient-end-support items. These reforms present an important opportunity to strengthen continuity of care and enable primary care providers to work more seamlessly with physicians around the needs of specific, priority and complex or chronic patient groups, including for Aboriginal and Torres Strait Islander communities.

The RACP continues to emphasise that the absence of initial MBS telehealth physician phone items is an access barrier for patients without the means to travel vast distances, and without adequate video technology or video enabled devices.[1] This barrier is particularly significant for older persons, in areas where there is poor internet access, and for Aboriginal and Torres Strait Islander peoples in remote communities, where digital access, affordability and infrastructure constraints are more pronounced. Whilst face-to-face consultations remain an important part of specialist care and are often preferrable, it is imperative to provide a full range of consultation options – whether face-to-face, video and phone – based on clinical need balanced with practical limitations.

Both video and telephone are essential telehealth services to support equitable access to care

Whilst video consultations are generally preferred, as they allow richer clinical interaction, the RACP has consistently emphasised that telephone consultations remain essential where video is not feasible.[2] This is critical in areas with limited digital infrastructure or for

[1] RACP, *RACP Submission to the MRAC Post Implementation Review of MBS Telehealth Items* (November 2023) https://www.racp.edu.au/docs/default-source/advocacy-library/mbs-review-advisory-committee-s-(mrac)-post-implementation-review-of-mbs-telehealth-items.pdf
[2] RACP, *RACP Submission to the MRAC Post Implementation Review of MBS Telehealth Items (*November 2023) https://www.racp.edu.au/docs/default-source/advocacy-library/mbs-review-advisory-committee-s-(mrac)-post-implementation-review-of-mbs-telehealth-items.pdf

patients facing connectivity, affordability or digital literacy barriers. Retaining both modalities is necessary to ensure equitable access and avoid widening existing rural and socioeconomic disparities.

Digital infrastructure and information sharing are critical to equitable telehealth and early intervention

Effective digital health infrastructure is foundational to equitable access to specialist care in rural, regional and remote areas.

To enable reliable and clinically appropriate telehealth delivery, the RACP calls for national investment in strengthening digital infrastructure so that telehealth services are consistently accessible to patients and clinicians across diverse geographic settings. This includes ensuring Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services are adequately supported to participate in and benefit from digital health systems.

Digital enablement also plays a critical role in supporting early intervention, continuity and coordination of care across primary, specialist, outreach and hospital services. In rural, regional and remote settings, people are more likely to receive care from multiple providers across primary, specialist, outreach and hospital services, often across jurisdictions. In this context, the availability, completeness and clinical usability of shared digital health information directly affect patient safety, quality of care and outcomes.

For Aboriginal and Torres Strait Islander patients, effective information sharing is particularly important to support culturally safe, coordinated care across services.

Current Medicare settings and limited enablement funding can constrain effective use of digital systems, including My Health Record, and preparedness for emerging ‘sharing by default’ requirements. Ongoing meaningful steps towards connectivity and inter-operability of different health record systems across public and private settings continue remain a critical need. Incomplete or inaccessible clinical information can delay diagnosis, duplicate investigations and undermine continuity of care, increasing the risk of acute deterioration and avoidable hospital presentation.

Targeted investment to support clinician participation in digital health systems, through improved interoperability between state, federal and private sector digital health systems, streamlined information-sharing processes and enhanced clinical usability of My Health Record, is therefore essential. This is particularly true in rural and remote contexts where access to local services is limited and care is often delivered across multiple settings.

Investment should explicitly support culturally safe data sharing and partnership with ACCHOs. This includes supporting Indigenous data governance and data sovereignty to empower Aboriginal and Torres Strait Islander communities with authority to govern and control their own data, including how it is collected, interpreted, used and shared.

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

Current Medicare settings contribute to avoidable emergency department presentations and preventable hospital admissions in rural, regional and remote areas by inadequately supporting care models that reflect clinical complexity, continuity and coordination outside hospital settings. These impacts are disproportionately experienced by Aboriginal and Torres Strait Islander peoples, who in many cases are more likely to present with more advanced or complex illness due to barriers to accessing timely specialist care.

Limited access to ambulatory specialist care and under-investment in digital health capability further constrain timely intervention and shared management in the community. Targeted Medicare reforms addressing these gaps would support earlier intervention, more comprehensive community-based care and reduced pressure on hospital services.

Higher disease burden in rural, regional and remote areas requires tailored Medicare settings

Rural, regional and remote communities experience higher rates of chronic disease, multimorbidity and injury, alongside younger population profiles and greater exposure to environmental and social drivers of ill health. Aboriginal and Torres Strait Islander peoples experience these burdens at significantly higher rates and at younger ages. Despite this higher burden, current Medicare settings do not adequately support timely, comprehensive, specialist-led care in community settings.

In particular, current fee-for-service arrangements are poorly aligned with integrated and multidisciplinary models of care that are needed to better clinically manage the needs of priority and complex patient groups; fee-for-service does not sufficiently support longer consultations, care coordination, outreach services, direct physician to GP advice-based models or team-based chronic disease management. This exacerbates avoidable delays in accessing care, undermines early intervention efforts, exacerbates patient multimorbidity and ultimately increases costs for hospital systems in rural, regional and remote areas. It also puts additional strain on Medicare beyond hospitals, with Medicare then absorbing the compounding costs of fragmented service delivery within primary care and between primary care and hospital systems.

Gaps in specialist access and Medicare settings contribute to preventable hospitalisation

People living in rural, regional and remote areas often face delayed or incomplete access to specialist care due to limitations in how services are structured, funded and connected across the health system.

Current Medicare settings do not consistently support timely specialist input, shared management with primary care, or continuity of care for people with complex or worsening conditions. Limited support for multidisciplinary coordination, constrained ambulatory care options, and uneven access to virtual and outreach specialist services mean that conditions

frequently deteriorate before specialist review occurs, contributing to avoidable emergency department presentations and preventable hospital admissions.[3]

These challenges are even more pronounced for Aboriginal and Torres Strait Islander peoples, who navigate systemic barriers and cultural safety concerns, highlighting the need for approaches that embed Indigenous leadership, partnership with ACCHOs, and respect for cultural safety.

Medicare items do not adequately recognise complexity and time required for care

Current Medicare settings do not adequately recognise the additional time required for physicians to care for patients with multiple comorbidities or complex conditions. This is particularly pronounced in rural, regional and remote communities, where the disease burden is higher and clinicians often manage care across broader scopes with fewer local supports. As a result, current Medicare settings inadvertently reward quantity over quality, rather than supporting consultations that enable the delivery of complex care, the resolution of multiple intertwining health issues, and care that is coordinated with multiple service providers.

The RACP is calling for additional or reconfigured physician Medicare items that better reflect the time and complexity required for the delivery of complex care.[4] These reforms would enable earlier and more effective management of chronic and complex conditions in community settings, and reduce downstream pressure on hospitals. Additional or reconfigured physician Medicare items can also enable specialists to better support more culturally safe clinical care.

More broadly, there are very few specialists for whom Medicare billing alone is sufficient to maintain service delivery in rural, regional and remote areas without subsidies. Medicare settings that incentivise specialist physician services to locations with reduced access – such as incentives for individual specialists to provide services, or targeted funding to increase public specialists in remote areas – could also be considered to promote better access to care.

Targeted Medicare payment loadings could be introduced to support physicians in rural, regional and remote areas, and could include higher loadings where appropriate, for example based on degree of remoteness and for services providing care to Aboriginal and Torres Strait Islander communities in rural, regional and remote areas.

Broader, whole-of-system funding reform and reforms to support the health workforce are also essential to support rural, regional and remote access to care. For example, current activity-based funding models under the *National Health Reform Agreement* and its

[3] RACP, *The Physicians' Prescription for Australia's Healthcare: 2026-2027 Pre-Budget Submission to the Australian Treasury* (November 2025) https://www.racp.edu.au/docs/default-source/advocacy-library/2026-pre-budget-submission-to-the-australian-treasury.pdf
[4] RACP, *The Physicians' Prescription for Australia's Healthcare: 2026-2027 Pre-Budget Submission to the Australian Treasury* (November 2025) https://www.racp.edu.au/docs/default-source/advocacy-library/2026-pre-budget-submission-to-the-australian-treasury.pdf

addendums do not always reflect the true costs of service delivery in rural areas. Flexible, blended and collaborative commissioning models between primary care, the ACCHO sector, and state-delivered healthcare, which involve the delivery of physician and other specialist healthcare, are also essential.

Broader reforms to support the specialist health workforce to deliver care in rural, regional and remote areas, such as providing comprehensive relocation support with housing, childcare and transport, would also support enhanced access to specialist care.[5] Reform of Medicare specialist items and workforce incentives and supports not only improve patient access, but also patient choice and autonomy, allowing patients to choose which clinician will best suit their care needs.

Lack of Medicare-funded ambulatory care options increases emergency department use

The absence of Medicare-funded, bulk-billed ambulatory care clinics in rural, regional and remote areas is a longstanding gap that continues to drive avoidable hospital use.

For prevalent conditions such as diabetes, obesity, paediatric conditions, geriatric syndromes and addictions, patients often have limited alternatives to emergency departments for multiple reasons, including a lack of accessible specialist outpatient services.

Investment in multidisciplinary ambulatory care and outreach services including geriatricians, paediatricians, addiction medicine physicians, palliative care physicians, and infectious disease physicians would support the provision of timely, coordinated care within local communities.[6] These services would support streamlined referral pathways from primary care, reduce reliance on emergency departments, and prevent unnecessary hospital admissions.

Chronic diseases and disorders, including mental health and developmental disorders, benefit from prevention and early intervention by primary care providers and physicians.

An example of this is improving diabetes management: if a patient's HbA1c (blood test showing their average blood sugar levels over the past two to three months) is lower, then the risk of complications is reduced, and the need for expensive inpatient care for diabetic ketoacidosis, diabetic retinopathy or renal disease is reduced.

Accessible Medicare-funded ambulatory care and outreach services can be inherently preventive and avoid hospital presentations by providing timely, community-based care.

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

[5] RACP, The Physicians' Prescription for Australia's Healthcare: 2026-2027 Pre-Budget Submission to the Australian Treasury (November 2025) https://www.racp.edu.au/docs/default-source/advocacy-library/2026-pre-budget-submission-to-the-australian-treasury.pdf

[6] RACP, *Pre-Budget Submission to the Australian Treasury* (January 2024) https://www.racp.edu.au/docs/default-source/advocacy-library/pre-budget-submission-to-the-australian-treasury.pdf

practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists.

Current Medicare settings do not adequately support mixed-team models of care in rural, regional and remote communities

Multidisciplinary teams including physicians, general practitioners, nurse practitioners, nurses, allied health professionals and other specialists, are essential to promoting health and managing complex and chronic conditions in rural, regional and remote communities.

Workforce shortages, higher disease burden and geographic isolation make coordinated, team-based models of care particularly critical in these settings, especially for Aboriginal and Torres Strait Islander communities.

Current Medicare settings do not adequately fund mixed-team models, structured case conferencing or collaborative chronic disease management.

Medicare items remain largely siloed, lack flexibility and fail to recognise the central role of physicians in diagnosis, complex care oversight, chronic disease planning and shared care with general practice and allied health.

Items supporting case conferencing, shared care and joint chronic disease planning are under-utilised and structurally under-supported, limiting effective multidisciplinary collaboration. They also do not support a wider range of collaborative models, such as direct physician to GP advice before a patient is seen by the physician, which can facilitate earlier and timely access to necessary care in the contexts of long waiting lists.

The RACP advocates for enabling models where physicians contribute to diagnosis, chronic disease planning, complex care oversight and shared care with general practice and allied health professionals, including in the *RACP Model of Chronic Care Management*[7,8] and a range of other models across specialties.[9]

Rural, regional and remote communities in particular require funding for visiting and outreach specialists, where distance from specialist services limits access to locally available care. Inadequate rebates for care coordination, limited support for multidisciplinary case conferencing and a lack of incentives for collaborative models constrain the effectiveness of mixed-team care and disadvantage rural, regional and remote patients.

[7] RACP, *Policy & Advocacy Priorities – Healthcare Reform: Integrated Care* (2026) https://www.racp.edu.au/policy-and-advocacy/policy-and-advocacy-priorities/healthcare-reform/integrated-care
[8] RACP, *RACP Model of Chronic Care Management: Complex Care, Consultant Physicians and Better Patient Outcomes – Streamlined Complex Care in the Community* (October 2019) https://www.racp.edu.au/docs/default-source/advocacy-library/c-final-mccm-document.pdf?sfvrsn=f873e21a_14
[9] RACP, Physicians and Paediatrician: Essential to multidisciplinary care – The role of specialists in the Government's primary care reform (May 2024) https://www.racp.edu.au/docs/default-source/advocacy-library/racp-brief-to-inform-the-unleashing-the-potential-of-our-workforce-scope-of-practice-review---overview-of-the-role-of-physicians-and-paediatricians-in-the-australian-government-s-primary-care-reform.pdf

For Aboriginal and Torres Strait Islander communities, visiting specialist models that are delivered in partnership with ACCHOs are critical to ensuring culturally safe, coordinated and trusted care.

These limitations are most pronounced where care coordination is inherently more complex, including for children and families, and older people with multiple or complex needs. Current funding settings do not adequately recognise the additional time required for comprehensive assessment, coordination and follow-up across providers. In paediatric care, timely interaction between physicians, general practitioners and other professionals is critical to effective shared care, yet current Medicare arrangements do not sufficiently support this collaboration. Amending physician case-conferencing items to allow appropriate liaison with non-health practitioners, such as schools and other service providers, would better reflect modern multidisciplinary practice in rural communities.

Recent telehealth reforms create an opportunity to better integrate primary care and specialist teams

The telehealth reforms announced in the 2025 Federal Budget create an important opportunity to better embed specialist input within mixed-team models of care in rural, regional and remote communities.

The reinstated physician telehealth phone consultation items provide a foundation for more consistent specialist engagement alongside primary care, particularly where in-person access is limited.

The patient-end support items introduced from 1 March 2026 will be critical in determining whether these reforms translate into meaningful improvements in continuity and coordination of care. If appropriately designed, these items could enable primary care providers and physicians to work more seamlessly together around the needs of specific, priority and complex or chronic patient groups, rather than reinforcing episodic or siloed care. This includes ensuring telehealth parity across modalities and appropriate rural loadings so virtual care reforms benefit underserved and remote populations, including Aboriginal and Torres Strait Islander communities.

However, these reforms are only a start. More work remains to be done on evolving the Medicare system and individual items to support the range of ways physicians work collaboratively with GPs, other specialists and professionals both now and into the future, in ways that support timely access to specialist care.

Targeted Medicare reform is required to enable effective mixed-team care and reduce reliance on hospitals

The RACP has consistently called for strengthened Medicare structures to support mixed-team models of care.[10,11,12] This includes enhanced support for multidisciplinary chronic disease management, specialist participation in shared care planning and improved access to visiting and outreach specialist services.

Without these reforms, mixed-team models remain constrained and communities continue to rely on hospital-based services. Targeted Medicare reform is required to enable multidisciplinary care in community settings, improve patient outcomes and reduce avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas.

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

The RACP has noted in this submission that current Medicare rebates do not adequately support integrated, team-based and community-embedded models of care, particularly those required to manage complex conditions in rural, regional and remote settings.

Fee-for-service item structures and funding mechanisms are often misaligned with the time, coordination and multidisciplinary input these models require. This can create financial and structural barriers for smaller, locally embedded clinics and multidisciplinary care teams delivering complex and coordinated care in community settings.

RACP advocates that Medicare reform should address these barriers by introducing loadings and new items that support specialists to provide coordinated, community-based care in underserved areas.

This is particularly relevant for ACCHOs and community-embedded services, which provide culturally safe, holistic care and are often central to coordinating specialist access for Aboriginal and Torres Strait Islander patients in rural and remote communities.

[10] RACP, *Pre-Budget Submission to the Australian Treasury* (January 2024) https://www.racp.edu.au/docs/default-source/advocacy-library/pre-budget-submission-to-the-australian-treasury.pdf
[11] RACP, *The Healthcare Australia Needs: Pre-Budget Submission to the Australian Treasury* (January 2025) https://www.racp.edu.au/docs/default-source/advocacy-library/racp-2025-pre-budget-submission-to-the-australian-treasury.pdf
[12] RACP, *The Physicians' Prescription for Australia's Healthcare: 2026-2027 Pre-Budget Submission to the Australian Treasury* (November 2025) https://www.racp.edu.au/docs/default-source/advocacy-library/2026-pre-budget-submission-to-the-australian-treasury.pdf

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.

Medicare must support earlier, integrated care to reduce downstream costs in rural, regional and remote areas

The RACP emphasises that Medicare reform should enable timely, integrated care in rural, regional and remote areas to improve outcomes and reduce avoidable pressure on hospitals.

For people with chronic and complex conditions, particularly in rural and remote settings, this requires Medicare settings that support specialist physician care integrated with primary care, rather than fragmented or siloed service delivery.[13]

Rural stress-testing should explicitly assess impacts on Aboriginal and Torres Strait Islander peoples, including effects on culturally safe care, and continuity of specialist services in ACCHO settings and partnership-based models in rural, regional and remote communities.

Sustainable Medicare reform for rural, regional and remote Australia depends on ensuring the right care is provided early and by the right mix of professionals. Strengthening preventive care, chronic condition management and coordination across multidisciplinary teams is central to improving patient outcomes and containing long-term system costs.

Expand telehealth flexibility and invest in digital capability to improve rural access

The RACP supports maintaining a full range of clinically appropriate telehealth options (video and telephone) to improve access for people facing barriers to in-person care, including those in rural and remote locations and Aboriginal and Torres Strait Islander communities. Telehealth flexibility is critical to enabling specialist and multidisciplinary care where local services are limited.

As mentioned above, the RACP calls for sustained investment in digital health capability, including virtual care models, remote monitoring and telehealth in rural, regional and remote areas, as well as videoconferencing technology support for priority populations.[14] Without this investment, telehealth reforms risk entrenching existing inequities rather than addressing them.

Shift from fee-for-service dominance towards blended funding to enable integrated team care

To ensure Medicare is fair, workable and sustainable for rural, regional and remote communities, the RACP supports a shift away from the current dominance of fee-for-service

[13] RACP, *Pre-Budget Submission to the Australian Treasury* (January 2024) https://www.racp.edu.au/docs/default-source/advocacy-library/pre-budget-submission-to-the-australian-treasury.pdf
[14] RACP, *Pathways to Wellbeing: Enhancing the Health and Wellbeing of All Australians – Pre-Budget Submission to the Australian Treasury* (January 2023) https://www.racp.edu.au/docs/default-source/advocacy-library/racp-2023-24-pre-budget-submission-to-aust-treasury.pdf

billing towards blended and value-based funding models.[15,16] Fee-for-service arrangements alone do not adequately support longer consultations, chronic disease management or multidisciplinary work.

Blended funding models would better enable integrated, team-based care delivered by general practitioners, nurses, allied health professionals and physicians, and would support the prevention and proactive management of chronic disease rather than late-stage, high-cost care.[17] The RACP has specifically called for blended funding to complement fee-for-service billing and to better reflect the time and complexity involved in caring for patients with chronic and complex conditions.[18]

Strengthen outreach and regional specialist pathways to make Medicare workable in rural, regional and remote areas

The RACP calls for strengthened support for regional and outreach specialist services as a core element of a sustainable Medicare system for rural Australia.[19] This includes funding for travel (especially in circumstances where the aviation industry discontinues or limits travel routes that are not profitable), administrative support and collaborative models that allow visiting and regionally based specialists to work effectively with local primary care teams.

Investment in multidisciplinary ambulatory care and outreach services, including physician-led models, would improve access to timely care for people with complex and chronic conditions within their local communities. These pathways are essential to reducing avoidable escalation to hospital care and ensuring Medicare settings function effectively in rural and remote contexts.[20]

Require rural 'stress-testing' of Medicare reforms to prevent unintended inequities

The RACP has consistently called for Medicare reforms to be designed, implemented and evaluated with explicit consideration of rural, regional and remote contexts to avoid unintended consequences that exacerbate existing inequities.[21] Medicare reforms without

[15] RACP, *Integrated Care: Physicians Supporting Better Patient Outcomes Discussion Paper* (March 2018) integrated-care-physicians-supporting-better-patient-outcomes-discussion-paper.pdf
[16] RACP, *Physicians and Paediatricians: Essential to Multidisciplinary Care – The Role of Specialists in the Government's Primary Care Reform: An Overview* (May 2024) https://www.racp.edu.au/docs/default-source/advocacy-library/racp-brief-to-inform-the-unleashing-the-potential-of-our-workforce-scope-of-practice-review---overview-of-the-role-of-physicians-and-paediatricians-in-the-australian-government-s-primary-care-reform.pdf
[17] RACP, *Physicians and Paediatricians: Essential to Multidisciplinary Care – The Role of Specialists in the Government's Primary Care Reform: An Overview* (May 2024) https://www.racp.edu.au/docs/default-source/advocacy-library/racp-brief-to-inform-the-unleashing-the-potential-of-our-workforce-scope-of-practice-review---overview-of-the-role-of-physicians-and-paediatricians-in-the-australian-government-s-primary-care-reform.pdf
[18] RACP, *Physicians and Paediatricians: Essential to Multidisciplinary Care – The Role of Specialists in the Government's Primary Care Reform: An Overview* (May 2024) https://www.racp.edu.au/docs/default-source/advocacy-library/racp-brief-to-inform-the-unleashing-the-potential-of-our-workforce-scope-of-practice-review---overview-of-the-role-of-physicians-and-paediatricians-in-the-australian-government-s-primary-care-reform.pdf
[19] RACP, *Pathways to Wellbeing: Enhancing the Health and Wellbeing of All Australians – Pre-Budget Submission to the Australian Treasury* (January 2023) racp-2023-24-pre-budget-submission-to-aust-treasury.pdf
[20] RACP, *Pre-Budget Submission to the Australian Treasury* (January 2024) https://www.racp.edu.au/docs/default-source/advocacy-library/pre-budget-submission-to-the-australian-treasury.pdf
[21] RACP, *The Roadmap for the Healthcare Australians Need: RACP Election Statement* (March 2025) https://www.racp.edu.au/docs/default-source/advocacy-library/2025-federal-election-statement-the-healthcare-australians-need.pdf

regard to workforce availability, service configuration and patient complexity in rural, regional and remote areas risk reducing access, continuity and quality of care.

This requires Medicare reforms to incorporate a structured rural impact assessment, including:

- assessing impacts on access, affordability and continuity of care in rural and remote areas;
- considering workforce distribution and service availability constraints;
- building in evaluation and transparent reporting on outcomes; and
- ensuring policy design is guided by contextual requirements, patient composition and clinical need.

Rural stress-testing should be embedded early in Medicare policy development and supported by ongoing evaluation and consultation to ensure evidence-informed reform and long-term planning aligned with national workforce and health reform strategies.[22]

g. Any other related matters.

The RACP identifies the following additional, interrelated issues critical to achieving equitable access to Medicare-funded care for rural, regional and remote Australians.

Equity and access for rural communities

Rural, regional and remote communities experience higher disease burden, greater socioeconomic disadvantage and poorer health outcomes than metropolitan populations, as the RACP recognises in the *RACP Regional, Rural and Remote Physician Strategy*.[23] Medicare policy settings that do not explicitly account for these structural differences risk entrenching inequities rather than alleviating them.

Addressing digital health capability, workforce distribution and service integration alongside Medicare reform is essential to improving equity, outcomes and long-term system sustainability across rural and remote Australia.

Addressing inequities for Aboriginal and Torres Strait Islander peoples requires Medicare reform to be aligned with principles of self-determination, cultural safety and partnership with ACCHOs, and to centre Aboriginal and Torres Strait Islander leadership and knowledge.

The experiences of culturally and linguistically diverse communities should also be considered carefully in the context of Medicare design and reform.

[22] RACP, *The Physicians' Prescription for Australia's Healthcare: 2026-2027 Pre-Budget Submission to the Australian Treasury* (November 2025) https://www.racp.edu.au/docs/default-source/advocacy-library/2026-pre-budget-submission-to-the-australian-treasury.pdf
[23] RACP, *Regional, Rural and Remote Physician Strategy* (June 2023) https://www.racp.edu.au/docs/default-source/about/college-council/regional-rural-and-remote-physician-strategy.pdf

Workforce distribution and service availability

Workforce maldistribution remains a critical constraint on the effectiveness of Medicare in rural and regional Australia.

Even where Medicare items exist, workforce shortages, particularly of physicians, can limit whether services are practically available to patients. There is a need for targeted incentives, regional training pathways, specialist outreach models and enabling infrastructure to attract and retain physicians in rural communities.[24]

Without coordinated workforce and service planning, Medicare reforms risk exacerbating inequities by expanding entitlements without ensuring local capacity to deliver care. Addressing workforce distribution alongside Medicare settings is therefore essential to ensuring Medicare-funded services translate into real access for rural patients.

Modernising paediatric MBS settings is essential to address rural child health inequity and prevent long-term system costs

The RACP is acutely aware of the need for improved, family-centred paediatric care in rural, regional and remote Australia. Children and adolescents in these areas as well as from socioeconomically disadvantaged backgrounds experience significant barriers to timely care, compounded by geographic isolation, long public waitlists and limited specialist availability.

In these communities, inequities are compounded by geographic isolation, limited access to public paediatric clinics and extended public waitlists. Current Medicare structures do not adequately reflect modern paediatric practice, embedding inequity early in life. For many families, private care becomes the only option but remains financially unattainable without adequate MBS support.

Reforming paediatric Medicare items, alongside rural loadings and telehealth parity, would improve access, support family-centred care and reduce long-term health system costs in a fiscally responsible manner.

Closing Comment and Next Steps

We welcome the Committee's consideration of our submission and look forward to working together to achieve improvements for people living in rural, regional and remote Australia.

If you require further information or if you would like to engage further with the RACP, please contact Ms Madelyn Smith, Senior Policy and Advocacy Officer, via the RACP Policy and Advocacy unit at policy@racp.edu.au.

[24] RACP, *The Physicians' Prescription for Australia's Healthcare: 2026-2027 Pre-Budget Submission to the Australian Treasury* (November 2025) https://www.racp.edu.au/docs/default-source/advocacy-library/2026-pre-budget-submission-to-the-australian-treasury.pdf