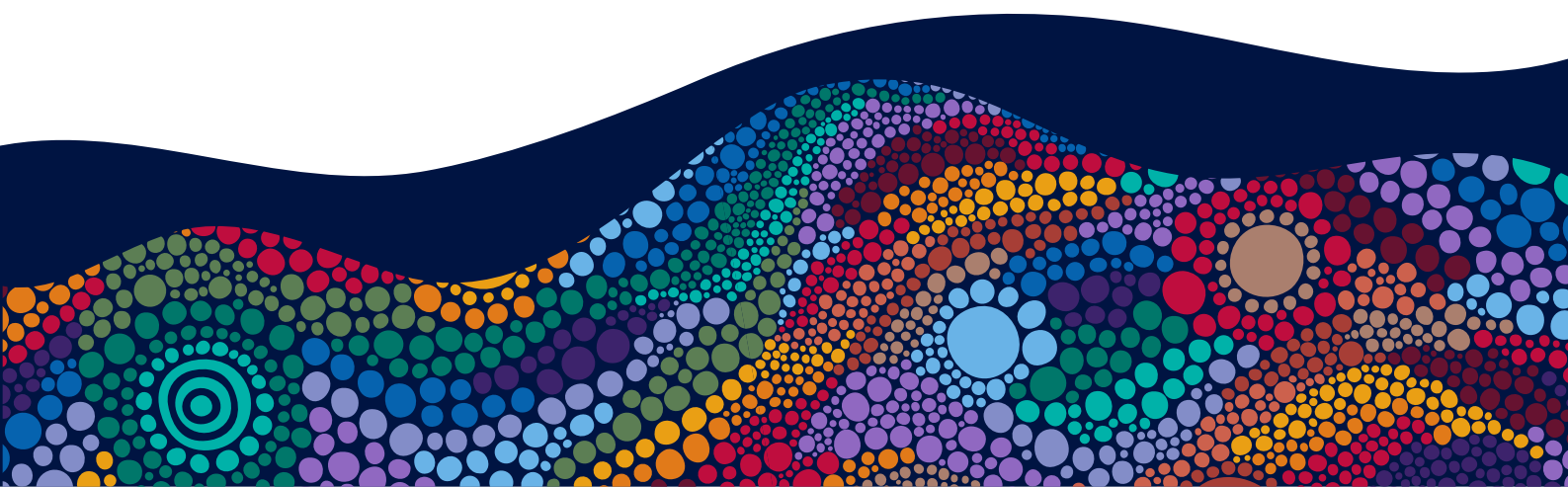


Health Insurance Amendment (Incentive Payments and Other Measures) Bill 2026

Submission to Senate Standing Committees
on Community Affairs

July 2026



About NACCHO

NACCHO is the national peak body representing 148 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership, and the eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 148 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

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Recommendations

NACCHO recommends:

- 1 Any interventions to address incentive payments in primary health care align with the National Agreement and its four Priority Reform Areas.
- 2 Recognising ACCHOs as a distinct service model and ensuring sector-specific needs are met within incentive payment frameworks.
- 3 Ensuring proportional compliance arrangements for small, rural and remote ACCHOs.
- 4 Consultation with NACCHO and the ACCHO sector before significant changes to incentive program rules.
- 5 Incorporation of the National Agreement and its four Priority Reform Areas when making or amending rules.
- 6 Rules that would allow up to 100 per cent of BBI and BBIP incentive payments to be redirected to organisations, particularly those with 19(2) exemption arrangements.
- 7 The WIP Practice Stream target the employment of specific primary health care staff, including non-dispensing pharmacists and community midwives.
- 8 Eligibility and criteria for incentive payments be co-designed with input from the ACCHO sector, the Australian Indigenous Doctors Association and other Aboriginal and Torres Strait Islander peaks.
- 9 Additional multipliers based on patient need to determine the size of PIP and WIP.
- 10 Revising the definitions of Aboriginal and Torres Strait Islander in the Bill.

Acknowledgements

NACCHO welcomes the opportunity to provide a submission to the Senate Standing Committees on Community Affairs. NACCHO supports the submissions to this consultation made by NACCHO Members and Affiliates.

National Agreement on Closing the Gap

Advocating for and securing the National Agreement on Closing the Gap was an historically significant act of Aboriginal and Torres Strait Islander self-determination. The National Agreement is evidence of a new era of engagement by and with Aboriginal and Torres Strait Islander people. It commits Australia to a new direction and is a pledge from all governments to fundamentally change the way they work with Aboriginal and Torres Strait Islander communities and organisations – to support self-determination and build the capacity of the community-control sector.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets *through implementation of the Priority Reforms*. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term.

The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people, and achieve life outcomes equal to all Australians. Governments at all levels have committed to the implementation of the National Agreement's four Priority Reform Areas, which offer a roadmap to meaningfully impact structural drivers of poor health and social outcomes for Aboriginal and Torres Strait Islander people:

Priority Reform Area 1 – Formal partnerships and shared decision-making

This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments, and to accelerate policy making that centres Aboriginal and Torres Strait Islander voices.

Priority Reform Area 2 – Building the community-controlled sector

Recognising that community-controlled services achieve better outcomes, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services, this Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap.

Priority Reform Area 3 – Transformation of mainstream institutions

This Priority Reform commits to systemic and structural transformation of government organisations to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform Area 4 – Sharing data and information to support decision making

This Priority Reform commits to shared access to regional data and information to inform local-decision making and support achievement of the first three Priority Reforms. This Priority Reform supports principles of Indigenous Data Sovereignty.

Despite some progress, the need for fundamental systemic reform remains evident. In its first review of the National Agreement on Closing the Gap, the Productivity Commission found that governments are not adequately delivering on their commitments. Despite support for the Priority Reforms and some good practice, progress has been slow, uncoordinated, and piecemeal.

The Commission noted that to enable better outcomes, governments need to relinquish some control, share decision making and acknowledge that Aboriginal and Torres Strait Islander people know what is best for their communities. Aboriginal Community Controlled Organisations, must be treated as critical partners rather than passive funding recipients, and trusted to design, deliver and measure government services in ways that are culturally safe and meaningful for their communities.

‘Too many government agencies are implementing versions of shared decision-making that involve consulting with Aboriginal and Torres Strait Islander people on a pre-determined solution, rather than collaborating on the problem and co-designing a solution’¹

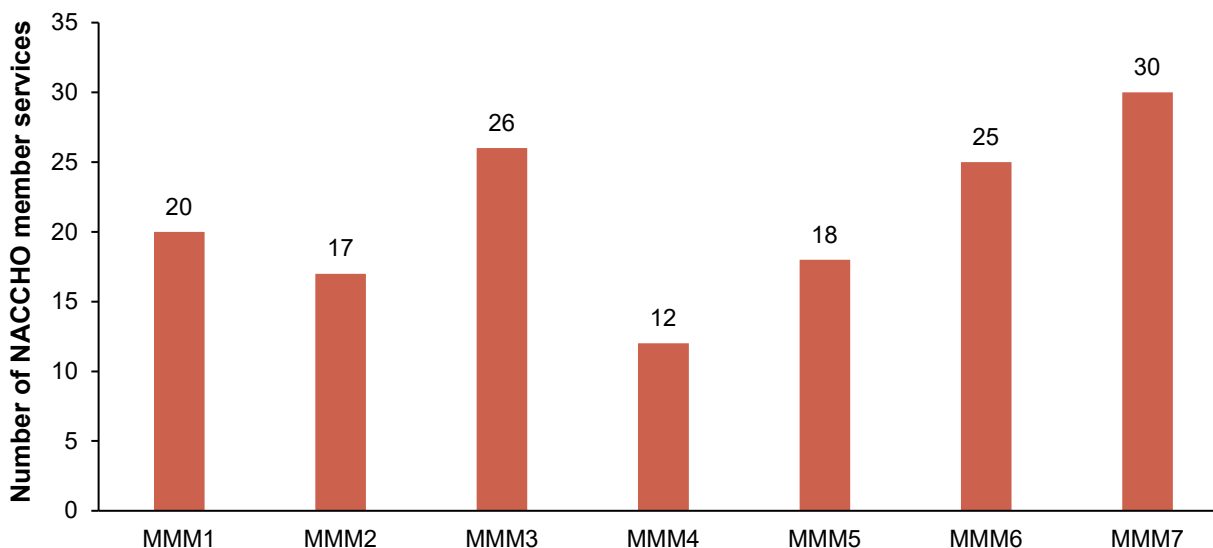
NACCHO recommends any interventions to address incentive payments in primary health care align with the National Agreement and its four Priority Reform Areas.

Background

The ACCHO sector has specific needs and considerations relating to primary health care incentive payments. ACCHOs provide comprehensive primary health care using multidisciplinary teams, with little to no fees for clients. Much of the care ACCHOs provide is holistic, connecting the physical, mental, social, emotional and spiritual dimensions of health and wellbeing and with a strong focus on prevention.

NACCHO member services are spread across Modified Monash Model remoteness categories. However, 55 services, or 37% of NACCHO members, deliver services in MM6 and MM7 (or remote and very remote) areas. A further 73 services (49% of members) deliver services in MM2-MM5 (regional and rural) areas.

Remoteness (Modified Monash Model) of NACCHO member services, based on area of service delivery, as of July 2026



ACCHO clients tend to be younger than the mainstream population. Most recent data from the Online Services Report found that in 2024-25, there were 456,036 clients who visited ACCHOs funded through the Indigenous Australians' Health Programme. Of these, 42% (193,238 clients) were under the age of 25.²

¹ Productivity Commission, Review of the National Agreement on Closing the Gap, Study Report, Canberra, 7 Feb 2024, <https://www.pc.gov.au/inquiries/completed/closing-the-gap-review/report>.

² Australian Institute of Health and Welfare (AIHW), Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections: Data, May 2026, <https://www.aihw.gov.au/reports/first-nations-people/indigenous-primary-health-care-results-osr-nkpi/data>.

However, Aboriginal and Torres Strait Islander people face an overall burden of disease (based on Disability Adjusted Life Years, or DALYs) at 2.1 times the rate of non-Indigenous Australians.³ Chronic disease tends to appear earlier in their lifetime, and complex multi-morbidities are more common.⁴

The Amendment outlines compliance arrangements – particularly record-keeping. While compliance is important, the administrative burden associated with funding can sometimes outweigh the value of the funding. Some ACCHOs receive funding from as many as 70 different departments, agencies, and organisations, each with unique reporting requirements and compliance arrangements, often for relatively small funding amounts. ACCHOs are service delivery organisations and are not resourced to manage this level of paperwork. This is particularly true in smaller, more remote ACCHOs that are primarily staffed by clinicians – with little or no ‘back end’ administrative staff.

NACCHO recommends recognising ACCHOs as a distinct service model and ensuring sector-specific needs are met within incentive payment frameworks.

NACCHO recommends ensuring proportional compliance arrangements for small, rural and remote ACCHOs.

Primary health care incentives and ACCHO sector

NACCHO welcomes formalisation of Commonwealth’s primary health care incentive payments through the *Health Insurance Amendment (Incentives Payments and Other Measures) Bill 2026*. It is understood that transitional arrangements will ensure existing PIP and WIP participants do not need to reapply for programs.

The Review of General Practice Incentives found that the ACCHO sector relies on Incentives (PIP & WIP Practice) for 18.2% of their Commonwealth funded income, compared to 8.1% for non-ACCHOs.⁵ This means that the ACCHO sector will face additional barriers if the rules guiding incentive payments are developed with only mainstream GPs.

Additionally, ACCHOs have highlighted the need to move beyond individual GP incentives toward funding arrangements which strengthen practices. NACCHO is having ongoing conversations with the Department of Health, Disability and Ageing regarding a needs-based funding arrangement.

Due to the complexity of service provision in the ACCHO sector, NACCHO would like input in developing the accompanying rules.

NACCHO recommends consultation with NACCHO and the ACCHO sector before significant changes to incentive program rules.

NACCHO recommends incorporation of the National Agreement and its four Priority Reform Areas when making or amending rules.

Bulk billing incentives

Recent changes to bulk billing incentives, including the expanded Bulk Billing Incentive (BBI) and the new Bulk Billing Practice Incentive Program (BBPIP), are positive in their aim to improve access to primary care

³ AIHW, First Nations Burden of Disease Study 2022, June 2026, <https://www.aihw.gov.au/reports/burden-of-disease/first-nations-burden-of-disease-study-2022/contents/burden-of-disease-in-first-nations-people>.

⁴ AIHW, Chronic physical health conditions and the mental health and wellbeing of First Nations people, December 2024, <https://www.aihw.gov.au/getmedia/17b8da79-3176-4fff-8dc7-ce23aa2ccbcf/aihw-imh-25-chronic-physical-health-conditions-and-the-mental-health-and-wellbeing-of-first-nations-people.pdf?v=20250611122020&inline=true>.

⁵ Expert Advisory Panel Report to the Australian Government, Review of General Practice Incentives, Department of Health, Disability and Ageing, 30 September 2024, <https://www.health.gov.au/resources/collections/review-of-general-practice-incentives?language=en>.

by increasing payments for bulk billed services. All ACCHOs are 100% bulk billing and are receiving additional Medicare funding through these initiatives.

However, the payment of BBPIP directly to General Practitioners (GPs) conflicts with the employment model and model of care in ACCHOs. For the most part, ACCHOs directly employ GPs under a salary model. These salaries are usually at levels above the Medicare revenue that the GP has claimed. Additionally, more than other GPs, the Medicare revenue generated by GPs in ACCHOs builds on the work of the primary care team to engage patients, support their attendance and contribute to completing Medicare items that generate a higher Medicare revenue, such as GP Chronic Condition Management Plans and Health Assessments.

Under the BBPIP arrangements ACCHOs are required to negotiate incentive payment arrangements with individual GPs if they want to direct the full BBPIP to the ACCHO to help support the GP's salary and the model of care. ACCHOs can risk losing access to locum services if they attempt to negotiate a different payment split through contractual arrangements. Each change to Medicare incentive settings triggers renegotiation of GP contracts, increasing pressure on already stretched corporate and finance teams. For services with limited administrative capacity, this may divert resources away from care delivery.

This dynamic places ACCHOs in a difficult position and reduces their ability to manage workforce costs sustainably. An ACCHO with 3x FTE GPs generates around \$900K less revenue a year through MBS benefits, bulk billing incentives, and PIP and WIP practice incentives than the same sized non-ACCHO GP practice, and this is worse for rural and remote services.⁶

Some ACCHOs already operate under a 19(2) exemption,⁷ reflecting their distinct role in delivering primary health care to communities.

NACCHO recommends rules that would allow up to 100 per cent of BBI and BBIP incentive payments to be redirected to organisations, particularly those with 19(2) exemption arrangements.

Workforce Incentive Payment – Practice Stream

NACCHO strongly supports the need for an increased focus on multidisciplinary team care to enhance access to health care and support improved outcomes particularly in rural areas.

The WIP Practice Stream is not effective in supporting practices to employ a modern multidisciplinary primary care team. At its current quantum, it will not be sufficient to support the action area 'boosting multidisciplinary team-based care' within the Primary Health Care 10 Year Plan.

According to Online Services Report (OSR) data, in 2024-25, the average ACCHO had a patient load of 3,000 clients and employs 11 full time equivalent primary care staff to support general practitioners – most commonly Aboriginal and Torres Strait Islander Health Workers and Practitioners, practice nurses and social and midwives.⁸ However, the maximum WIP will only support three of these staff, with the remainder primarily funded through block funding. While the ACCHO sector is rightly highlighted as the exemplar of multidisciplinary primary care in Australia, the mainstream payment system unfortunately falls short of supporting this model.

Due to the small incentive amount relative to patient load, WIP is most commonly used to supplement the income of staff who can also bill Medicare. This results in practices prioritising the employment of high Medicare billing primary care staff over other staff, such as non-dispensing pharmacists who have limited ability to generate other revenue.

While the WIP has been extended to include pharmacists, this has not been effective or useful in the ACCHO context. With no overall increase in the quantum of funding, and pharmacists unable to generate additional

⁶ Expert Advisory Panel Report to the Australian Government, Review of General Practice Incentives, Department of Health, Disability and Ageing, 30 September 2024, <https://www.health.gov.au/resources/collections/review-of-general-practice-incentives?language=en>.

⁷ <https://www.health.gov.au/our-work/coag-section-192-exemptions-initiative/about?language=en>.

⁸ NACCHO analysis of AIHW, Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections: Data, May 2026, <https://www.aihw.gov.au/reports/first-nations-people/indigenous-primary-health-care-results-osr-nkpi/data>.

MBS income, the ACCHO sector has prioritised the employment of other clinical staff who can generate MBS income.

As per MSAC recommendations regarding the *Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management* (IPAC) project,⁹ public funding should be provided to directly employ pharmacists in ACCHOs without needing to displace other staff.

The impact and effectiveness of WIP – Practice Stream could be improved through targeted increases to the maximum WIP payment for the employment of specific primary health care staff. There is high quality evidence for the effectiveness of non-dispensing pharmacists¹⁰ and community midwives employed within primary care settings,¹¹ and targeted funding for these staff would have significant impact on progress towards the objectives of the Primary Health Care 10-year plan.

NACCHO recommends the WIP Practice Stream target the employment of specific primary health care staff, including non-dispensing pharmacists and community midwives.

Practice Incentive Payment – Indigenous Health Incentive

The PIP IHI is an important income source for ACCHOs due to the high number of Aboriginal and Torres Strait Islander patients with significant complexity. Some ACCHOs have reported it makes up 25% of their combined Medicare and PIP revenue.

The previous fee structure, which required annual sign-up, was inefficient. Recent improvements, including lifetime registration and fees focussed on outcome payments are a significant improvement. The recent expansion to include children with chronic disease and people of all ages with mental illness are also important improvements to the impact of the incentive.

Within the ACCHO setting, PIP IHI is an effective mechanism to boost fee for service revenue and support longer consultations and care planning within the constraints of 100% bulk-billing services. ACCHOs already have established cultural safety through their governance structures and high percentage of Aboriginal and Torres Strait Islander staff. In this context, the incentive is effective in promoting chronic disease care plans and reviews through the Tier 1 outcome payment.

Outside of the ACCHO setting, the criteria for a practice to meet the cultural safety eligibility requirement has little impact on culturally safe care, and the thresholds set for continuity of care Tier 2 outcome payments are set incredibly low.

The practice criteria for eligibility for the PIP IHI is too low to promote culturally safe care. Aboriginal and Torres Strait Islander people continue to experience racism in healthcare settings¹² yet the incentive payment is made to culturally unsafe practices regardless of Aboriginal and Torres Strait Islander people's experience of care.

Racism is a key determinant of health¹³ and the delivery of culturally safe health care is critical to achieving outcomes under the National Agreement on Closing the Gap. While cultural competence for Aboriginal and

⁹ Smith, D., Couzos, S., Tremlett, M., Loller, H., Stephens, M., Nugent, A., Vaughan, F., Hendrie, D., Buttner, P., Biros, E., Integrating Pharmacists within Aboriginal Community Controlled Health Services (ACCHSs) to improve Chronic Disease Management (IPAC) Project, June 2020, <https://www.health.gov.au/sites/default/files/2023-06/integrating-practice-pharmacists-into-aboriginal-community-controlled-health-services-final-report.pdf>.

¹⁰ Previous NACCHO analysis of AIHW, Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections: Data, May 2026, <https://www.aihw.gov.au/reports/first-nations-people/indigenous-primary-health-care-results-osr-nkpi/data>.

¹¹ Kildea, S., Gao, Y., Hickey, S., Nelson, C., Kruske, S., Carson, A., Currie, J., Reynolds, M., Kay Wilson, K., Watego, K., Costello, J., Roe, Y., Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: a prospective, non-randomised, interventional trial, The Lancet Global Health, Volume 9, Issue 5, 2021, ISSN 2214-109X, [https://doi.org/10.1016/S2214-109X\(21\)00061-9](https://doi.org/10.1016/S2214-109X(21)00061-9).

¹² Kairuz, C.A., Casanelia, L.M., Bennett-Brook, K., Coombes, J., Yadav, U.N., Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait Islander peoples living in Australia: a systematic scoping review. BMC Public Health 21, 1302 (2021). <https://doi.org/10.1186/s12889-021-11363-x>

¹³ Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., Gee, G., Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. PLoS One. 2015 Sep 23;10(9):e0138511. doi: 10.1371/journal.pone.0138511.

Torres Strait Islander people look different in different communities, a critical aspect is the understanding that only the person who is recipient of a service or interaction can determine whether it is culturally safe.¹⁴

However, eligibility to claim the payment is only defined by the participation of a minimal number of staff in cultural awareness training. The amount of staff training cannot determine whether cultural safety has been achieved for patients. To truly have impact on culturally safe care, eligibility for the incentive should be co-designed with input from the ACCHO sector, the Australian Indigenous Doctors Association and other Aboriginal and Torres Strait Islander peaks.

Equally, the criteria for the Tier 2 outcome payment is set insufficiently low to incentivise proactive, regular chronic disease care. The outcome payment will have little impact and the threshold of just five MBS services in 12 months incentivises inadequate care of many people with a chronic disease. Indeed, the threshold is set *lower* than the average number of primary care consultations for Aboriginal and Torres Strait Islander patients, regardless of chronic disease status (5 visits/year as threshold vs. 7 visits/year as national average MBS consultations).

Research in the Northern Territory has shown a much higher number of consultations is required to prevent hospitalisations, with 20 – 30 consultations per year being associated with the lowest number of hospitalisations for people with diabetes, ischaemic heart disease or renal disease.¹⁵ Co-design on a more appropriate threshold, informed by evidence, should be used to improve the impact and effectiveness of this outcome payment.

NACCHO recommends eligibility and criteria for incentive payments be co-designed with input from the ACCHO sector, the Australian Indigenous Doctors Association and other Aboriginal and Torres Strait Islander peaks.

Calculation of block payments using Standard Whole Patient Equivalents

The use of Standard Whole Patient Equivalents (SWPEs) to calculate PIP and WIP payments disadvantages ACCHOs due to the age-structure of the Aboriginal and Torres Strait Islander population. As the Australian PHC system moves towards a greater proportion of payments through block payments, there needs to be reform of the formula used to calculate the size of payments.

SWPE appears to be based on current Medicare use, rather than healthcare need, reflected by the fact that men have a lower SWPE in adult age groups, despite their higher mortality rates and the need to incentivise them to engage in preventive care.

The heavy bias toward higher SWPE for older patients significantly disadvantages ACCHOs. The median age of the Aboriginal and Torres Strait Islander population is 23 and only 4% of the population is aged 65 or over, compared to 14% of the non-Indigenous population. Care needs for younger Aboriginal and Torres Strait Islander people are higher due to the early onset of chronic diseases such as diabetes and renal disease.

The multiplier used to determine the size of PIP and WIP should be based on patient need, in addition to the existing loadings due to remoteness. As an interim measure, a multiplier could be based on area level socioeconomic disadvantage and Indigenous status as identified through the Voluntary Indigenous Identifier Framework. As data collection improves in primary care through MyMedicare and reforms to information standards, the formula used could better reflect need based on higher quality data.

NACCHO recommends additional multipliers based on patient need to determine the size of PIP and WIP.

¹⁴ AIHW, Cultural safety in health care for Indigenous Australians: monitoring framework, July 2023, <https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/background-material>.

¹⁵ Zhao, Y., Wright, J., Guthridge, S., Lawton, P., The relationship between number of primary health care visits and hospitalisations: evidence from linked clinic and hospital data for remote Indigenous Australians. BMC Health Serv Res. 2013 Nov 6;13:466. doi: 10.1186/1472-6963-13-466. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226196/>

Data

Now that government is establishing a legislative framework for WIP, PIP and bulk billing incentives, it may be an appropriate time to consider the primary care data environment. The 2024 *Review of General Practice Incentives - Expert Advisory Panel Report to the Australian Government* suggested that:

“To support the growth of mature primary care data, the government could consider investing in mechanisms for gathering, analysing and publishing (while maintaining privacy) information on the scale of primary care, ownership structures, and the costs of delivering primary care in Australia. An independent pricing authority should use data to recommend pricing changes to the government based on changes in the cost of delivering services. The pricing authority would also need to engage with ACCHOs and other non-private primary care providers with different financing arrangements and data governance (such as principles of Indigenous Data Governance).”¹⁶

This could align with existing projects, such as the National Primary and Acute Care Data Linkage Project (NPACDLP). The NPACDLP plans to link primary care data with acute care (hospital) data, as well as mortality data and other national data collections, with the aim to have a separate but linked ACCHO sector data environment as part of the data flow. The NPACDLP is currently in its ‘interim engagement’ phase – that is, it is between design and implementation.

Definition of Aboriginal and Torres Strait Islander

As part of the main amendment to the *Health Insurance Act 1973*, according to the explanatory memorandum, the following definitions will be added:

Aboriginal person is defined as a person of the Aboriginal race of Australia.

Torres Strait Islander is defined as a descendant of an Indigenous inhabitant of the Torres Strait Islands.¹⁷

It is not clear why these particular definitions have been chosen. The working definition adopted by Federal Government departments determining eligibility to selected services and benefits is:

An **Aboriginal or Torres Strait Islander person** is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.^{18, 19}

NACCHO recommends revising the definitions of Aboriginal and Torres Strait Islander in the Bill.

¹⁶ Expert Advisory Panel Report to the Australian Government, Review of General Practice Incentives, Department of Health, Disability and Ageing, 30 September 2024, <https://www.health.gov.au/resources/collections/review-of-general-practice-incentives?language=en>.

¹⁷ Parliament of the Commonwealth of Australia House of Representatives, Explanatory Memorandum: HEALTH INSURANCE AMENDMENT (INCENTIVE PAYMENTS AND OTHER MEASURES) BILL 2026, https://parliinfo.aph.gov.au/parliInfo/download/legislation/ems/r7491_ems_5a8733a7-9215-41ac-8cdf-4404d2477d9f/upload_pdf/JC018354.pdf;fileType=application%2Fpdf#search=%22legislation/ems/r7491_ems_5a8733a7-9215-41ac-8cdf-4404d2477d9f%22.

¹⁸ Department of the Parliamentary Library Information and Research Services, Research Note: The Definition of Aboriginality, Number 18, 2000-01, https://parliinfo.aph.gov.au/parliInfo/download/library/prspub/7M036/upload_binary/7m0366.pdf;fileType=application%2Fpdf#search=%22library/prspub/7M036%22.

¹⁹ Australian Indigenous HealthInfoNet, The Australian Indigenous HealthInfoNet Guidelines for Aboriginal and Torres Strait Islander Terminology, https://healthinfonet.ecu.edu.au/healthinfonet/getContent.php?linkid=675466&title=The+Australian+Indigenous+HealthInfoNet+guideline+s+for+Aboriginal+and+Torres+Strait+Islander+terminology&contentid=44676_1.