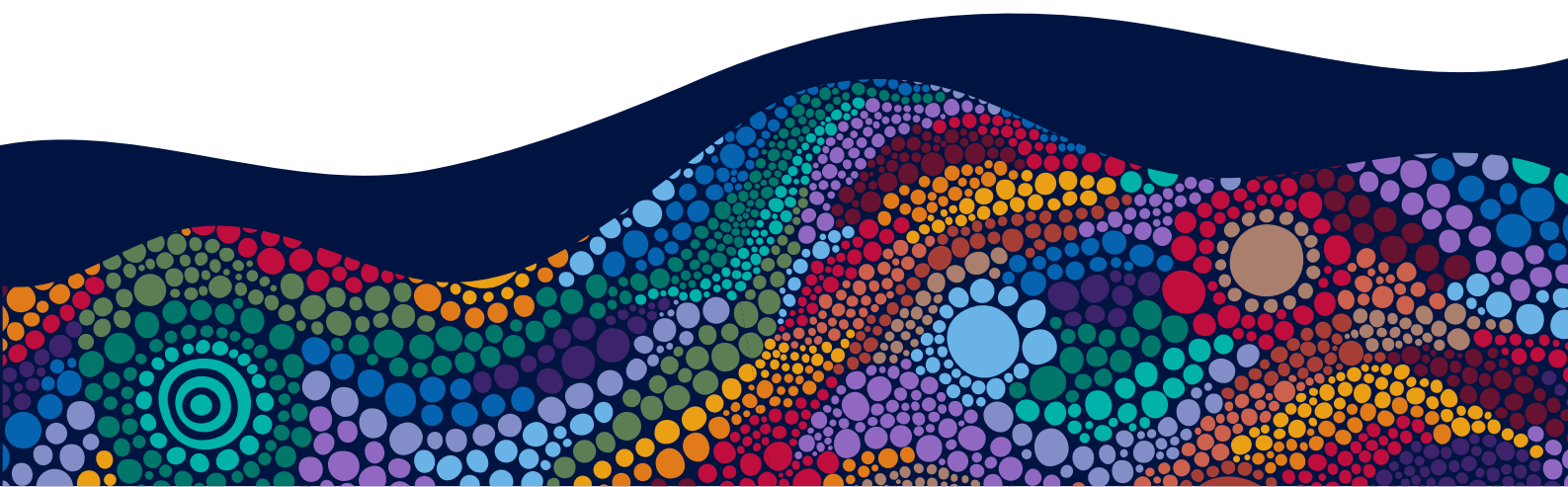


Rural, regional and remote Medicare access and funding

Submission to the Rural and Regional Affairs and Transport References Committee

March 2026



About NACCHO

NACCHO is the national peak body representing 149 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 149 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 improve Medicare access and funding for rural, regional and remote communities align with the National Agreement and its four Priority Reform Areas.
- 2 MBS activity-based funding is supplemented by funding reform for needs-based block funding for ACCHOs.
- 3 Appropriate block funding, adjusted for patient need (e.g. remoteness, SES, Indigenous status) rather than fee for service to better support multidisciplinary models of care.
- 4 Implementing the *Strengthening Medicare Taskforce Report* recommendations for flexible, practice level funding to support multidisciplinary team-based care.
- 5 Redirecting up to 100% of incentive payments to ACCHOs operating under 19(2) exemptions.
- 6 MyMedicare be amended to allow Aboriginal and Torres Strait Islander people to register with up to three ACCHO services.
- 7 Nomination of a preferred provider is optional, rather than mandatory for clients registering with an ACCHO under MyMedicare.
- 8 Assignment of benefit compliance arrangements allow confirmation of consent to be submitted in a variety of ways if required, not just through digital platforms.
- 9 Deferring assignment of benefit compliance for ACCHOs until the enduring assignment of benefit model commences in January 2027 and ACCHO clinical information systems are able to provide full options for digital assignment of benefit.
- 10 Clear guidance on enduring assignment of benefit arrangements is developed in partnership with the sector.
- 11 Enduring assignment of benefit across multiple ACCHOs.
- 12 That ACCHOs delivering urgent or emergency care in rural and remote communities is reformed. Options include expanding funding to ACCHOs as Urgent Care Clinics or enabling access to the same activity-based funding for urgent and emergency services as hospital emergency departments.

Acknowledgements

NACCHO welcomes the opportunity to provide a submission to the inquiry into rural, regional and remote Medicare access and funding. We acknowledge the valuable input received from:

- Aboriginal Health Council of South Australia (AHCSA)
- Aboriginal Health Council of Western Australia (AHCWA)
- Aboriginal Health and Medical Research Council (AH&MRC)
- Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- Kimberley Aboriginal Medical Services (KAMS)
- Nganampa Health Council
- Nunkuwarrin Yunti of South Australia
- Oak Valley (Maralinga) Aboriginal Corporation
- Pika Wiya Health Service Aboriginal Corporation
- Umoona Tjutagku Health Service
- Queensland Aboriginal and Islander Health Council (QAIHC)
- Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- Waminda (South Coast Women's Health & Wellbeing Aboriginal Corporation)
- Winnunga Nimmityjah Aboriginal Health and Community Services (WNAHCS)

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 improve Medicare access and funding for rural, regional and remote communities align with the National Agreement and its four Priority Reform Areas.

Funding model

In remote areas, Medicare accounts for less than 20 per cent of ACCHO revenue. Each GP working in an ACCHO generates significantly less Medicare income than a GP in a mainstream practice, because ACCHOs prioritise continuity of care, prevention and shared responsibility across multidisciplinary teams.

Current funding levels are insufficient to meet the complex and growing health needs of communities. ACCHOs are frequently expected to deliver a broad range of primary health care services, including chronic disease management, mental health, and preventative health, without adequate resourcing to do so.

Medicare remains largely structured around short, episodic, GP-led, fee-for-service consultations, privileging throughput over continuity, prevention and multidisciplinary care. In contrast, ACCHOs deliver substantial work that sits outside individual billable encounters. This includes care coordination, follow-up, outreach, family and community engagement, cultural support, health promotion and prevention. These activities are essential to achieving good health outcomes but are largely invisible within MBS. Even with reforms to support longer consultations and multidisciplinary team care, fee-for-service, Medicare alone cannot fund the full scope of ACCHO activity.

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>.

The resulting funding shortfall is met through a mix of IAHP block funding, short-term programs and competitive grants, contributing to financial instability, administrative burden and workforce insecurity. A shift toward stable, long-term, needs-based block funding is essential to underpin comprehensive, multidisciplinary care.

Stable core funding for ACCHOs under a needs-based capitation model is an effective way to support services to more fully meet the health needs of their clients and drive outcomes.

There is a pre-existing strong commitment by Australian governments and the sector to develop a needs-based funding model in the Health Sector Strengthening Plan under the national Closing the Gap Framework. This seeks to action Clause 45 of the National Agreement on Closing the Gap where it has been agreed elements of a strong community-controlled sector include, *a dedicated, reliable and consistent funding model designed to suit the types of services required by communities, responsive to the needs of those receiving the services, and developed in consultation with the relevant peak body.*

A needs-based funding formula has been developed, and provided to Government, to inform further discussion with the Australian Government, states and territories and other health system stakeholders on appropriate funding arrangements to achieve needs-based funding for the sector.

NACCHO recommends MBS activity-based funding is supplemented by funding reform for needs-based block funding for ACCHOs.

Better support for multidisciplinary care

ACCHO teams include Aboriginal Health Practitioners (AHP), Aboriginal Health Workers (AHW), nurses, allied health professionals and social and emotional wellbeing staff, however, most MBS items can only be claimed through GPs. Consequently, much of the work undertaken in ACCHOs by other clinicians is unfunded.

The average ACCHO services 3,500–4,000 clients and employs around 13 FTE primary care staff to support GPs, most commonly Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, nurses and midwives.² Yet the maximum workforce incentive payment for multidisciplinary care supports less than two staff. The relatively small incentive amount can impact workforce, encouraging practices to prioritise high Medicare-billing roles over other team members, who have less capacity to generate MBS revenue.

Better support for multidisciplinary care under the MBS requires appropriate block funding, adjusted for patient need (e.g. remoteness, SES, Indigenous status) rather than fee for service.

NACCHO recommends appropriate block funding, adjusted for patient need (e.g. remoteness, SES, Indigenous status) rather than fee for service to better support multidisciplinary models of care.

Strengthening Medicare Taskforce Report

NACCHO supports the direction of reform outlined in the *Strengthening Medicare Taskforce Report*,³ particularly the shift away from GP centric funding toward blended, practice-level funding models. This shift is critical to modernising the Medicare Benefits Schedule (MBS) and ensuring it reflects how primary care is delivered in practice, especially in Aboriginal and Torres Strait Islander communities and rural and remote areas.

Practice level block funding supports multidisciplinary, coordinated and person centred care. Blended, practice level funding strengthens service sustainability by giving practices the flexibility to respond to local needs, invest in workforce stability, and support care models that extend beyond standard Medicare items.

² NACCHO analysis of 2021-22 Online Services Report data <https://www.aihw.gov.au/reports/indigenous-australians/indigenous-primary-health-care-results-osr-nkpi/contents/nkpi>

³ [Strengthening Medicare Taskforce Report](#)

Importantly, it enables ACCHOs to more effectively deliver their comprehensive, culturally safe model of care, which integrates clinical and care services with prevention, early intervention, care coordination and social and emotional wellbeing support.

Appropriately, the report also prioritises affordable access to care, recognising that cost remains a significant barrier for many Aboriginal and Torres Strait Islander people and other disadvantaged communities. It highlights the need to expand urgent and after-hours primary care to reduce avoidable hospital presentations, particularly in areas with limited workforce capacity or fragmented service systems. Underpinning these reforms is the urgent need to grow, support and better distribute the primary care workforce, including GPs, rural generalists, nurses, nurse practitioners, Aboriginal Health Practitioners and allied health professionals. Together, these reforms provide a strong foundation for a more equitable, sustainable and culturally responsive primary care system.

NACCHO recommends implementing the *Strengthening Medicare Taskforce Report* recommendations for flexible, practice level funding to support multidisciplinary team-based care.

ACCHO model of care

ACCHOs have been leaders in delivering culturally safe, comprehensive primary health care since the 1970s. Their community driven governance, local knowledge and cultural authority mean they are uniquely placed to provide holistic, wraparound care grounded in family, culture and community. Evidence consistently shows that ACCHOs achieve better outcomes than mainstream services, with Aboriginal and Torres Strait Islander people 23 per cent more likely to access and remain engaged with community- controlled- services.⁴ Many Aboriginal and Torres Strait Islander people actively bypass mainstream providers to seek care where cultural safety is assured and where services reflect their lived experiences and community values.⁵

ACCHOs achieve this through delivering a holistic model of care, which:

- Underscores the importance of connecting the physical, mental, social, emotional and spiritual dimensions of health and wellbeing to promote preventive and comprehensive care, with a strong focus on prevention not solely through focusing on treatment.
- Prioritises the values of community, culture and the deep connection to the land as integral elements of overall wellness.
- Recognises the significance of traditional healing methods, cultural protocols and community-driven initiatives in fostering the wellbeing of Aboriginal and/or Torres Strait Islander communities.
- Integrates the concept of 'joined up services', to ensure that healthcare services are coordinated and work together seamlessly to provide comprehensive support for individuals and communities.

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 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 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

⁴ NACCHO, Core Services and Outcomes Framework, June 2021, <https://csof.naccho.org.au/wp-content/uploads/2022/10/Core-Services-Outcomes-Framework-full-document.pdf>.

⁵ Kathryn S Panaretto, Mark Wenitong, Selwyn Button and Ian T Ring, Aboriginal community controlled health services: leading the way in primary care, *Med J Aust* 2014; 200 (11): 649-652. | doi: 10.5694/mja13.00005

to engage patients, support their attendance and to contribute to completing Medicare items that generate a higher Medicare revenue, such as GP Chronic Condition Management Plans and Health Assessments.

However, 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 GPs 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 undermines 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 GP practice, and this is worse for rural and remote services.⁶

ACCHOs have highlighted the need to move beyond individual GP incentives toward funding arrangements which strengthen practices.

NACCHO supports changes that would allow up to 100 per cent of incentive payments to be redirected to organisations, particularly those with 19(2) exemption arrangements.

NACCHO recommends redirecting up to 100% of incentive payments to services operating under 19(2) exemptions.

MyMedicare

MyMedicare does not adequately reflect the ways in which Aboriginal and Torres Strait Islander people access health care particularly in rural, regional and remote areas. Restrictions that limit patients to nominating a single practice and require nomination of an individual doctor, can create unintended barriers for patients who require access to services across multiple locations.

Patient mobility

Many patients move between remote communities and regional or metropolitan health hubs to access specialist, tertiary or ongoing care. Urban ACCHOs play a critical role in supporting patients who relocate temporarily or long-term for specialist treatment, family obligations or cultural reasons. These patterns are evident nationally - in Western Australia, patients from remote communities frequently travel to Perth, placing sustained demand on urban ACCHOs.

Patient mobility is also common across rural and remote communities, where individuals routinely access care from two or three services. In some regions, ACCHOs operate within shared infrastructure, common clinical information systems or formal regional alliances, such as the Kimberley Aboriginal Medical Services network or the Northern Aboriginal and Torres Strait Islander Health Alliance in North Queensland. In other cases, services are not formally connected, making the ability to register with multiple practices essential to support continuity of care across disconnected systems.

Analysis of GP non-referred attendance items in 2023 found that 6.7% of Aboriginal and Torres Strait Islander patients accessing ACCHOs attended two or more ACCHOs within the year.⁷ This indicates that approximately one in fifteen ACCHO patients are directly affected by restrictions on multiple practice nomination. The current MyMedicare system is resulting in a high administration burden for ACCHOs in rural

⁶ Expert Advisory Panel Report to the Australian Government (2024). 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 Ember Advisors (2024). Analysis on patterns of service use, preferences, and access to services for the Department of Health, Disability and Ageing (not publicly available).

and remote communities who are constantly re-enrolling patients, often in clinics with limited administrative staff, pulling clinical staff from clinical care. The ability for patients to register with multiple services would better support the high level of patient mobility across remoteness settings.

Limiting multiple practice nomination to services operating under a section 19(2) exemption, would ensure the policy remains targeted. ACCHOs receiving Indigenous Australians' Health Programme (IAHP) funding already operate under a 19(2) exemption, reflecting their distinct role in delivering primary health care to communities.

NACCHO recommends MyMedicare be amended to allow Aboriginal and Torres Strait Islander people to register with up to three ACCHO services.

Provider nomination

MyMedicare requires a practice to nominate a patient's preferred GP. In many rural and remote ACCHOs high workforce mobility results in ACCHOs having to make frequent updates to the nominated GP. This, along with the need to re-register patients imposes a significant administrative burden on ACCHOs, many of which experience high staff turnover and operate with limited or no dedicated administrative support.

The requirement to nominate an individual doctor under MyMedicare is poorly suited to ACCHO workforce models, as multidisciplinary, team-based care is not dependent on continuity of a single clinician. Workforce shortages, high staff turnover and reliance on locum or fly-in fly-out models make individual doctor nomination impractical and, in some cases, counterproductive. Similar issues have been raised by rural GPs working across multiple clinical settings that are part of separate organisations.

NACCHO supports optional nomination of a preferred provider for ACCHO services to allow more time and resources to be devoted to patient care.

NACCHO recommends nomination of a preferred provider is optional, rather than mandatory for clients registering with an ACCHO under MyMedicare.

Assignment of benefit

Digital assignment of benefit (AoB) creates challenges for ACCHO services. ACCHOs operate flexible, community-centred models that prioritise outreach, off-site delivery, home visits, community settings, and opportunistic care, often in areas with limited or unreliable digital connectivity. Requiring real-time digital consent at the point of care assumes access to technology and connectivity that is frequently unavailable.

Digital AoB systems that require online forms or platform-based interactions risk delaying care, discouraging service uptake, and increasing administrative burden. In addition, ACCHOs frequently support clients with complex needs who may face barriers to digital engagement, including limited digital literacy, shared or inconsistent access to devices, language barriers, or mistrust of digital systems. Requiring patients to navigate digital consent processes can shift administrative burden onto clients and undermine culturally safe care.

Overall, digital AoB reforms that are designed around mainstream, clinic based or telehealth centric models fail to account for the relational, mobile, and community embedded nature of ACCHO service delivery. Without substantial flexibility and non-digital options, such reforms are unlikely to operate effectively in ACCHO settings and may unintentionally reduce access to care or increase administrative burden for services already operating in resource constrained environments.

While ACCHOs support the intent of AoB reforms, digital-first compliance settings introduced before enduring systems are in place risk unintended consequences. Given the scale of change required and ongoing limitations in clinical and claiming software used across the sector, ACCHOs require appropriate implementation timeframes to establish workable systems before compliance activities commence.

AoB-related compliance requirements should be deferred until after the enduring AoB model is established and implemented in January 2027, providing certainty and avoiding the need for interim solutions. ACCHOs require additional time and support to address structural barriers to digital access and greater flexibility around how they can submit confirmation of consent.

Enduring assignment of benefit

In principle, NACCHO supports the concept of enduring assignment of benefit. As with MyMedicare registration, this should be available to clients across multiple ACCHOs. However, there needs to be clear guidance around enduring assignment processes to ensure services are well prepared for implementation.

Processes must safeguard client choice in assignment of benefit, particularly where this can be provided to multiple services. It will be important to ensure services cannot assign enduring benefit on behalf of a patient without their knowledge or explicit, informed consent.

NACCHO recommends assignment of benefit compliance arrangements allow confirmation of consent to be submitted in a variety of ways if required, not just through digital platforms.

NACCHO recommends deferring assignment of benefit compliance for ACCHOs until the enduring assignment of benefit model commences in January 2027.

NACCHO recommends clear guidance on enduring assignment of benefit arrangements is developed in partnership with the sector.

NACCHO recommends enduring assignment of benefit across multiple ACCHOs.

Emergency care parity

There is a significant funding gap between what ACCHOs can claim when providing urgent or emergency care and what hospital emergency departments receive through activity-based funding. In many rural and remote communities, ACCHOs are the only contact for urgent care and often provide emergency level services due to distant hospital access. Despite this, ACCHOs are funded through primary care arrangements that do not reflect the intensity, complexity or cost of urgent and emergency care.

ACCHOs often operate in environments with limited workforce, high acuity presentations, and significant after-hours demand. Many employ clinicians who manage urgent and emergency presentations alongside routine primary care, yet current funding arrangements do not adequately recognise or support this work.

Emergency departments are paid substantially more for comparable presentations, despite urgent care being safely and effectively delivered by ACCHO services. This results in ACCHO services covering the additional costs associated with urgent and emergency care. In the long-term, this limits ACCHOs' ability to staff afterhours services, maintain clinical capability for emergency care, and invest in infrastructure required to safely deliver urgent care, with flow on effects to the quality of primary care due to stretched staffing.

Ensuring ACCHOs have access appropriate funding for urgent and emergency care would promote equity across the health system, better reflect the care ACCHOs already provide, and support service sustainability in rural and remote communities. The two main options for ACCHOs that are the main providers of urgent and emergency care in their communities is to expand funding to Urgent Care Clinics or have access to the same activity-based funding for urgent and emergency care as hospital emergency departments. Currently 4 ACCHOs in the NT receive funding as an Urgent Care Clinic and informal feedback is that it is supporting appropriate after hours staffing and improved primary care services.

Funding reform for these ACCHOs would also align funding with patient need rather than care setting, strengthen community based urgent care, and reduce avoidable hospital presentations.



NACCHO recommends that ACCHOs delivering urgent or emergency care in rural and remote communities is reformed. Options include expanding funding to ACCHOs as Urgent Care Clinics or enabling access to the same activity-based funding for urgent and emergency services as hospital emergency departments.