Aboriginal Health and Medical Research Council of NSW

Inquiry into Rural, Regional and Remote access to Medicare

17 April 2026

AH&MRC
Aboriginal Health & Medical Research Council of NSW

Office address:
Gadigal Country
Level 4, 280 Pitt Street,
Sydney NSW 2000

Postal address:
PO Box 193
Matraville NSW 2036

T +61 2 9212 4777
E ahmrc@ahmrc.org.au
W www.ahmrc.org.au

About the AH&MRC

The AH&MRC, formerly the Aboriginal Health Resource Co-op (AHRC) was established in 1985 following a recommendation of the Brereton Report by the NSW Aboriginal Task Force on Aboriginal Health in 1982-83.

The AH&MRC assists the ACCHO Sector across NSW to ensure they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities.

As the Peak Body for Aboriginal Health in NSW the AH&MRC represents the rights and interests of 52 Member Services. The AH&MRC is committed to the delivery of four key priorities. These are:

- Aboriginal Community Control and Innovation
- Education and Workforce
- Research and Data
- Governance and Finance

The AH&MRC works collaboratively with the ACCHO Sector across NSW to ensure accessibility, sustainability and adequate resourcing of a skilled workforce providing comprehensive primary health care services for Aboriginal communities.

Summary

The AH&MRC, as the peak body for NSW ACCHOs, maintains that the Medicare system needs urgent and significant reforms to ensure that Aboriginal people have access to high-quality, culturally safe primary health care.

The current Medicare funding arrangements is not enabling a financially viable public health system and is inadvertently restricting Aboriginal people from accessing timely and ongoing care as needed. While Medicare reforms introduced in November 2025 were intended to increase access to bulk billing services and improve continuity of care, ACCHOs have been adversely impacted by the changes.

The following key issues highlight why the current Medicare system is unsustainable for ACCHOs and why targeted, needs-based Medicare reform is essential to improving health outcomes for Aboriginal people.

Background

Access to health care is dependent on various factors such as affordability, availability (at the right place and at the right time) and specific population needs.[1] For Aboriginal people, the social and cultural determinants of health and wellbeing play a significant role in accessing health care. Aboriginal people experience significant health inequities which are driven by unequal access and use of health care services.

ACCHOs are preferred primary health care providers (and sometimes the only provider) for Aboriginal people and service a significant proportion of communities in regional, rural, and remote NSW. Despite this, ACCHOs continue to be underfunded and under recognised for the delivery of essential health services to Aboriginal people.

[1] 3.14 Access to services compared with need - AIHW Indigenous HPF

The structural limitations of Medicare do not meet the needs of ACCHOs and the communities they serve. Policy reform of Medicare frequently overlooks the comprehensive and team-based model of care delivered by ACCHOs. As such, Medicare Benefits Schedule (MBS) items often do not reflect the longer consultation time required to deliver culturally safe care, fail to capture multidisciplinary care models and do not reimburse non-clinical but essential access supports (e.g. transport, outreach). As a result, ACCHOs face structural barriers in claiming Medicare revenue relative to the true cost of service delivery and despite servicing populations with high levels of need and complexity.

Although Aboriginal people are eligible for Medicare, access remains inequitable. Barriers include geographic isolation, limited availability of mainstream bulk-billing services, and lower levels of service access in rural and remote areas. ACCHOs mitigate many of these barriers by providing culturally safe and accessible services. However, the mismatch between need and Medicare funding means that access is not fully realised. Limitations in Medicare revenue, mean that ACCHOs rely on a combination of Commonwealth and State funding to remain financially viable. Medicare income often represents only a portion of total revenue and is frequently used to cross-subsidise unfunded or underfunded services. Despite being a high-volume provider of Medicare-eligible services, ACCHOs are not able to fully leverage Medicare funding. The gap between Medicare income and actual service costs are particularly pronounced in remote settings, where delivery costs are much higher.

AH&MRC response

AH&MRC welcomes this opportunity to respond to the Australian Government's inquiry into rural, regional, and remote access to Medicare. Key issues identified by member services around Medicare funding and incentive structures are discussed below.

ACCHOs are not proportionately remunerated for health assessments or long to very long consultations.

The changes to the Bulk Billing Practice Incentive Program (BBIP) which expands incentives to all bulk-billing patients, rather than only those with a Health Care Card and the tripling of the bulk billing incentive is a welcome reform. However, the changes focus heavily on incentive payments without addressing the underlying issue of inadequate Medicare Benefits Schedule (MBS) item rebate. Current funding structures encourage practices to prioritise a high volume of short consultations, which cumulatively generate substantial revenue while offering limited remuneration for longer, more complex appointments. For example, a level B consultation (6-20 minutes) attracts $43.90 plus the bulk-billing incentive for every patient. Yet a Level D consultation (over 40 minutes) provides only $125.10, and Level E (over 60 minutes) provides $202.65.[2] The current system incentivises patients to be seen every 6 minutes in addition to the bulk-billing incentive. A practice seeing eight patients for short, six-minute consultations can generate $351.20, plus an additional $317.20 from the tripled bulk-billing incentive. In contrast, a single long consultation generates only $202.65 and attracts just one bulk-billing incentive payment of $39.65. This discrepancy means that longer consultations and comprehensive health assessments remain financially disincentivised.

Importantly, this funding model does not align with or support the ACCHO model of care which relies on longer, comprehensive consultations and holistic health assessments. By failing to revise MBS item costings to reflect the time and complexity required for culturally safe care, the reforms risk undermining the very model that delivers the best outcomes for Aboriginal communities.

[2] MBS-Quick-Reference-Guide-MM6-2026.pdf

Removal of dedicated item numbers for Mental Health Treatment Plan (MHTP) reviews could be impacting the quality and consistency of mental health care.

With the removal of dedicated item numbers for MHTP reviews, previously protected time to discuss mental health concerns are absorbed into standard GP consults, which can result in mental health reviews being rushed or not occurring at all. Patients are effectively forced to choose between addressing their mental health needs or attending to other priorities such as scripts or referrals to specialists. This trade-off undermines the delivery of holistic, patient-centred care. Given the importance of structured and culturally safe follow-up care within ACCHOs, dedicated item numbers for MHTP reviews should be re-instated.

Inadvertent de-registration of ACCHO patients has resulted in Medicare claims being rejected

There are a number of operational and structural challenges that continue to limit the participation of ACCHOs in MyMedicare.

NSW ACCHOs have reported that a growing number of patients have been inadvertently registered to MyMedicare with other healthcare providers after receiving limited or episodic care. As a result, when these patients attend their regular ACCHO for a GP chronic condition management plan (GPCCMP), claims for item numbers 965/967 (GPCCMPs and reviews) are being rejected because the patient is now listed as MyMedicare-registered elsewhere. This situation leads to repeated administrative requirements, causing frustration for patients and increasing workload for nursing, administrative, and billings staff.[3]

Furthermore, members have reported their quarterly PIP-IHI payments are being reduced as a consequence of their patients being inadvertently re-registered with other health services. It is a double disadvantage against ACCHOs when they are unable to claim for Chronic Care Management Plans (CCMPs) and Mental Health Treatment Plans (MHTP) and then their Standardised Whole Patient Equivalent (SWPE) is reduced, given that SWPE is determined by the total cost of MBS items claimed. These structural gaps with MyMedicare are contributing to an overall reduction in the Medicare revenue that ACCHOs are able to generate.

Medicare does not adequately support the ACCHO model of care

Medicare does not adequately support the ACCHO model of care and the team-based structures that underpin it. ACCHOs rely on a mixed workforce inclusive of Aboriginal Health Workers/Practitioners, nurses, allied health professionals and GPs. Yet many services delivered within this model cannot be claimed under Medicare, including essential activities such as care coordination and a significant proportion of nursing and allied health work.

The exemption in the Health Insurance Act that allows ACCHOs to generate Medicare income is critical for sustaining and growing the Aboriginal health workforce, however billing restrictions and systemic workforce shortages mean that it is not enabling the level of service growth needed to meet community needs. The limited number of Medicare-claimable items for nurses and allied health services place substantial financial pressure on ACCHOs.

To ensure ACCHOs can continue to deliver comprehensive, community-led care, there is a pressing need to consider Medicare reform that better reflects the true cost and structure of

[3] CEO-Summit-2025-MyMedicare-BB-PIP.pdf

ACCHO models. Considering these limitations, there is a strong need for expanding the use of block funding and needs-based capitation models. Medicare is currently designed to fund episodic, fee-for-service activities and does not adequately support preventative health or the relational wrap around care that ACCHOs provide. A more flexible funding approach would allow ACCHOs to invest in prevention and sustain their team-based care as core elements of the ACCHO model and what is known to be essential to the long-term health outcomes of Aboriginal people.

Conclusion

Improving rural, regional and remote access to Medicare requires reforms that recognise the unique role that ACCHOs play in culturally safe, comprehensive primary health care. The experiences of NSW ACCHOs demonstrates that the current Medicare model are limiting ACCHOs from meeting community needs. These challenges are compounded by workforce shortages and funding models that incentivise episodic, high-volume care rather than prevention and holistic support.

To ensure Aboriginal communities receive the care needed, Medicare must evolve to reflect the true cost and structure of the ACCHO model. Strengthening Medicare through needs-based reform, reinstating essential item numbers, resolving MyMedicare registration issues and expanding complementary funding mechanisms such as block funding and capitation will provide the stability required to support ACCHOs to deliver their full model of care and ultimately improve access.

Recommendations

The AH&MRC proposes the following recommendations:

1. Reform GP consultation items to properly fund long and complex consultations and health assessments.
2. Restore specific MHTP review items to ensure protected time for culturally safe and structured mental health follow up, and tracking of reviews.
3. Address MyMedicare registration issues affecting ACCHO patients in partnership and ensure ACCHOs can claim GPCCMP and MHTPs without administration barriers.
4. Reform Medicare to adequately support mixed-team models of care which are critical in rural and remote areas and are the basis of culturally safe, holistic care provided by ACCHOs.

Ms Nicole Turner
Chief Executive Officer
Aboriginal Health & Medical Research Council

For further information please contact:

Nathan Taylor – Director of Intelligence on ntaylor@ahmrc.org.au