Submission to the Senate Standing Committees on Rural and Regional Affairs and Transport

Inquiry into Rural, Regional and Remote Medicare Access and Funding

Submitted by: National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA)
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Annexure A: NATSIWA Chairperson Submission

As an annexure to this submission, we have included a Chairperson's submission. Prepared by Sarah Corrigan, Chairperson and NSW Director of NATSIWA, and an Aboriginal Health Practitioner, it provides additional professional and lived experience perspectives particularly in relation to Medicare access, mixed-team models of care, and the practical impacts of current system settings on Aboriginal and Torres Strait Islander people in rural, regional and remote communities that complement and strengthen the organisation's submission.

About NATSIWA

The National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA) is the national peak body representing Aboriginal and Torres Strait Islander women across Australia. NATSIWA provides a collective national voice to ensure that the leadership, lived experience and policy priorities of Aboriginal and Torres Strait Islander women are centred in government decision-making.

NATSIWA is funded through the Australian Government's Gender Equality Strategy under the Office for Women and works to strengthen the participation, safety, wellbeing and leadership of Aboriginal and Torres Strait Islander women and girls. As a national alliance, NATSIWA engages with Aboriginal and Torres Strait Islander women across urban, regional, rural and remote communities to elevate community perspectives in national policy and reform processes.

NATSIWA works across policy reform, systemic advocacy and community engagement to address structural barriers faced by Aboriginal and Torres Strait Islander women in areas including safety, health, housing, employment, education and justice. Our work is grounded in the principles of self-determination, cultural authority and community-led solutions. Through engagement with community leaders, service providers, researchers and government stakeholders, NATSIWA contributes to national policy development across a range of portfolios including gender equality, domestic and family violence, social and emotional wellbeing, economic participation and Closing the Gap[6].

Aboriginal and Torres Strait Islander women hold cultural authority, community responsibility and intergenerational leadership roles.

Executive summary

The National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA) provides this submission to ensure that the voices, lived experiences and priorities of Aboriginal and Torres Strait Islander women are central to this Inquiry into rural, regional and remote Medicare access and funding.

For Aboriginal and Torres Strait Islander women, particularly those living in rural, regional, remote and very remote communities, Medicare is not consistently delivering equitable access to healthcare.[1] While Medicare is intended to be a universal system, it continues to

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operate in ways that reflect metropolitan assumptions and service models that do not align with the realities of our communities.

Women are navigating complex and compounding barriers to care, including long travel distances, limited or intermittent service availability, workforce shortages, cost pressures, and a lack of culturally safe and trusted services. These challenges are further intensified by the broader context in which many Aboriginal and Torres Strait Islander women live, where poverty, housing insecurity, disability, family violence, and caring responsibilities intersect and directly impact the ability to access timely and appropriate healthcare.

For many women, access to healthcare is not a simple matter of making an appointment. It involves coordinating transport across long distances, managing the care of children and family members, navigating systems that are not culturally safe, and, in some cases, avoiding local services altogether due to privacy concerns, stigma, or previous negative experiences. In smaller communities, the lack of anonymity and culturally appropriate care can be a significant barrier, particularly for women seeking support for mental health, reproductive health, or experiences of violence.

Recent Medicare changes, including those introduced on 1 November 2025, have sought to strengthen continuity of care. However, from the perspective of Aboriginal and Torres Strait Islander women, these changes have not resolved existing inequities and may, in some cases, create additional barriers, particularly where access to telehealth and provider choice is restricted in already low-access environments. In communities where there may be only one provider, or where services are delivered on a visiting basis, flexibility is essential. Policies that assume stable, continuous access to a single provider do not reflect the realities of rural and remote service delivery.

The consequences of these systemic gaps are significant. Women are delaying care, going without care, or relying on emergency departments[3] for issues that should be managed in primary care settings. This contributes to higher rates of preventable illness, increased hospitalisations, and poorer health outcomes for Aboriginal and Torres Strait Islander women and their families.

This submission is grounded in what Aboriginal and Torres Strait Islander women are telling NATSIWA across communities. It reflects consistent experiences of systems that are difficult to navigate, not designed for their circumstances, and too often failing to meet their needs. It also reflects the strength, resilience and leadership of women who continue to advocate for better outcomes for themselves, their families and their communities.

NATSIWA is clear that incremental change is not sufficient. Medicare requires structural reform to ensure it is equitable, accessible and sustainable for rural and remote communities. This includes embedding equity and human rights[8] in system design, strengthening culturally safe and community-led models of care, ensuring flexible access pathways such as telehealth, and providing sustainable funding that reflects the realities of delivering care outside metropolitan areas.

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At its core, this submission calls for a Medicare system that works for Aboriginal and Torres Strait Islander women—one that recognises their role as carers, leaders and decision-makers within their families and communities, and ensures they can access the care they need, when and where they need it.

Without this shift, inequities will persist, and Aboriginal and Torres Strait Islander women will continue to experience avoidable harm within a system intended to provide universal care.

1. Impact of the 1 November 2025 Medicare Changes on Access to Primary Care (including Telehealth)

Recent Medicare changes introduced from 1 November 2025 have sought to strengthen continuity of care through mechanisms such as MyMedicare registration and linking telehealth access to a patient's nominated provider or usual practice. These changes are intended to improve coordination and long-term care relationships.

Issues and Impacts

In rural, regional, remote and very remote areas, these settings do not reflect how care is accessed in practice. Many communities experience:

- Limited or no permanent GP workforce
- Reliance on visiting, outreach or short-term providers
- Long wait times and inconsistent service availability

For Aboriginal and Torres Strait Islander women, access is further shaped by:

- Cultural safety and trust
- Privacy concerns in small communities
- Experiences of stigma and discrimination
- The need to access providers outside their local area

As a result, linking telehealth to a single provider can restrict access, particularly for women seeking mental health support, reproductive health care, or support related to family violence.

Rather than strengthening continuity, these changes risk:

- Delays in care
- Disengagement from services
- Increased reliance on emergency departments
- Worsening health outcomes

Continuity of care in rural and remote Australia must be flexible and patient-led, not constrained by provider availability where options are limited.

Recommendations

- Introduce flexible telehealth access for rural and remote patients

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- Establish exemptions to MyMedicare-linked requirements in low-access areas
- Protect patient choice and access to trusted providers
- Undertake an urgent review of November 2025 changes with a First Nations and rural lens

2. Financial Sustainability of Independently Owned Rural General Practices

Current Medicare funding arrangements remain heavily reliant on fee-for-service models[5] and incentive structures that assume stable patient volumes and workforce availability.

Issues and Impacts

Independently owned rural practices operate in:

- Low-volume, high-complexity environments
- Communities with high need but limited capacity to pay
- Contexts where workforce recruitment and retention is difficult

Bulk billing incentives and new funding programs provide some support, but they do not fully address:

- The cost of delivering care in remote settings
- The need for multidisciplinary staffing
- Administrative burden on small practices

This places small, community-based clinics at risk of:

- Financial instability
- Workforce burnout
- Service reduction or closure

For Aboriginal and Torres Strait Islander women, the loss of local services means:

- Increased travel and cost
- Reduced access to culturally safe care
- Greater reliance on hospital systems

Small, community-embedded practices are essential infrastructure and must be sustainably funded, not left to market forces.

Recommendations

- Introduce base funding or viability payments for rural practices
- Move toward blended funding models (not just fee-for-service)
- Increase investment in multidisciplinary teams[7]
- Reduce administrative burden for small providers

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3. Contribution of Medicare Settings to Avoidable ED Presentations and Hospital Admissions

Medicare settings that fail to support timely and accessible primary care contribute directly to increased emergency department use and preventable hospitalisations.

Issues and Impacts

In rural and remote communities:

- GP access is limited or delayed
- After-hours services are scarce
- Chronic disease management is inconsistent

As a result, women and families:

- Present to emergency departments for non-urgent care
- Delay seeking care until conditions worsen
- Experience avoidable hospital admissions

For Aboriginal and Torres Strait Islander women, these impacts are intensified by:

- Barriers to culturally safe care
- Socioeconomic disadvantage
- Caregiving responsibilities

High ED use is not a failure of individuals—it is a failure of system design and access.

Recommendations

- Strengthen primary care access and early intervention
- Invest in community-based and preventative care models
- Improve after-hours service availability
- Monitor outcomes through equity-based indicators

4. Adequacy of Medicare Support for Mixed-Team Models of Care

Rural and remote healthcare relies on multidisciplinary teams[7], including nurses, nurse practitioners, allied health professionals, Aboriginal and Torres Strait Islander health workers, and visiting specialists.

Issues and Impacts

Current Medicare settings:

- Remain GP-centric
- Fragment funding across multiple programs
- Do not adequately fund team-based care

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This limits the ability of services to:

- Deliver holistic care
- Respond to complex needs
- Sustain workforce models that reflect community realities

For Aboriginal and Torres Strait Islander women, culturally safe care is often delivered through team-based, community-connected approaches, which are under-supported.

Multidisciplinary and culturally safe care must be recognised as core, not supplementary, to Medicare.

Recommendations

- Expand funding for team-based care models
- Strengthen support for Aboriginal and Torres Strait Islander health workforce
- Introduce flexible funding that reflects local service models

5. Impacts on Corporate Providers vs Small Community Clinics

Current Medicare funding and compliance arrangements can disproportionately benefit larger providers.

Issues and Impacts

Large corporate providers are better able to:

- Manage administrative requirements
- Absorb financial risk
- Scale services across locations

Small, community-based clinics:

- Operate with limited resources
- Face higher administrative burden
- Are more vulnerable to funding changes

This creates a risk that:

- Community-based services decline
- Care becomes less locally responsive
- Cultural safety and trust are reduced

Community-embedded services must be protected as critical access points for rural and remote communities.

Recommendations

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- Review funding models to ensure equity between provider types
- Reduce compliance burden for small services
- Introduce targeted support for community-based clinics

6. Reforms Needed to Ensure Medicare is Fair, Workable and Sustainable

Current Medicare settings require structural reform to ensure equity across rural and remote Australia.

Issues and Impacts

Without reform:

- Inequities will persist
- Access gaps will widen
- Health outcomes will continue to diverge

Medicare must be redesigned to reflect equity, human rights[8] and the realities of rural and remote communities.

Recommendations

- Embed equity and human rights[8] in legislation
- Mandate rural and First Nations impact assessments
- Introduce rural stress-testing of all reforms
- Strengthen safety nets and affordability measures

7. Additional Matters: First Nations Women and System Design

Medicare reform must recognise the specific role and experiences of Aboriginal and Torres Strait Islander women.

Issues and Impacts

Women are:

- Primary caregivers and system navigators
- Disproportionately impacted by access barriers
- Managing complex family and community needs

Yet their voices are often absent in system design.

Medicare must be informed by the lived experiences and leadership of Aboriginal and Torres Strait Islander women.

Recommendations

- Ensure First Nations women's voices are embedded in policy design

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- Align reforms with Closing the Gap[6] Priority Reforms
- Invest in community-led solutions

Conclusion

Medicare, as Australia's universal health system, must work for all Australians, regardless of where they live.

For Aboriginal and Torres Strait Islander women in rural, regional, remote and very remote communities, this is not currently the case. The evidence is clear: access is inconsistent, services are limited, and systems are not designed with the realities of our lives in mind. Women continue to navigate significant barriers to care, resulting in delayed treatment, avoidable illness and increased reliance on hospital systems.

This submission has outlined how current Medicare settings are contributing to inequitable outcomes and has identified the structural reforms required to ensure the system is fair, workable and sustainable.

NATSIWA is clear that reform must go beyond incremental change. Medicare must be reoriented around equity, cultural safety and access, with policies and funding models that reflect the realities of rural and remote communities. This includes strengthening community based services, supporting multidisciplinary care, ensuring flexible access through telehealth, and embedding First Nations voices in system design.

At its core, Medicare must recognise the role of Aboriginal and Torres Strait Islander women as leaders, caregivers and decision-makers within their families and communities, and ensure they are able to access timely, culturally safe and appropriate care.

This Inquiry presents a critical opportunity to reshape Medicare so that it delivers on its promise of universal access. NATSIWA urges the Committee to take forward reforms that ensure no woman is left without care because of where she lives.

References

1. AIHW Rural and Remote Health
2. AIHW Preventable Hospitalisations
3. AIHW Emergency Department Care
4. Dept Health Medicare Changes 2025
5. Workforce Incentive Program
6. Closing the Gap Report 2024
7. National Rural Health Alliance
8. UNDRIP & ICESCR

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NATSIWA Chairperson Submission.

I am a proud Darkinjung woman who lives and works on Awabakal County and has provided this submission as the Chairperson and NSW Director of the National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA) and request it be read with our main submission. I have provided this deeper insight into D, E, F and G as I am an Aboriginal Health Practitioner who provides services through Medicare, a Cultural Safety Advisor for AHPRA and provide cultural consultancy and training with a specialisation in training healthcare and education providers.

I also provide services to NDIS clients and have participated in several professional and lived experience panels and roundtables convened by NDIA.
I have qualifications in Aboriginal trauma-informed care and recovery practice, AOD, Mental Health and am a qualified trainer and assessor. I also have a son who has been a frequent flyer of the hospital systems due to a rare illness at birth and who has been an NDIS participant since its very original pilot program in Newcastle, NSW.

I have chosen not to provide many formal references and/or statistics as the data to support my submission is the same evidence and data set which supports the Federal Governments Closing the Gap strategy. I have provided a submission which provides grassroots examples of how mob and health practitioners with mob experience the Medicare system. I would welcome the privilege and opportunity to discuss this submission further with you face-to-face at any upcoming enquiries.

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 practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists;*

e) *the impacts of current Medicare rules and incentive arrangements on large corporate providers compared with small, community-embedded rural clinics;*

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; and*

g) *any other related matters.*

D) Mixed-team models have been funded across Primary Healthcare Networks in NSW and often include specific at-risk cohorts of Aboriginal and Torres Strait Islander patients, e.g. specific teams to address Diabetes and Cardiac conditions however these multi-disciplinary teams very rarely specify the inclusion of Aboriginal Health Practitioners within these teams and are not considered as part of the tender process. The addition of an Aboriginal Health Care Practitioner would increase the team's MBS billable occasions of care available to Aboriginal and/or Torres Strait Islander people and would also support culturally safe, responsive and

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competent healthcare in general practice (non- Aboriginal Medical Service (AMS) or Community Controlled Organisation).

There is also a focus on providing mixed-team models to address chronic health conditions and/or non-emergency urgent primary healthcare. However there is an argument that the expansion of a hybrid model of Mental Health Urgent Care Clinics with mixed-team models to address social and emotional wellbeing (mental health) for Aboriginal and/or Torres Strait Islander people through the establishment of Urgent Care clinics which provide a "one stop shop" for SEWB and primary healthcare for Aboriginal and/or Torres Strait Islander people better reflects the Aboriginal Social Emotional Wellbeing Wheel which is a core pillar of providing culturally safe and responsive healthcare across all settings to Aboriginal and/or Torres Strait Islander people.

This point is relevant to point C of this submission. Provision of an extended hours, bulk billed holistic mixed-team model urgent care clinic for Aboriginal and/or Torres Strait Islander people could reduce the rates of presentation for mental health at Psychiatric Emergency Care (PEC) and general ED. Often mob will present to hospital with significant acute and active symptomology of mental illness which does not meet threshold for admission but still requires multi-disciplinary culturally safe and responsive mental healthcare in a community setting within the next 1-3 days.

It is noted that within the call for this submission in point D there is no reference to Aboriginal Health Practitioners however in rural and remote AMS these Aboriginal Health Practitioners/Workers are frontline primary and allied healthcare workers with a clinical scope of practice and specific PBS Item numbers and referral pathways.

E) This response is informed by lived professional and consumer experience and formal and informal information gathering from colleagues, psychology service providers and Aboriginal and/or Torres Strait Islander people, particularly for Aboriginal and/or Torres Strait Islander women and children with a focus on current Medicare rules and incentive arrangements for Aboriginal and/or Torres Strait Islander people to access bulk-billed Psychology, Psychiatry and Allied Health Supports with a SEWB focus through Medicare' pathways Mental Health Care Plan and Access to Better Health for Indigenous Australians.

Medicare rules relating to the number of visits for Indigenous Australians to access Allied Health Professionals and/or Psychology and/or Psychiatry through bulk billed services or gap only services is limited to between 6-12 dependent on the pathway over a 12month period. Often these allocated visits must be allocated across multiple allied health practitioners which reflects the complexity and high level of comorbidities of Indigenous Australians' health and wellbeing. It is recommended that the number of visits across a 12-month period to access Allied Health and/or Psychology and/or Allied Health for SEWB is increased to up to 24 visits per 12months for each allied health profession and that unused visits can accrue as opposed to being reset each 12month period.

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The cost of a 7 day inpatient stay needing critical care across all health settings according to IB2025_022.pdf from NSW Health 2025 is $50, 386.00 and if a 7 day follow up was required in a rural hospital the same source costs this 7 day stay in a psychiatric hospital setting to be $4305.00 costing a total of $54691. This same cost could fund 753 Allied Health visits at the full fee cost of $72.65. This does not include costs associated for inpatient non-billable occasions of care and/or costs associated with hospital follow up in community with patients post discharge.

A quick literary review of evidence-based research and data can support the argument that where possible early intervention, regular follow-up and culturally safe, respectful and competent care reduces the rates of hospitalisation and financial costs (both to the individual and government) associated with burden of disease for Aboriginal and/or Torres Strait Islander people is significantly reduced.

Incentive arrangements for psychologists and psychiatrists to provide full bulk-billed appointments in private practice settings is significantly less than the amount they can charge privately, through other government department referrals and NDIS PAPL fees for the same services.

This has resulted in many physical bricks and mortar psychology and psychiatry practices no longer offering face-to-face, fully bulk-billed appointments. In addition to the disparity of rates for face-to-face appointments between patient and practitioner, Medicare incentives also do not reflect the complex model of care a psychologist and/or psychiatrist provides these patients including financial compensation for reports, case conferences, f/up letters, referrals etc. I have approached practitioners to request bulk-billed services for clients I work with, and their feedback is they would like to be able to offer this service to my First Nations patients however the complexity of care they require to provide beneficial treatment is not financially viable and/or not supported by current Medicare MBS incentives.

There has been a rise in online psychology services providing 100% bulk billed sessions using a Medicare Mental Healthcare Plan however these services are often owned by large corporations and it is unclear how these corporations ensure they are providing culturally safe and responsive services for not only Aboriginal and/or Torres Strait Islander people but all of those from diverse and marginalised backgrounds e.g. our queer community, those living with a disability and culturally and linguistically diverse. Online appointments also require access to reliable internet, access to technology to attend appointment online, e.g. phone/laptop and that the patient has a private and safe space to attend these appointments, all of these may not be possible for mob living in rural and remote communities.

Smaller practices which are embedded in community in rural areas and also within regional areas for First Nations mob, are essential to close the gap in healthcare for First Nations people. AMS' at regional and rural areas are at capacity and the inadequate financial reimbursement and lack of culturally specific mixed-teams model of care combined with restrictive rules regarding maximum visits with an Allied Health Practitioner prevents local

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Community Controlled Organisations and also individual First Nations health practitioners opening private practices, which could provide a mix of bulk-billed healthcare services and fee-paying to the whole community. Mob owned and run private healthcare practices provides income and builds financial capacity for Aboriginal and/or Torres Strait Islander people and employment pathways for First Nations community members.

Psychologists and Psychiatrists who do bulk billing currently have closed books and/or waiting list which are often over 12-18months and longer in rural and remote communities with some services only being provided via visiting specialists.

F&G) The situation outlined above prevents vulnerable Aboriginal and/or Torres Strait Islander children and youth under the age of 25 from accessing bulk-billed psychiatric assessments. To have a psychiatry assessment bulk billed under MBS Item Number 75857 a referral must be provided by a psychologist or paediatrician. (Unfortunately, a similar situation occurs with bulk-billing pediatricians around long waitlists or nil practitioners' bulk-billing). Private costs for a full psychiatric diagnostic assessment cost between $2500 to $6000. This is a cost that is out of reach for most First Nations parents and young people and often the subject of "politics" when asking Government organisations such as state child protection to provide funding for this. Without a diagnosis the following occurs for many Aboriginal children and young people (and this then affects their carers, usually a female identifying First Nations person):

Inability to access appropriate accommodations and classroom allocations in education settings as a diagnosis is often needed to formalise these arrangements for students.

Increased engagement with child protection services due to parent/carer being unable to access services and funding to support them to provide positive behaviour support and interventions to better manage their children's behaviours of concern often stemming from an undiagnosed and untreated mental illness and psychosocial disability.

Increased interactions with the justice system including police and incarceration.

Increased substance disorder, abuse and addiction often as the persons direct experience of untreated symptoms of mental illness e.g. using alcohol to obtain treat insomnia caused by recurring nightmares which could be better managed through CBT, appropriate mental health medications and therapeutic yarning.

Inability to access NDIS and/or continue to stay on NDIS. This is of particular concern as currently there is a large cohort of vulnerable Aboriginal and/or Torres Strait Islander children who accessed the NDIS scheme through the Early Childhood Intervention pathway and this *did not* require a full diagnosis and/or the legislation at that time allowed for some NDIS funding to cover the full diagnostic assessment (as above) but this resulted in the young child meeting threshold for Early Intervention through NDIS funding but *did not* receive a diagnosis consistent with the DSM-V5 but had the recommendation of a reassessment at a later date.

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These assessments can no longer be funded by NDIS; there is limited if any access to Medicare bulk-billed diagnostic assessments and families do not have capacity to pay privately for full assessments. This places many Aboriginal and/or Torres Strait Islander children at risk of being removed from the NDIS due to not having a confirmed diagnosis, but will still have same behaviours of concern and probably psychosocial disability but no clear pathway to access treatment for same.

I would recommend that a joint working party is formed between NDIA and Medicare government departments to address this issue and create a dedicated pathway for children who are currently funded by NDIS through the ECI pathway have access to a bulk-billed diagnostic assessment to determine eligibility for ongoing NDIS and/or suitability for alternative supports.

A general comment is that Aboriginal and/or Torres Strait Islander Health Practitioners and/or Workers registered with AHPRA are an underutilised healthcare workforce and resource and provide healthcare which is both clinically and culturally informed. It is recommended that the Federal government engage with peak Aboriginal and Torres Strait Islander bodies such as NATSIWA, NAATSIHWP, AIDA, Lowitja Institute to explore how this workforce can be expanded and further developed to provide consistent care across a national scope of practice which is readily recognised by the healthcare workforce with their scope being adequately reflected in the MBS.

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