27 March 2026

Committee Secretary
Senate Standing Committees on Rural and Regional Affairs and Transport
PO Box 6100
Parliament House
Canberra ACT 2600

Registered Charity
ABN 42 006 173 379
Level 7, 461 Bourke Street
Melbourne VIC 3000
Telephone 03 9670 1000
StrokeLine 1800 STROKE (1800 787 653)
strokefoundation.org.au

Sent by email: rrat.sen@aph.gov.au

Dear Sir/Madam

**Stroke Foundation's response to the Senate Standing Committees on Rural and Regional Affairs and Transport Inquiry into 'Rural, regional and remote Medicare access and funding'**

As the voice of stroke in Australia, Stroke Foundation welcomes the opportunity to respond to this inquiry on 'Rural, regional and remote Medicare access and funding'. The key points in our submission are summarised below.

## Key points

- In recent years, an increase in the number of patients with complex healthcare needs in rural, regional and remote areas, has not been accompanied by an increase in Medicare rebates, which has put a significant strain on the ability of GP practices in these areas to deliver bulk-billed services and for patients to afford out-of-pocket costs.
- In the last four years, the Australian Government has invested significantly in increased bulk-billing incentives for GPs, including in rural, regional and remote areas, to address this issue.
- The most recent investment, a two-part bulk-billing incentive package for general practice which took effect on 1 November 2025, has had an immediate and significant impact, resulting in the largest quarterly increase in the number of GP services bulk-billed nationally since the first phase of the COVID-19 pandemic. The largest increases were observed in regional centres and towns.
- It is too early to determine whether increases in bulk-billing rates in rural, regional and remote areas will be sustained, and if they will contribute to improved patient outcomes and a reduction in avoidable emergency presentations and hospital admissions in these communities.
- There are concerns within the profession that increasing bulk-billing incentives may indirectly encourage shorter consultations, which are not appropriate for managing complex cases, and further embed a primary care fee-for-service funding model that is not fit for purpose. There is a clear need for a more flexible, 'blended' primary care funding model that reflects the needs of each patient.
- GPs are also concerned that full bulk-billing would undermine their practice's financial sustainability, and it is critical that improved access to primary care, through more free GP services, is balanced against the need to maintain the viability of practices.
- Stroke Foundation, along with 20 other patient and healthcare organisations, is calling on the Australian Government to increase the Medicare rebate for longer GP consultations by 40 percent, to ensure Australians living with chronic and complex conditions such as stroke are able to manage their conditions more effectively.
- Currently, multidisciplinary team-based care, which is critical for the effective management of chronic and complex conditions, is not adequately supported by Medicare, and this needs to be addressed as part of a broader overhaul of funding models for primary care.

## Introduction

Stroke Foundation is a national charity that partners with the community to prevent stroke, save lives and enhance recovery. We do this through raising awareness, empowering health professionals to deliver high quality, best-practice care to stroke patients, facilitating research, and supporting survivors of stroke. We advocate for better systems, processes and resources to help health professionals deliver world class stroke care.

Chronic health conditions such as stroke are the leading cause of illness, disability and death in Australia. There are an estimated 45,785 stroke events in Australia annually and more than 440,000 survivors of stroke are living in our community.[1] The lifetime costs associated with strokes that occurred in Australia in 2023 exceed $15 billion ($350,000 per person), including healthcare, lost productivity and unpaid carer costs.[1] Research shows that without a concerted effort to improve stroke awareness and prevention, the number of annual stroke events in Australia is expected to reach 72,000 by 2050.[1]

We know that more than 80 percent of strokes can be prevented,[2] and that stroke prevention remains the most effective means of reducing the impact of stroke in Australia.

Australian and international evidence shows that strong primary care systems result in better health outcomes, lower rates of avoidable hospitalisations, and significant cost savings.[3] For chronic conditions, including stroke, a comprehensive and integrated primary care system is critical to identifying and managing individuals at high risk, halting disease progression, preventing avoidable complications, and providing treatment at an earlier stage.

Stroke Foundation applauds the reforms the Australian Government has undertaken in recent years to strengthen our primary care system, including by increasing access to primary care services and encouraging multidisciplinary team-based care.

Regional Australians are 17 percent more likely to suffer a stroke than those in metropolitan areas,[4] while hospitalisation and death rates for stroke are 1.1 times higher in people from remote and very remote areas compared with major cities.[5] This disparity with regard to stroke morbidity and mortality is due to a combination of factors, including reduced access to primary care services in rural, regional and remote communities compared with metropolitan areas.

## Impact of 1 November 2025 Medicare changes on rural, regional and remote Australians

The current primary care system in Australia continues to be oriented toward treating illness and disease, rather than prevention or wellness. There needs to be shift in how the public perceives the role of primary care. People should be encouraged to engage with primary care services not only when unwell, but as a means of maintaining good health. As Australia's cost of living crisis worsens, there is evidence that more people are delaying visits to the general practitioner (GP) due to out-of-pocket costs.

Data from the Australian Bureau of Statistics has shown that the number of people who delayed or did not see a GP when they needed due to cost, increased from 3.5 percent in 2021-22, to 7.7 percent in 2024-25.[6] We know from consultations with the stroke community that out-of-pocket costs are a barrier to accessing primary care services for survivors of stroke, their families and carers.

When geographical differences in bulk-billing and out-of-pocket costs for GP services in Australia have been examined, rural practices, particularly those in remote and very remote areas, have been shown to have both the highest rates of bulk-billing[7] and the highest rates of out-of-pocket costs, nationally.[7, 8]

In rural, regional and remote areas, patients are more likely to have chronic conditions and poorer health outcomes.[9] These patients have fewer GP appointments per year,[10] and may have to travel significant distances in order to access bulk-billing GP services, requiring longer consultations in order to manage their complex healthcare needs.[9] Patients with complex needs also require greater coordination between providers across a large geographical area, increasing the administrative and referral burden for practices that may need to charge higher fees in order to offset this.[10] Those patients who are unable to access bulk-billing GP services may choose to skip or delay essential appointments, or visit hospital emergency departments where there are no associated out-of-pocket costs.[9]

In recent years, an increase in the number of patients with complex healthcare needs in rural, regional and remote areas has not been accompanied by an increase in Medicare rebates, which has put a significant strain on the ability of GP practices in these areas to deliver bulk-billed services and for patients to afford out-of-pocket costs.[9] Recognising the need to address this problem, in the last four years, the Australian Government has invested significantly in increased bulk-billing incentives for GPs in rural, regional and remote areas.

*Access to Medicare services*

In January 2022, rural bulk-billing incentives for GPs increased with remoteness, based on the Modified Monash Model (MMM) classification of the location, with incentives rising from 160 percent (for MM 3–4 locations, large/medium rural towns) to 190 percent (for MM 7 locations, very remote areas) of the metropolitan bulk-billing incentive, improving the viability of GP practices, and reducing out-of-pocket costs for patients, in these communities.[8]

In November 2023, bulk-billing incentives for GP consultations for children under 16, pensioners and concession card holders were tripled, with additional scaling for rurality, resulting in incentives that were between 50 percent and 90 percent higher for GPs in rural, regional and remote areas compared with those in metropolitan areas. This significantly improved access to GP services for patients in these areas.[7]

Most recently, in support of their 2025 election pledge to increase the bulk-billing rate to 90 percent by 2030, the Australian Government has implemented a two-part incentive package for general practice. Firstly, bulk-billing incentives for GP consultations have been tripled, and expanded to all patients, not just children, pensioners and concession-card holders, and are even higher for practices in rural, regional and remote areas. Secondly, under a Bulk Billing Practice Incentive Program (BBPIP), practices that bulk bill all eligible patients receive a 12.5 percent incentive payment. These changes took effect on 1 November 2025.

Data from the Australian Government's national GP bulk-billing snapshot, for the period between 1 November 2025 and 31 January 2026, has shown that these changes have had an immediate and significant impact.[11] Specifically, 81.4 percent of GP services were bulk-billed, up from 77.1 percent for the same period a year earlier, which represents the largest quarterly increase since the first phase of the COVID-19 pandemic.[11] The largest increases in bulk-billing rates were observed in regional centres and towns, and the number of practices that bulk bill all their services has also increased, from approximately 2,300 to more than 3,400.[11]

While these changes have achieved their intended purpose in the short-term, it is too early to determine whether these increases in bulk-billing rates in rural, regional and remote areas will be sustained, and if they will contribute to improved patient outcomes and a reduction in avoidable emergency presentations and hospital admissions in these communities. It is incorrect to assume that access to primary care is a proxy measure for quality of care, and there are concerns within the profession that increasing bulk-billing incentives may indirectly encourage shorter consultations, which are not appropriate for managing complex cases, and further embed a primary care fee-for-service funding model that is not fit for purpose.[12] There is a clear need for a more flexible, 'blended' primary care funding model that reflects the needs of each patient.

Currently, not every long consultation (Level C [20–40 minutes] and Level D [40+ minutes]) with a GP can be bulk billed, and the per minute value of Medicare rebates falls as patients spend more time with their GP.[13] Therefore, increasing the Medicare rebate for longer GP consultations is the only way to reduce the out-of-pocket costs for patients who can't be bulk billed.[13] We, along with 20 other patient and healthcare organisations, are calling on the Australian Government to increase the Medicare rebate for long consultations by 40 percent, to ensure Australians living with chronic and complex conditions such as stroke are able to see their GP for longer in order to manage their conditions more effectively.[13]

*Financial sustainability of general practices*

A key challenge of the new bulk-billing incentive scheme is whether the income from this scheme is adequate for rural, regional and remote GPs and practices to cover their operating costs, which often consume at least 30 to 40 percent of their gross billings.[12] For practices that use mixed billing models, where GPs elect to bulk bill some patient groups and privately charge other patients who are able to pay a

gap fee, or private billing models where GPs charge all patients for consultations, these operating costs are built into the gap fees charged. The focus of the Australian Government's investment in bulk-billing incentives is to encourage more practices to move to a universal bulk-billing model, where their only income is the government Medicare rebate; however, if that rebate is less than the cost-recovery level, practices risk operating at a loss, and this is a significant concern for the primary care sector.

A recent national survey found 66 percent of GPs plan to retain their current billing practices, in spite of the new incentives, suggesting that many fear full bulk-billing may undermine their practice's financial sustainability.[12] It is critical that improved access to primary care, through more free GP services, is balanced against the need to maintain the viability of practices.

The cost of delivering primary care services in rural, regional and remote areas, where consultations are generally longer and the scope of practice is broader, is higher than in metropolitan areas.[14] Importantly, each rural, regional and remote community is unique, and different practices operate under a variety of business models.[14] Therefore, the new bulk-billing incentives will be more successful in some practices than others. Many practices are likely to continue to bulk bill vulnerable patients, and charge those who are able to pay, in order to maintain the viability of their services.

## Adequacy of Medicare support for mixed-team models of care

Many people with chronic and complex conditions such as stroke are likely to require at least two, or possibly three or four different health professions to provide care. Allied health professionals and nurses, including nurse practitioners, play a significant role in chronic disease and multimorbidity management through prevention, early intervention, maintaining people's wellness, preventing deterioration and reducing acute episodes requiring hospitalisation. Allied health professionals also optimise people's function and independence, and play a critical role in stroke rehabilitation and recovery.

Expanding the role of allied health professionals and nurses, and enabling them to work to their full scope of practice as part of a multidisciplinary primary care team, will enable GPs to focus their time on higher level diagnostic activity, intervention and care decision making, promoting an integrated care model and an improved patient experience. Importantly however, a number of significant barriers exist, including limited opportunities to utilise the Medicare Benefits Schedule (MBS) to access these health professionals and workforce shortages in rural, regional and remote areas.

In recent years, new items have been added to the MBS to enable allied health professionals and nurse practitioners to participate in multidisciplinary team-based case conferences for patients with chronic conditions, strengthening care coordination and team-based care. In addition, barriers preventing nurse practitioners from prescribing medicines under the Pharmaceutical Benefits Scheme (PBS), and working to their full scope of practice to provide services under the MBS independent of GPs, have been removed. Patients with chronic conditions, including survivors of stroke, are able to access care by allied health professionals through an MBS Chronic Condition Management Plan; however, the annual limit of five sessions in total is inadequate, and a review of the current Plan is needed, to determine if it is appropriate for, and meeting the needs of survivors of stroke and other patients with complex care needs.

In Australia, people living in rural, regional and remote areas have less access to health professionals compared with those in metropolitan areas.[15] This is due to both a shortage of many health professional occupations, as well as a maldistribution of the available workers. For example, the 2024 Occupation Shortages List showed national shortages in 13 allied health professions.[16] In addition, allied health professions generally reduce in prevalence per 100,000 population with geographic remoteness, with the lowest numbers seen in small rural towns or very remote areas.[16]

The Australian Government has invested in the Workforce Incentive Program (WIP) – Practice Stream, which provides financial incentives to help general practices across the country, including in rural, regional and remote areas, with the cost of engaging a range of health professionals, including allied health professionals. The WIP – Practice Stream, which is the Australian Government's main workforce initiative for the allied health sector, is focused on supporting multidisciplinary team-based models of care, and helping practices to meet the healthcare needs of patients with chronic and complex conditions; however, a recent review has shown that it is not working effectively and is largely supporting the employment of nurses,[16] highlighting the need for strengthening of this program.

## Summary

The Australian Government's new bulk-billing incentive scheme has achieved its intended purpose in the short-term, resulting in a significant increase in the number of bulk-billed GP services, with the largest increases observed in regional centres and towns. Ongoing evaluation will be needed to determine if these initiatives are able to deliver increased access, through more free GP services, without compromising the quality of these services or the financial viability of rural, regional and remote general practices.

If we are to reduce the growing inequities in Medicare, and more effectively manage patients with chronic and complex conditions, including through better support for multidisciplinary team-based care, it will be critical to address the limitations of the current fee-for-service primary care payment model.

Thank you for the opportunity to provide feedback as part of this inquiry.

Yours sincerely

**Dr Lisa Murphy**
**CEO**
**Stroke Foundation**

## References


1. Kim J et al. on behalf of the Stroke Foundation. 2024. Economic Impact of Stroke Report 2024. Melbourne, Australia.
2. O'Donnell MJ et al; INTERSTROKE investigators. 2016. Global and regional effects of potentially modifiable risk factors associated with acute stroke in 32 countries (INTERSTROKE): a case-control study. Lancet. 88:761-775.
3. Starfield B, Shi L, Macinko J. 2005. Contribution of primary care to health systems and health. Milbank Q. 83:457-502.
4. Deloitte Access Economics. 2017. Stroke in Australia – No postcode untouched.
5. Australian Institute of Health and Welfare. 2025. Heart, stroke and vascular disease: Australian facts, AIHW, Australian Government.
6. Australian Bureau of Statistics. 2025. Patient Experiences. ABS. Available at: https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release
7. Rural Doctors Association of Australia. May 3, 2024. Rural patients reap benefits of bulk billing changes [Media Release]. Available at: https://rdaa.com.au/Aus/Aus/News/2024-articles/Rural-patients-reap-benefits-of-bulk-billing-changes.aspx
8. Saxby K, Zhang Y. 2025. Bulk-billing rates and out-of-pocket costs for general practitioner services in Australia, 2022, by SA3 region: analysis of Medicare claims data. Med J Aust. 222: 144-148.
9. Glenister K et al. 2019. The mosaic of general practice bulk billing in regional Victoria. Aust J Gen Pract. 48: 77-78.
10. O'Sullivan BG, Kippen R, Hickson H, Wallace G. 2022. Mandatory bulk billing policies may have differential rural effects: an exploration of Australian data. Rural Remote Health. 22: 7138.
11. Australian Government Department of Health, Disability and Ageing. 2026. National GP Bulk Billing Snapshot – 1 November 2025 to 31 January 2026. Available at: https://www.health.gov.au/sites/default/files/2026-02/national-gp-bulk-billing-snapshot-1-november-2025-to-31-january-2026.pdf
12. Lim E. 2025. Policy Meets Practice: Financial Modelling of Bulk-Billing and Practice Incentives Reform in Australian General Practice. Open Journal of Applied Sciences. 15: 3131-3145.
13. Royal Australian College of General Practitioners. March 3, 2026. An Open Letter to Australia's Parliamentarians on Supporting People Living With Chronic Diseases. Available at: https://www.racgp.org.au/FSDEDEV/media/documents/Advocacy/An-open-letter-to-Australia-s-Parliamentarians-on-supporting-people-living-with-chronic-diseases.pdf
14. Australian College of Rural and Remote Medicine. November 3, 2025. ACRRM: Bulk billing incentives welcome – but require flexibility for rural communities [Media Release]. Available at: https://www.acrrm.org.au/about-us/news-events/news/2025/11/03/acrrm-bulk-billing-incentives-welcome-but-require-flexibility-for-rural-communities
15. National Rural Health Alliance. 2025. Rural Health in Australia Snapshot 2025. Available at: https://www.ruralhealth.org.au/wp-content/uploads/2025/02/NRHA-Rural-Health-in-Australia-Snapshot-2025.pdf
16. Allied Health Professionals Australia. 2024. AHPA Pre-Budget Submission 2025-26. Available at: https://static1.squarespace.com/static/678eeb3ee0b5bb3e0b85c165/t/67e222564815cf31afa7d986/1742873185694/AHPA_Pre-BudgetSubmission25–26.pdf