31 July 2026

Senator Ellie Whiteaker
Chair, Senate Community Affairs Legislative Committee
PO Box 6100
Parliament House
Canberra ACT 2600

By email: community.affairs.sen@aph.gov.au

Dear Senators

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

Thank you for the Committee's letter of 29 June 2026 inviting input from the Australian College of Rural and Remote Medicine (ACCRM) on the above Bill, we welcome the opportunity to provide this submission.

ACRRM's vision is for *'Healthy rural, remote and First Nations communities through excellence, social accountability, and innovation'*. Key to this is access to doctors, including Rural Generalists who are appropriately skilled and supported to provide comprehensive health services in rural and remote communities.

ACRRM has more than 7,000 members including doctors living and working in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members deliver expert frontline medical care in a diverse range of environments such as general practices, hospitals, Aboriginal Medical Services and other remote settings. ACRRM plays an important role in strong representation and advocacy for these dedicated professionals and the rural and remote communities they serve, and it is from this perspective that ACRRM provides the following perspectives.

ACRRM acknowledges the need for this Bill to provide a clear and consistent legislative basis for Commonwealth health incentive payment programs (including for bulk billing, general practice aged care, GP practice and workforce incentives) given they are currently administered without a dedicated legislative scheme tailored to their establishment, eligibility, participation, compliance and review arrangements.

ACRRM notes, as highlighted in the explanatory memorandum for this Bill, the Commonwealth's "long-standing use of incentive payments to support quality improvement, affordability, access, digital health uptake, rural and remote service delivery, Aboriginal and Torres Strait Islander health outcomes, after-hours care, health workforce distribution and education and training."

Incentive payments in the rural and remote context

ACRRM welcomes the intent of ongoing investments in the Medicare Benefits Schedule (MBS) and related incentive programs to improve availability, affordability an access to health care. It is also noted that many of these incentive payments are particularly intended to support practice in rural and remote areas. However, to achieve the policy objectives, the design of these incentive schemes must be appropriate and enable necessary flexibility to specifically recognise and address challenges in in rural and remote areas.

ACRRM raises these matters in particular noting that there are no proposed changes to the incentive programs or related payment amounts in the draft legislation, including to specifically target and support local, comprehensive rural and remote health care. This is despite evidence of a persisting underspend on government funded health care in rural and remote areas (see The Forgotten Health Spend report by the National Rural Health Alliance) alongside long-standing disparities in health care access and health outcomes compared to people in major cities.

Those living in rural and remote parts of Australia continue to experience significant difficulty accessing comprehensive health care due to a range of factors including a shortage of appropriately skilled professionals, particularly where there is an insufficient critical mass to sustainably support a range of necessary services and associated staff. This ultimately impacts health outcomes for people in these communities who consequently experience lower life expectancy and higher rates of chronic disease and hospitalisation.

The effectiveness of incentive schemes to address such challenges is dependent on their practical applicability and impact. The role of primary healthcare, and particularly general practice is both unique and critical in rural and remote communities where services can be limited, infrequent and significant distances away.

Incentive payments and the role of Rural Generalists

ACRRM also notes that there is no change to substantive eligibility criteria in the draft legislation, however current requirements can be difficult for Rural Generalists to meet.

Rural Generalists are General Practitioners with additional training in advanced procedural skills to deliver comprehensive primary care, hospital-based care, emergency medicine and population health in rural and remote communities. The extended and specialist services provided by Rural Generalists are critical in rural and remote communities where populations can be small and the health workforce limited.

Without large hospitals in many rural and remote locations, 24/7 access to health services is often provided by small general practices, with GPs or Rural Generalists responding to urgent presentations and stabilising patients. In cases where there are small hospitals, local GPs or Rural Generalists also often provide medical services for these facilities either on their own or on a rostered basis.

For many Rural Generalists whose practice typically spans general practice, emergency medicine, procedural medicine and hospital care, they are consequently providing comparatively less primary care. The requirement to complete 96 days of primary care in addition to procedural medicine, emergency

medicine, hospital work, on-call commitments and other roles such as aged care in reality requires doctors to work significantly more than 1.0 FTE to meet this eligibility criteria. Further, this can also create an unintended circumstance where a Rural Generalist may provide the very services these incentives are designed to support - aged care, emergency care and procedural medicine - yet remain ineligible because they cannot meet the minimum primary care threshold.

Eligibility requirements for incentive payments can particularly disadvantage Rural Generalists employed by hospitals, on sessional contracts or part-time (predominantly in emergency medicine) where many provide significant emergency and procedural services that are essential to rural communities, but do not contribute to eligibility criteria for incentive payments.

Health incentive payments and the MBS

ACRRM particularly notes the relationship of health incentive payments to the MBS, but that the activity-based nature of the MBS is decreasingly an appropriate or sustainable funding model in rural general practice. In many circumstances block or blended funding models are best suited to enable the comprehensive healthcare required in smaller rural and remote markets, rather than complete reliance on the MBS, bulk billing or other related incentive payments.

For example, Rural Generalists commonly address multiple issues in a single consultation while also integrating chronic disease management, preventative care and procedural care. However, current bulk billing and other incentive structures do not adequately account for the cost and time associated with maintaining such clinically complex and procedural services in rural settings.

The costs of delivering healthcare services have risen substantially, and the current global context is likely to see that worsen in the short term. Rural general practices often operate with materially higher fixed costs and the additional challenge of small local populations, limiting economies of scales. As such, it is the experience of ACRRM members that even with additional incentives, the MBS and the associated incentive structures are in many cases insufficient to cover operating costs for rural general practice. Further, it is noted that indexation has not been applied to these incentive programs over recent years, ultimately decreasing their dollar value to practices.

ACRRM members have also previously raised concerns regarding unintended consequences of policy settings encouraging increased MBS utilisation including universal bulk billing that may incentivise shorter consultations, limiting issues that can be addressed in each visit and creating the requirement for further follow ups. This would further reduce appointment availability, create additional burden for rural and remote patients and increase fragmentation of care leading to worsening health outcomes.

ACRRM welcomes efforts and the intent of changes to the MBS and incentive programs that seek to improve access to health care and contribute to avoiding emergency department presentations and hospital admissions through enhanced availability and affordability of primary healthcare services. This is particularly important in rural and remote areas where health outcomes are poorer and rates of hospital presentations are higher, including for reasons that are potentially preventable. However, such policy intent must also be embedded in funding structures beyond the MBS and recognising that improving health care service access and health outcomes for rural and remote Australians requires more than incentives.

We appreciate the opportunity to contribute to this important inquiry. If you have any queries relating to this feedback, please contact ACRRM at policy@acrrm.org.au .

Yours sincerely,

Dr Rod Martin

President