

Submission to the inquiry into Rural, regional and remote Medicare access and funding

Submitted by: Royal Australasian College of Surgeons (RACS)

On behalf of: RACS Rural Surgery Section Committee

To: Committee Secretary, Senate Standing Committees on Rural and Regional Affairs and Transport
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Dear Committee Members,

RE: RACS Submission to Rural and Regional Affairs and Transport References Committee inquiry into Rural, regional and remote Medicare access and funding

The Royal Australasian College of Surgeons (RACS) appreciates the opportunity to contribute to this inquiry into Rural, regional and remote Medicare access and funding.

RACS is the leading advocate for surgical standards, professionalism, education and training in Australia and Aotearoa New Zealand. We represent close to 8,600 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates (SIMGs). The College trains surgeons in nine main specialties: Cardiothoracic, General, Neurosurgery, Orthopaedic, Otolaryngology Head and Neck, Paediatric, Plastic and Reconstructive, Urology, and Vascular surgery.

The communities in rural, regional and remote areas have worse health outcomes than those in metropolitan communities including a 1.1- to 1.4-times higher mortality rate, 2.4-times higher potentially avoidable death rate and up to 13 years shorter life expectancy ¹. Rural, regional and remote people face persistent challenges in accessing services that are timely and affordable compared to metropolitan



areas. RACS recognised these inequities and acted by undertaking significant work on implementing its Rural Health Equity Strategic Action Plan.² It outlines RACS' social responsibility to work toward rural health equity by increasing the rural surgical workforce, reducing workforce maldistribution and building sustainable surgical services. This work underpins RACS' response to this inquiry.

1. Responses to Terms of Reference

When examining this inquiry's Terms of Reference (TOR), RACS will be addressing parts a, c, d, f and g of the TOR.

a) the impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians

RACS notes the changes made on 1 November 2025 MBS items in relation to telehealth MBS items for non-GP specialists (such as surgeons). This includes item numbers for initial consultation attendances via video (91822), and subsequent consultations via video (91823) and phone (91833).³ The limitation to have the initial consultation only by video can unintentionally disadvantage patients in very remote areas where the lack of internet connectivity and digital health literacy are likely barriers to positive uptake of telehealth by video.⁴ Recent Australian studies on the use and patient perceptions of telehealth have demonstrated that there is a positive link between patients' preference for telehealth and the distance travelled and the costs incurred to access services from their surgeon in-person.^{5,6} Telehealth via telephone has also been shown to be preferred modality among surgeons with telephone making up 80% of MBS item claims for telehealth.⁷

The deletion of 50% rural loadings on 1 January 2022 (MBS item 99) was justified on the proviso that new item numbers for telehealth would be added to the MBS.⁸ While this introduction benefits metropolitan patients, it unintentionally deprioritises patients in rural, regional and remote areas. The decision to delete item 99 effectively increases waiting times to access specialists, and defunds rural, regional and remote health. This is particularly important where more patients are waiting longer for outpatient services each year⁹ with RACS Fellows reporting a decline in public outpatient clinics in rural, regional and remote areas.

The MBS should seek to reimburse specialists with an outcome focus, rather than limiting how telehealth is used. Therefore, RACS would recommend the reinstatement of MBS items for initial specialist consultation via telephone (91832) and rural loading (99). Additional safeguards to prevent possible overservicing of telehealth via telephone delivered in metropolitan areas could be to introduce a geographical eligibility criteria restricting the use of the item number for specialist consultation by telephone to regional, rural and remote patients in Modified Monash (MM) classified areas 2-7.

RACS also notes the changes made on 1 November 2025 in relation to surgical assistance item numbers for Nurse Practitioners (e.g. non-medical practitioners).¹⁰ This includes items 93718 and 93719. The introduction of these new items is a positive step for rural patients and their surgeons who rely on non-medical surgical assistants to provide surgical assistance where there is a limited pool of medically trained surgical assistants, especially in the rural, regional and remote settings. In RACS' submission to the Medicare Benefits Schedule Review Advisory Committee (MRAC) - Surgical Assistant Working Group Draft Report, the College recommended that non-medical surgical assistants, with the appropriate training and experience, can be utilised in rural settings and would reduce the propensity for operating lists to be cancelled due to limited medically trained surgical assistants, allowing rural patients to have procedures closer to home.¹¹ Expanding MBS eligibility to non-medical surgical assistants, with the appropriate training and experience is important to equity for rural patients and rural surgeons' financial sustainability.

c) the extent to which current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas;

Better access to surgical care and better outcomes from surgical diseases is contingent on strong primary health services. It is widely acknowledged that the delivery of primary health services in rural, regional and remote areas is more expensive to deliver compared to urban centres. Part of the reason why rural, regional and remote people experience poorer health outcomes is that lack of access to affordable primary care services which translates to lesser access to preventative care, less opportunity for cancer screenings and GP consultations that would lead to referrals to a surgeon and other medical specialists. Consequently patients are more likely to develop preventable diseases or present with more advanced disease and attend emergency, all of which are known to lead to poorer outcomes from surgical care.^{12,13,14} Strong primary care services also enable specialists to share care of patients, enabling some aspects of surgical care to be delivered closer to home and virtually, with the primary care team collaborating with the distant surgical team or with outreach surgical teams. Strong, affordable models of primary care in rural, regional and remote areas are essential to achieve health outcomes from surgical conditions, diseases and procedures.

Specialist outpatient services act as a critical link between primary care and hospital care, ensuring patients receive care without requiring a formal, costly, and resource-intensive inpatient admission. Due to the maldistribution of specialists combined with the significant distance and travel time required to attend appointments it highlights the distinctly inequitable access to public outpatient services for rural, regional and remote patients. Typically, in an urban setting, patients have access to free public hospital specialist outpatient clinics. For patients in rural, regional and remote areas, many hospitals do not provide public outpatient clinics resulting in patients needing to travel long distances or attend private specialist practices. Private specialist practices in rural, regional and remote areas are more expensive to operate as there are fewer specialists and less opportunity for economies of scale, while also serving communities with higher socioeconomic disadvantage and less capacity to pay private fees. Higher MBS rebates for outpatient services delivered in rural, regional and remote settings would incentivise more non-GP specialists to these underserved communities.

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;

Primary care delivered in a rural, regional and remote setting is more complex than urban care. In the absence of a full complement of medical and surgical specialists, rural generalists and rural GPs take on more care in advanced practice areas, leading to more complex care. Often it is difficult for them to refer patients on, when specialist services are not available locally and travel to services can be time consuming and expensive for patients. Funding models that recognise the underspend on healthcare in rural areas, due to an undersupply of non-GP specialist services, are needed, that provide higher remuneration are needed to compensate rural primary care clinics for the additional, extended scope of complex work they do.

Reforms to support outreach specialist services as a core element of a sustainable Medicare system for rural Australia must include funding for travel, administrative support and collaborative models that allow visiting specialists to work effectively with local primary care providers. These visiting specialists are referred to as rural focused urban specialists (RUFUS) and play an integral role to support their rural, regional and remote colleagues, provide outreach, telehealth and culturally safe patient care when transfer to urban centres is necessary.¹⁵ RACS advocates for more funding that allow surgical Trainees to be involved in outreach service delivery. The Specialist Training Program (STP) presents an opportunity to expand surgical training to include outreach work exposure.

Medicare support for mixed team models of care is vital for interdisciplinary models of service delivery to be financially sustainable. Outlined below are some examples.

- The introduction of MBS items for surgical assistance by Nurse Practitioners, mentioned earlier, is a positive shift towards providing procedural services to patients close to home in rural, regional and remote areas, where there is a limited pool of medically trained surgical assistants.
- RACS notes that as of December 2025, the review of rural generalist access to MBS items is underway with the establishment of an MRAC working group.¹⁶ This is an important step to ensure patients seeking care from rural generalists and rural GPs are not financially disadvantaged.
- Furthermore, RACS notes the introduction of patient-end-support MBS items from 1 March 2026.¹⁷ This would allow patients to be supported by their local GP or Nurse Practitioner through a video conference with a specialist or consultant physician also working in private practice. Ensuring patient end support item numbers adequately reflect the cost of delivering the service would encourage expansion of collaborative models of telehealth (secondary telehealth), involving specialists at one end and rural generalists/rural GPs at the patient end. The inability to examine patients is a significant barrier to telehealth surgical consultations.
- Collaborative models enable the examination to be undertaken by the GP under the direction of the surgeon, reducing the need for patients to travel for examination, promoting skills transfer from surgeon to GP, streamlining communication and teamwork and strengthening professional networks between rural and urban teams.

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

Applying a rural lens to policy initiatives can ensure that decision making does not create unintended consequences for rural, regional and remote communities. The requirement for a rural stress testing must consider the complex clinical needs of the community, access to health services (physical facility and telehealth), workforce configuration, financial sustainability of practices and the impact on whole-of-system. Reforms to Medicare should focus on patient outcomes, place and service needed; and be flexible on process and healthcare worker providing the service.

Other jurisdictions such as the New Zealand Ministry of Health review new policies with a checklist guided by its rural lenses policy. It was developed by the Ministry for Primary Industry. The 'Rural Proofing Policy' was endorsed by NZ Cabinet and presented to the public on 13 June 2018 and aims to update policy creation guidelines.¹⁸ It stated that the effectiveness of rural proofing on policy would be assessed through a proposed report to cabinet by June 2021. The rural proofing policy required government to add a rural lens to the normal policymaking process, to consciously remove any urban bias and think through potential rural implications of policies.

Funding reform of Medicare should also consider rural loading based on remoteness. Higher MBS rebates should be allocated for those with the greatest distance to travel to a free public hospital specialist outpatient service. This could be tied to Modified Monash Model categories.

g) Any other related matters.

In the event patients are referred to specialists based in another location (often in a metropolitan setting), this can come at a significant cost to the patient and their families. Patient transport assistance schemes are inadequate. The percentage rebated is much less than 50% of travel and accommodation costs, the reimbursement model means families must incur an expense, then have the capacity to complete forms, have them signed by GP and specialist and submit to government, then wait for rebate, which may take months. The reimbursement model compounds access barriers for people with low incomes living in rural, regional and remote areas, in particular.

Reforms to increase travel assistance will provide meaningful relief for many rural, regional and remote patients and their families who face significant financial and logistical burdens when accessing essential healthcare. Improving travel assistance must sit alongside a broader strategy to strengthen specialist care in rural, regional and remote areas, allowing patients to access care closer to where they live.

2. Recommendations

RACS recommends:

- reinstating MBS items for initial specialist consultation via telephone (91832) and rural loading
- increasing the MBS rebates for specialist consultations and outpatient procedures for rural, regional and remote areas, with higher indexation graded according to increasing remoteness
- increasing funding for outreach work as a core element of Medicare, with funding for outreach training positions
- increasing MBS rebates for patient end assistance
- supporting the establishment of a rural lens to policy initiatives in order to mitigate any unintended consequences on health practitioners and patients in rural, regional and remote settings.

3. Closing remark

Thank you for the opportunity to contribute to this inquiry into Medicare access and funding in rural, regional and remote communities. We look forward to working with the Committee and other stakeholders to ensure rural, regional, remote communities have equitable access to surgical services and that any Medicare-related incentives are reflective of the integral role that surgical teams play in providing integrated rural, regional and remote care.

Yours sincerely,

Dr Bridget Clancy FRACS
Chair, Rural Surgery Section
Royal Australasian College of Surgeons

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