

Submission to the Senate Inquiry into Rural, Regional and Remote Medicare Access and Funding

**Lung Foundation Australia
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Level 4, 12 Cribb Street, Milton QLD 4064

PO Box 1949, Yuggera Country Milton QLD 4064

ABN: 36 051 131 901

1800 654 301

Lungfoundation.com.au

enquiries@lungfoundation.com.au

About Lung Foundation Australia

For more than 30 years, Lung Foundation Australia (LFA) has walked alongside people living with lung disease and lung cancer, helping them navigate some of life's hardest moments with care, knowledge and hope. We provide trusted support through our nurses, peer support programs and social workers. We fund research that leads to better treatments. We speak out for people who need lung health to be taken seriously. Everything we do helps protect the gift of breath, so that more Australians can breathe easier, live well and feel less alone.

Responses to the Terms of Reference

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

The 1 November 2025 Medicare changes were designed to improve access to bulk-billed general practice services for all Australians with a Medicare card. Two key reforms were introduced¹:

1. **Expansion of bulk-billing incentive payments** to all Medicare-eligible patients (previously limited to children under 16 and Commonwealth Concession Card Holders), thereby encouraging practices to bulk bill a wider range of general practice services.
2. **A new voluntary practice-level program** offering quarterly payments to clinics that commit to bulk billing all eligible services for Medicare-eligible patients.

Early data indicates these changes are achieving their intended effect. Bulk-billing rates have risen nationally, and the number of fully bulk-billing practices has increased^{2,3}. This upward trend is also visible in rural, regional, and remote communities, suggesting the reforms are improving affordability across geographic areas².

These gains are particularly important in the context of persistent cost-of-living pressures. People with chronic lung disease often face substantial out-of-pocket healthcare costs⁴ and have been negatively impacted by recent cost-of-living increases according to our 2024 Cost of Living Survey⁵. The expansion of bulk-billed services is a welcome reduction in the financial barriers to care for people living with a lung disease.

"Reducing out-of-pocket expenses for appointments, scans, medicines means they become more affordable and accessible; this allows us to actually go to appointments and take our medicine, which then enables us to have better control of our health conditions and reduces pressure on the health system overall."

– 2024 LFA Cost of Living Survey respondent from regional New South Wales

However, bulk billing alone cannot address the structural challenges that shape access to primary care in rural and remote communities. Workforce shortages and limited availability of services constrain the practical impact of these reforms. The changes also reinforce service delivery demands on general practitioners, which may not be the most efficient or effective model for managing rising rates of complex chronic disease⁶. This is particularly relevant in rural and remote communities, where

chronic disease burden is higher and mixed-team models of care may offer a more sustainable and accessible alternative.

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

Lung diseases are among the leading causes of potentially preventable hospitalisations (PPHs) in Australia. Chronic obstructive pulmonary disease (COPD) is the leading chronic condition contributing to PPHs⁷, while pneumonia and vaccine-preventable influenza account for a substantial share of vaccine-preventable PPHs⁷ and represent the third-highest expenditure category among all PPH conditions⁸. As a result, health system spending on these diseases is driven predominantly by public hospital admitted-patient care⁹.

Although these issues affect all Australians, the burden is disproportionately higher in rural and remote communities. In 2023–24, health system spending on COPD was approximately three times higher in very remote areas and around twice as high in remote areas compared with major cities (per 100,000 people)¹⁰. These differences were largely attributable to higher hospital expenditure and comparatively lower spending on primary health care in remote and very remote areas¹⁰. Similar patterns are observed for lower respiratory infections including influenza and pneumonia¹⁰.

Multiple layers of disadvantage contribute to these inequities. People living in rural and remote areas experience higher health needs, poorer access to services, and higher costs of care delivery¹¹. These challenges reflect complex structural, geographic, workforce, and socioeconomic factors that collectively limit the availability and uptake of effective primary and preventive care. Within this broader context, Medicare settings play a contributing role. This is not only because Medicare influences affordability, but also because it shapes who can deliver care, how services are funded, and whether rural models of prevention and chronic disease management are viable. It is also important to note that the split in funding responsibilities between the Commonwealth (for primary care) and state and territory governments (for hospital services) may contribute to fragmentation, limiting coordination and sustained action on avoidable hospital care.

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 is becoming increasingly complex due to rising rates of chronic disease, multimorbidity and an ageing population⁶. While general practitioners (GPs) are well-equipped to provide comprehensive care, the scale and complexity of need is making it increasingly challenging for them to do so alone⁶. Mixed-team models that draw on the expertise of other health professionals can improve access, support more proactive care, and ensure patients receive the right care from the right provider⁶.

These issues are particularly pertinent in rural, regional and remote communities, where disease burden is often higher. However, these same settings face unique barriers to implementing effective team-based care. Workforce shortages, service viability challenges and geographic isolation all play a role, and Medicare settings contribute to these challenges. The following examples from respiratory care illustrate how these issues play out in practice.

Vaccination delivery:

Vaccination is an important component of respiratory preventative care, reducing the impact of respiratory infections across the population and protecting at-risk populations including people with a lung disease. Under current Medicare settings, nurses are unable to administer National Immunisation Program vaccinations independently in general practice for a Medicare Benefits Schedule (MBS) rebate to be claimed; they must do so under GP supervision (i.e. the GP must be present on site), despite this being within their scope of practice and safe with appropriate training¹². In rural and remote communities where GP availability is limited and where there is a greater reliance on the nursing workforce¹¹, this situation is a barrier to vaccination.

"In my rural area doctor is only available for 2 half days per week. Getting an appointment when you need is not always possible."

– 2024 LFA Adult Vaccination Survey respondent from rural/remote Victoria

Changes to Medicare could better support general practice nurses to undertake vaccination tasks within their scope (see Term of Reference F), improving access to vaccination and reducing preventable hospitalisations (see Term of Reference C).

Spirometry:

Lung function testing conducted with spirometry is an essential component of evidence-based diagnosis and management of lung diseases¹³. Under current Medicare settings, GPs can independently bill for spirometry conducted in general practice or can refer patients for spirometry conducted in respiratory laboratories. In general practice, the high costs of equipment, infection control compliance, and low reimbursement rates make in-house testing difficult for many practices. In rural and remote communities, GP workforce shortages and limited availability of respiratory laboratories further limit access to spirometry.

While other adequately trained health professionals including pharmacists and nurses can be valuable team members in administering and supporting effective spirometry¹⁴⁻¹⁶, current MBS funding does not incentivise nurse or pharmacist-led testing. While a practice nurse may perform the test under a GP's supervision, the rebate is only payable to the GP. Pharmacists currently have no mechanism to bill the MBS for spirometry, even if they are fully trained.

Revised or alternative funding arrangements may be required to support sustainable access to effective spirometry in rural and remote communities. A single model is unlikely to be suitable across all settings; options should reflect local workforce, capacity and service models (see Term of Reference F).

Pulmonary rehabilitation:

Pulmonary rehabilitation (PR) is a twice-weekly, six- to eight-week structured program combining supervised exercise training and education to support people with chronic lung disease. Participation in PR improves symptom management, physical capacity, and quality of life and reduces the risk of hospital readmission following disease flare-ups¹⁷. It is the only evidence-based non-pharmacological intervention for COPD, strongly recommended in the Australian and New Zealand Guidelines for the Management of COPD¹⁸ and the new COPD Clinical Care Standard developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC)¹⁹.

Despite this, access to PR is limited across the country, with challenges particularly pronounced outside metropolitan centres. Hospital-funded programs in rural and remote communities are scarce or non-existent, and long travel distances make attendance impractical and costly for many patients.

The COPD Clinical Care Standard recommends expanding PR into primary care settings, delivered by physiotherapists or accredited exercise physiologists¹⁹. However, current Medicare settings do not support this model. Chronic disease management items restrict eligible conditions, limit which provider types can deliver funded group services, and cap the total number of sessions per patient per year. These structural limitations prevent PR from being delivered in primary care, even in communities where suitable allied health professionals are available.

Medicare reform is needed to enable safe, evidence-based PR delivery in rural and remote communities. Improving access to PR would reduce avoidable hospitalisations (see Term of Reference C) and support provision of guideline-recommended care in these areas.

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

People living in rural, regional and remote communities collectively experience poorer health outcomes and more limited access to care compared to people living in major cities¹¹. The cost of delivering services is also often higher in smaller and more geographically dispersed communities¹¹. Medicare reform can help to address some, but not all, of these structural inequities. In the context of respiratory care, the following reforms would make Medicare fairer, more workable and more responsive to the needs of people living outside metropolitan centres. The reforms respond directly to the barriers to mixed-team respiratory care described under Term of Reference D.

Vaccination delivery:

Lung Foundation Australia supports Medicare reform to allow appropriately trained general practice nurses to administer vaccinations without direct GP supervision. This would better reflect team-based care in general practice and improve efficiency, particularly in rural, regional and remote settings where workforce capacity is constrained and nurses often play a critical role in service delivery.

This recommendation has broad support. The Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP) have both called for reforms that would enable more efficient use of practice nurses in vaccine delivery within general practice^{12,20}. Lung Foundation Australia also notes that this reform was supported by a range of stakeholders through the National Immunisation Strategy implementation consultation process²¹, and that in our 2024 Adult Vaccination Survey, 85% of more than 3,000 respondents agreed that nurses should be able to give recommended vaccines in general practice without the patient needing an appointment with a doctor²². Enabling nurse-delivered vaccination within general practice would improve access, reduce missed opportunities for prevention, and make better use of limited GP time in rural communities.

Spirometry:

Medicare reform should support more flexible spirometry delivery models in rural, regional and remote communities, while maintaining appropriate quality and clinical governance. Depending on local workforce and infrastructure, options could include nurse-, pharmacist- or GP-led spirometry clinics with remote respiratory scientist or specialist oversight; outreach models; or community pharmacy pathways linked to general practice. Medicare reform must support both access and quality in rural, regional and remote settings, rather than assume metropolitan testing models will work in these areas.

Pulmonary rehabilitation:

Medicare reform should enable PR to be delivered more flexibly through primary care and community-based models, including where clinically appropriate via telehealth, home-based or hybrid approaches. The MBS Review Advisory Committee (MRAC) are currently reviewing MBS-referred chronic condition management services²³, providing an important opportunity to address these gaps.

Lung Foundation Australia has recommended reforms to expand the conditions eligible for group services, broaden the provider types eligible to deliver them, increase the number of funded services available, and allow delivery via telehealth where clinically appropriate. These changes would support PR access nationally but would be especially important in rural and remote communities where they would enable more flexible approaches for PR delivery based on local workforce, infrastructure, and needs. If MBS-referred chronic disease management services are not adapted in this way, alternative reforms may need to be considered to encourage PR participation outside of metropolitan centres.

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