Australasian College of Paramedicine

T 1300 730 450 E policy@paramedics.org
Level 3, 478 George Street, Sydney NSW 2000 Australia
ABN 39 636 832 061 | ACN 636 832 061

Submission: Parliamentary inquiry into rural, regional and remote Medicare access and funding

About the College

The Australasian College of Paramedicine (the College) is the peak professional body representing and supporting paramedics across Australasia. We champion the role of paramedics in emergency, urgent and primary care, driving a connected, multidisciplinary approach to high-quality healthcare in all communities.

The College is future-focused and committed to enhancing person-centred care through sustainable, evidence-based approaches and holistic workforce initiatives that see paramedics valued and utilised across the healthcare system for their unique capabilities.

With our reach across Australasian jurisdictions, practice contexts and employment relationships, the College is uniquely positioned to lead and advocate for the role of paramedics across the broader healthcare system to ensure they work to their full scope of practice.

Introduction

Thank you for the opportunity to provide feedback on the *parliamentary inquiry into rural, regional and remote Medicare access and funding*. We welcome the Government's commitment to improving health equity and outcomes for people living in rural, regional and remote Australia.

This submission considers the impact of the 1 November 2025 changes to Medicare access and funding in rural, regional and remote contexts and outlines key recommendations from the perspective of the paramedicine profession.

Recommendations

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

While the 1 November 2025 changes may improve the financial sustainability of some practices and reduce out-of-pocket costs for patients, they do not address the underlying workforce constraints that limit appointment availability in many communities.[1] This reflects the broader and more complex challenges facing rural, regional and remote health service provision.

National health policy frameworks consistently call for multidisciplinary, team-based models that fully utilise Australia's diverse health workforce, including allied health professionals - such as paramedics, to deliver primary healthcare to rural, regional and remote Australian.[1-8] Paramedics work seamlessly within multidisciplinary teams, and are highly trained health professionals with advanced clinical knowledge, complex decision-making capability and expert judgement, with strong reach into communities.[5-7]

Despite this, they remain excluded from the Medicare Benefits Schedule (MBS), restricting their integration into primary and urgent care models. As a result, opportunities to reduce pressure on general practice, improve access, and deliver timely, person-centred care in underserved communities continue to be missed. In the absence of Medicare reform recognising paramedic-delivered care, these access challenges will persist despite broader funding changes.

There is also a significant opportunity to better integrate paramedics into telehealth-enabled models of care. Investment in paramedicine within digital health models would support innovation, improve data quality and health record integration, and enable the safe adoption of emerging technologies, including AI-supported care. Realising this potential requires the paramedicine profession to be embedded in digital health design from the outset, rather than incorporated retrospectively.

b. the financial sustainability of independently owned rural general practices under current Medicare funding and incentive structures

Independently owned rural general practices face significant and growing financial pressure due to rising operational costs and persistent workforce recruitment and retention challenges.[9] These pressures are compounded by current Medicare settings, which do not effectively support multidisciplinary, team-based care and constrain opportunities for safe and appropriate task-sharing across the health workforce.[1] As a result, rural practices are limited in their ability to adopt more efficient and sustainable models of care, despite national policy frameworks consistently calling for approaches that fully utilise Australia's health workforce.[1-8]

As a result, the paramedicine workforce remains underutilised due to outdated funding structures and misaligned legislation. Without recognition of paramedic-delivered care under the MBS, rural general practices cannot fully leverage available workforce capacity. This constrains their ability to manage demand, operate efficiently, and maintain financial sustainability, contributing to ongoing risks to practice viability and flow-on impacts for access, continuity, and quality of care in rural, regional and remote communities.

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

Current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas by failing to adequately fund multidisciplinary care pathways, and by incentivising episodic, rather than coordinated, care. This reduces the availability of appropriate care in the community and reinforces reliance on hospital services.

Paramedics already respond to a significant proportion of cases that could be safely managed outside of hospital settings if appropriate funding and referral pathways were in place. Evidence and service experience demonstrate that paramedic-supported models can reduce unnecessary emergency department conveyance, provide treatment-in-place or referral to appropriate services, and improve patient experience and system efficiency.[5-7]

However, the exclusion of paramedics from the MBS limits their ability to deliver funded alternatives to hospital transport and practice to their full scope. This reinforces default pathways to emergency departments, even where care could be safely delivered in the community, contributing to ongoing system inefficiencies and avoidable hospital demand.

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

Despite rising demand for health services and clear national policy direction, current Medicare settings do not adequately support multidisciplinary, team-based models of care in rural, regional and remote communities.[1] Improving access to primary care and addressing workforce maldistribution remain national priorities; however, even with the 1 November 2025 changes, Medicare funding arrangements have not kept pace with the models of care required to meet these needs.

While paramedicine was formally recognised as a registered profession under Ahpra in 2018 through the establishment of the Paramedicine Board of Australia (ParaBA),[10] legislation and funding arrangements have not kept pace with the profession's evolution. This limits practice beyond jurisdictional ambulance services and constrains paramedics' contribution to integrated, team-based care.

For more than a decade, models in the United Kingdom have demonstrated that paramedics can safely and effectively expand access, enhance continuity, and strengthen system responsiveness as part of multidisciplinary teams.[11] In Australia, this direction is emerging through the Health Ministers' 19 April 2024 request for the Paramedicine Board of Australia to explore endorsement pathways for Advanced Practice Paramedics,[12] and the 13 August 2025 Medicare Urgent Care Clinic Operational Guidance, which includes paramedics alongside doctors and nurses.[13]

However, Medicare does not currently recognise or fund paramedic-delivered care within multidisciplinary teams. As a result, the paramedicine workforce remains underutilised, limiting the effectiveness of mixed-team models and constraining access to coordinated, person-centred care in rural, regional and remote communities.

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

Current Medicare funding and incentive structures may disproportionately advantage larger corporate providers, which are better positioned to absorb financial pressures, operate at scale, and navigate complex funding arrangements.[14] In contrast, small, community-embedded rural clinics often operate with limited workforce capacity and narrow financial margins, and rely on flexible, locally tailored models of care to meet community needs.[9]

Paramedics are frequently embedded within, or closely connected to, these communities and can support outreach and in-home care, provide after-hours and urgent care coverage, and facilitate integration with local health and social services. These roles are particularly valuable in rural, regional and remote settings, where service gaps and workforce shortages are most pronounced.

The absence of MBS funding for paramedic-delivered care limits the ability of smaller, community-based services to adopt innovative, team-based and community-responsive models. This further entrenches structural inequities between large corporate providers and locally embedded clinics, with direct implications for access, continuity, and the long-term sustainability of care in rural and remote communities.

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

To ensure Medicare is equitable, workable, and sustainable in rural, regional and remote contexts, targeted reform is required to better align funding with contemporary models of care, workforce capability, and community need. The College recommends the following reforms:

1. Recognise and fund paramedics under the MBS

Introduce targeted MBS items to enable appropriately trained paramedics to deliver and bill for primary and urgent care within their scope of practice. This would improve access to timely care, reduce pressure on general practice and emergency departments, and support more efficient use of the health workforce.

2. Enable multidisciplinary, team-based funding models

Reform Medicare funding and incentive structures to better support integrated, team-based care, including paramedics, general practitioners, nurses, nurse practitioners, and allied health professionals. This should include flexible and blended funding approaches that support shared care, task-sharing, and continuity across providers.

3. Fund alternatives to hospital-based care pathways

Introduce funding mechanisms that support treatment-in-place, referral, and community-based care models, including those delivered by paramedics. This would reduce avoidable emergency department presentations and preventable hospital admissions, particularly in rural, regional and remote communities.

4. Strengthen telehealth and digitally enabled models of care

Expand Medicare settings to support paramedics and other clinicians to participate in telehealth-enabled care, including facilitating virtual consultations, in-home assessment, and remote monitoring. Investment should also support interoperability, data quality, and safe adoption of emerging technologies, including AI-supported care.

5. Introduce rural loading and flexible funding mechanisms

Ensure Medicare funding reflects the higher costs and operational realities of delivering care in rural and remote areas. This includes strengthening rural loadings, enabling flexible service models, and avoiding one-size-fits-all funding approaches that disadvantage thin or failing markets.

6. Align Medicare reform with broader workforce and regulatory reform

Ensure Medicare changes are coordinated with national reforms relating to scope of practice, prescribing, digital health, and workforce planning. This includes supporting the development of advanced practice paramedicine roles and enabling full utilisation of the health workforce.

Conclusion

Current Medicare settings do not fully reflect the realities of healthcare delivery in rural, regional and remote Australia. While the 1 November 2025 changes are a positive step, they have not addressed the structural challenges affecting access to care, the sustainability of rural general practice, and ongoing system inefficiencies.

A consistent gap across these issues is the underutilisation of paramedics within funded models of care. As highly trained, regulated health professionals with strong reach into rural, regional and

remote communities, paramedics are well placed to improve access, support general practice, and deliver safe, effective care in community settings. However, their continued exclusion from the MBS limits the effectiveness of multidisciplinary care and constrains the system's ability to respond to local need.

Targeted reform is required to ensure Medicare is fair, flexible, and sustainable in rural, regional and remote contexts. This includes recognising and funding paramedic-delivered care, enabling integrated, team-based models, supporting alternatives to hospital-based care, and embedding rural considerations into future policy design.

With these changes, Medicare can better align with contemporary models of care, strengthen the sustainability of health services, and support more equitable, person-centred outcomes for rural, regional and remote Australians.

References

1. Australian Government Department of Health, Disability and Ageing. Strengthening Medicare Taskforce Report. Dec 2022. Available from: https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en, accessed Mar 2026.
2. Australian Government Department of Health, Disability and Ageing. Mar 2022. Australia's Primary Health Care 10-Year Plan 2022-2032. Available from: https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en, accessed Mar 2026.
3. Australian Government Department of Health, Disability and Ageing. National Medical Workforce Strategy 2021-2031. Jun 2024. Available from: https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031?language=en, accessed Mar 2026.
4. P. Breadon, D. Romanes. A New Medicare: Strengthening General Practice. Dec 2022. Available from: https://grattan.edu.au/report/a-new-medicare-strengthening-general-practice/, accessed Mar 2026.
5. National Rural Health Alliance. Primary Care Rural Integrated Multidisciplinary Health Services (PRIM-HS). Jan 2023. Available from: https://www.ruralhealth.org.au/primary-care-rural-integrated-multidisciplinary-health-services/, accessed Nov 2025.
6. Australian Government Department of Health, Disability and Ageing. M. Cormack. Unleashing the Potential of our Health Workforce: Scope of Pratice Review. Nov 2024. Available from: https://www.health.gov.au/our-work/scope-of-practice-review, accessed Mar 2026.
7. Australian Government Department of Health, Disability and Ageing. Ngayabah Gadan Consensus Statement: Rural and Remote Multidisciplinary Health Teams. Oct 2023. Available from: https://www.health.gov.au/resources/publications/the-ngayubah-gadan-consensus-statement-rural-and-remote-multidisciplinary-health-teams?language=en, accessed Mar 2026.
8. Australian Government Department of Health, Disability and Ageing. National Preventive Health Strategy. Dec 2021. Available from: https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030?language=en#:~:text=The%20strategy%20aims%20to%20improve,the%20overall%20burden%20of%20disease, accessed Mar 2026.
9. O'Sullivan BG, Kippen R, Hickson H, Wallace G. Mandatory bulk billing policies may have differential rural effects: an exploration of Australian data. Rural and Remote Health 2022; 22: 7138. https://doi.org/10.22605/RRH7138
10. Paramedicine Board, Ahpra. Registration. Updated Mar 2023. Available from: https://www.paramedicineboard.gov.au/Registration.aspx, accessed Mar 2026.
11. Wagstaff B, Mistry V. The integration of paramedics into primary care. Br J Gen Pract. 2020 Feb 27;70(692):123. http://doi.org/10.3399/bjgp20X708545

12. Health Ministers Meeting (HMM). Communique 19 April 2024 – Brisbane. Apr 2024. Available from: https://www.health.gov.au/sites/default/files/2024-04/health-ministers-meeting-hmm-communique-19-april-2024.pdf, accessed Mar 2026.
13. Australian Government Department of Health, Disability and Ageing. Medicare UCC Operational Guidance. Dec 2025. Available from: https://www.health.gov.au/resources/publications/medicare-ucc-operational-guidance?language=en, accessed Mar 2026.
14. The Medical Journal of Australia. C. Swannell. General practice size and ownership models: impact on patient outcomes. May 2021. Available from: https://www.mja.com.au/journal/2021/general-practice-size-and-ownership-models-impact-patient-outcomes, accessed Mar 2026.