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Second-class citizens — The rural health divide

A submission to the Senate Rural and Regional Affairs and Transport Committee's Inquiry into rural, regional and remote Medicare access and funding.

Australians living in non-urban areas are dying younger, often from preventable diseases. These deaths could be avoided if these communities had access to timely and affordable healthcare. With access to care, including primary, specialist, and allied health services, diseases can be diagnosed, managed, and even prevented.

Hamdi Jama
Jack Thrower
Morgan Harrington

April 2026

The Australia Institute – Research that matters

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Summary

Medicare is not designed for non-urban Australians, and it continues to fail people living in rural and remote communities. These areas are experiencing shortages of medical professionals, including general practitioners and specialists. Partly due to these shortages, people in these communities attend medical appointments less regularly than city-dwellers, meaning less Medicare benefits subsidies flow to these areas, despite their generally older and sicker populations. Together, these factors mean that Australians living in non-urban areas experience worse health outcomes and lower life expectancies. Despite rural and remote areas having barely any private hospitals and fewer specialists, non-urban residents are pushed to buy private health insurance they cannot use and subsidise the insurance of urban dwellers. This system is inequitable, bad for human health, inefficient and costly. Instead of spending on preventing or avoiding illness and disease, significant resources are spent on treating these illnesses. Fixing this system will involve considerable change, either by amending the Medicare system to better recognise how it fails rural and remote residents, or by recognising these issues as a fundamental market failure and providing primary health services directly through government-run clinics and programs.

In summary, we make the following four recommendations:

- **Recommendation 1:** Apply a remoteness loading across all Medicare items and ensure they are specifically weighted to benefit individuals and healthcare providers residing in non-urban areas.
- **Recommendation 2:** Implement funding models that combine traditional Medicare billing with guaranteed base salaries and additional funding for multidisciplinary teams practising in non-urban areas.
- **Recommendation 3:** Directly provide primary health services in rural and remote communities. This could be directly controlled by the Commonwealth Government or via Commonwealth support for State and Territory Governments.
- **Recommendation 4:** Residents of rural and remote Australia should be exempt from private health insurance surcharges and forced coverage in areas where private hospital services are not reasonably accessible.

These recommendations address some of the key areas influencing healthcare accessibility and affordability for people living in these communities, which will reduce the burden of death and disease and go a long way to reducing health inequality among Australians.

This submission to the Senate Rural and Regional Affairs and Transport Committee's Inquiry into rural, regional, and remote Medicare access and funding specifically relates to these terms of reference:

• reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians;

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

• other related matters.

Introduction

The Australia Institute welcomes the opportunity to make this submission to the Senate Rural and Regional Affairs and Transport Committee's Inquiry into rural, regional and remote Medicare access and funding.

Australians living in rural and remote communities have a higher burden of disease and disease-related disability, and a lower life expectancy than their urban counterparts.[1] While this is partly driven by social and economic determinants such as lower income, education, and access to housing and healthy food, it is also the result of inadequate healthcare.

Regardless of where they live, Australians pay into the Medicare system through their tax dollars and the Medicare levy.[2] Medicare promises universal access to healthcare services, but it is failing those living outside cities (non-urban areas), contributing to a gap in health outcomes for some seven million Australians. The harsh reality for these Australians is that they travel long distances and pay high out-of-pocket costs only to navigate a healthcare system that is understaffed and underfunded.

The Australian Bureau of Statistics (ABS) categorises locations based on their distance from essential services. It segments Australia into five groups: major cities, inner regional, outer regional, remote, and very remote.[3] The Modified Monash Model classifies remoteness into seven levels (from metropolitan to very remote community), considering remoteness and population size.[4] Both remoteness classifications are used by the Australian government to understand the geographic distribution of services such as healthcare. In this report, we use the term 'non-urban' to refer to any area outside metropolitan and regional centres unless otherwise specified.

Geographic distance from a healthcare centre can be a matter of life and death. In very remote areas, which are furthest from the kinds of care most Australians take for granted, premature death (death before the age of 75) makes up sixty per cent of all deaths —

[1] Australian Institute of Health and Welfare (2025) *Rural and remote health*, https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health; McBride (2023) The Unlucky Country: Life expectancy and health in regional and remote Australia. Part 1: NSW, https://australiainstitute.org.au/report/the-unlucky-country-2/

[2] Glover, L., & Woods, M. (2020) *Australia: International health care system profile*, https://www.commonwealthfund.org/international-health-policy-center/countries/australia

[3] Australian Bureau of Statistics (2023) *Australian Statistical Geography Standard (ASGS) Edition 3: Remoteness Areas*, https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure/remoteness-areas

[4] Australian Government Department of Health, Disability and Ageing (2025) *Modified Monash Model*, https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

double the rate of those in major cities.[5] Australians in remote and very remote communities are twice as likely as the national average to die from heart disease.[6] Many of these deaths could be avoided through early intervention. For example, heart disease is a disease of lifestyle, meaning better awareness of risk factors and early detection through primary healthcare (like GPs) could improve outcomes for Australians in non-urban areas.

The disparity in health outcomes is further highlighted by life expectancy figures. In rural communities, people die younger, with some communities experiencing up to eight and a half years lower life expectancy. In New South Wales, on average, a rural resident can expect to die five years earlier than someone in metropolitan Sydney.[7] These five years represent individual tragedies but also have an impact on Australia as a whole, contributing to the loss of human potential and family stability. These realities expose the failure of the Commonwealth and State and Territory governments to protect their most isolated and vulnerable citizens.

Lack of access to essential healthcare services plays an important role in this inequity. For some Australians living in remote areas, the sheer distance that has to be travelled to see a health professional is a barrier that discourages early intervention for preventable conditions[8] and the treatment of acute injuries.[9] This is partly exacerbated by poor transport infrastructure[10], which can mean that a simple doctor's appointment requires an overnight stay away from home and significant time away from work or family. This is an insurmountable barrier for some Australians living in non-urban communities.

But the obstacles are not just geographic; they are also socioeconomic. Non-urban communities are poorer than city-dwelling communities. Despite this, the distribution of Medicare benefits is skewed towards richer, more urban areas. This means that, despite contributing to Medicare through taxes in the same way as everyone else, millions of Australians in non-urban areas are effectively treated as second-class citizens.

[5] Australian Institute of Health and Welfare (2025) *Deaths in Australia: Remoteness area*, https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/variations-between-population-groups/remoteness-area

[6] National Rural Health Alliance. (2026). *Cardiovascular disease in rural Australia: Factsheet,* https://www.ruralhealth.org.au/publications/factsheets/

[7] McBride (2023) *The Unlucky Country: Life expectancy and health in regional and remote Australia*

[8] Mseke, Jessup, & Barnett (2024) 'Impact of distance and/or travel time on healthcare service access in rural and remote areas: A scoping review', *Journal of Transport & Health*. https://doi.org/10.1016/j.jth.2024.101819

[9] Taylor, Peden, & Franklin (2022) 'Disadvantaged by More Than Distance: A Systematic Literature Review of Injury in Rural Australia' *Safety*, https://doi.org/10.3390/safety8030066

[10] Maganty, et al. (2023) 'Barriers to rural health care from the provider perspective' *Rural and Remote Health*, https://doi.org/10.22605/RRH7769

The problem extends beyond Medicare. In 2003, The Australia Institute reported significant disparities in healthcare access for rural Australians,[11] showing that access to private hospitals is highly restricted in non-urban areas and practically non-existent in remote and very remote regions. Yet residents of these areas face the same pressures to take up private health cover, and the same financial penalties for failing to do so, compounding both the health *and* financial inequity they face.

[11] Denniss, R. (2003) *Health spending in the bush: An analysis of the geographic distribution of the private health insurance rebate*, https://australiainstitute.org.au/report/health-spending-in-the-bush-an-analysis-of-the-geographic-distribution-of-the-private-health-insurance-rebate/

Australia has a shortage of rural health workers

Primary healthcare service workers — for example, GPs, nurses, pharmacists, allied health, and mental health professionals — are the first point of contact when people get sick. They manage, diagnose and treat illness, but they also communicate important health messaging. For example, they communicate the link between behavioural risk factors (like sun exposure, poor diet and smoking) and chronic diseases. Therefore, primary healthcare providers are fundamental to a healthy community.

However, several systemic hurdles make it difficult for healthcare workers to operate in rural and remote communities. These include health behaviours, low health literacy, transport barriers and geographic isolation. These barriers make healthcare more costly to provide and compound primary health workers' inability to provide adequate and timely care in non-urban areas.

Under Medicare, healthcare providers are paid a set rate per service, known as "fee-for-service".[12] The fee-for-service model emphasises volume over value or quality of care. This model is incompatible with rural and remote areas because running a viable business requires serving a high volume of patients. For many primary health providers, this serves as a deterrent to practice in non-urban areas.

These factors contribute to a shortage of workers in non-urban areas, and some rural towns with small populations lack even a single doctor.[13] This shortage contributes to poor access to primary care services; without these services, diagnosis, treatment and long-term management of health conditions are delayed or missed.

SHORTAGE OF RURAL GPS

Non-urban areas require more doctors per person than urban areas. This is because their populations are older and have higher rates of behavioural risk factors such as alcohol consumption, smoking, poor diet and physical activity, which lead to higher rates of

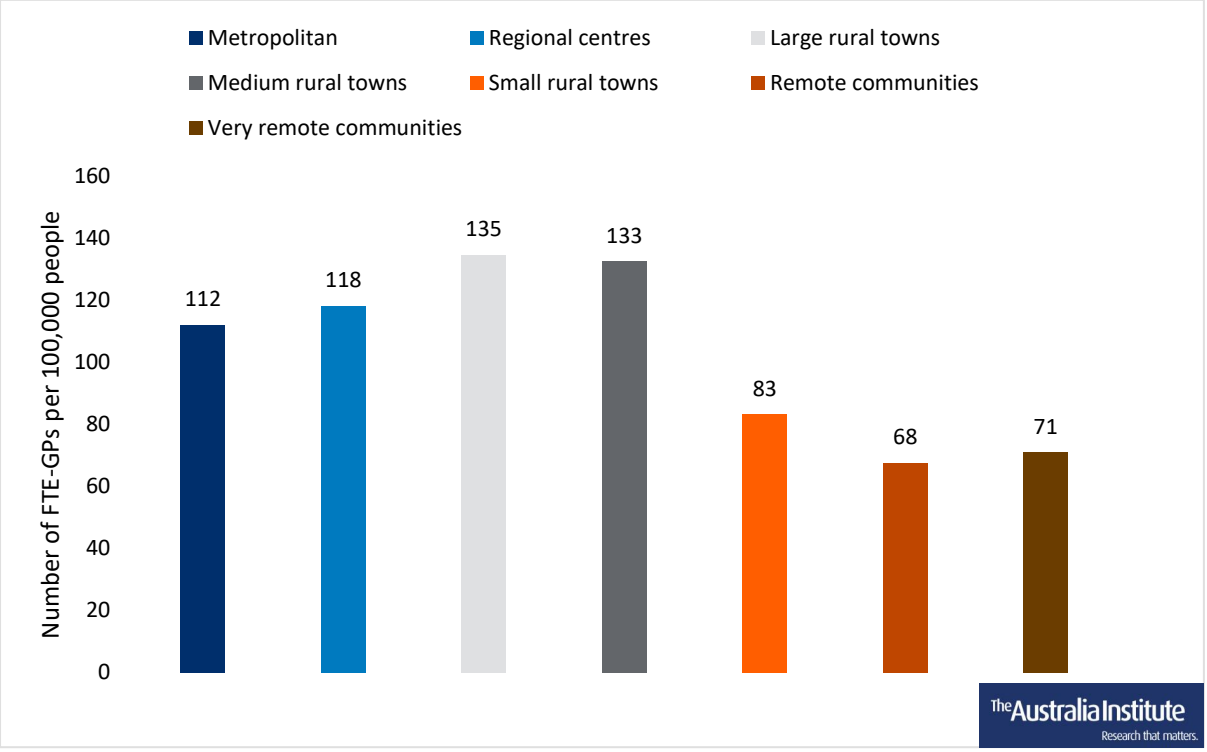
[12] McGuire & Newhouse (2018) 'Medicare Advantage: Regulated Competition in the Shadow of a Public Option', *Risk Adjustment, Risk Sharing and Premium Regulation in Health Insurance Markets: Theory and Practice*, https://doi.org/10.1016/B978-0-12-811325-7.00019-1

[13] Brennan & Sanders (2025) 'Towns with no doctors say election health proposals a "bandaid" approach', ABC News, https://www.abc.net.au/news/gp-shortage-rural-communities-queensland-federal-election-2025/105205838

preventable illnesses.[14] As mentioned above, providing healthcare in these communities is more difficult, due to reasons including poorer infrastructure and lower population density.[15]

Despite this greater need, rural and remote communities often have fewer GPs than urban areas. In 2025, small rural towns had 26% fewer GPs per person than metropolitan areas; meanwhile, remote communities had 37% fewer (**Figure 1**).

Figure 1: Primary care GPs per 100,000 people, by remoteness, 2025



Sources: Data from the Australian Government Department of Health, Disability and Ageing: Primary Care GP statistics, GP full-time equivalent (FTE) per 100,000 population. https://hwd.health.gov.au/resources/data/gp-primarycare.html

This shortage contributes to delayed access to medical care and, in part, may explain why people in rural and remote communities are less likely to see a GP than those living in major cities.[16]

The situation is worse still in remote Indigenous communities, where more than half of surveyed residents did not seek medical help when needed. One reason for this lack of

[14] National Rural Health Alliance. (2025). *Health risk factors in rural Australia* (Fact sheet). https://www.ruralhealth.org.au

[15] Australian Institute of Health and Welfare (2025). Rural and remote health.

[16] Australian Institute of Health and Welfare (2025). Rural and remote health.

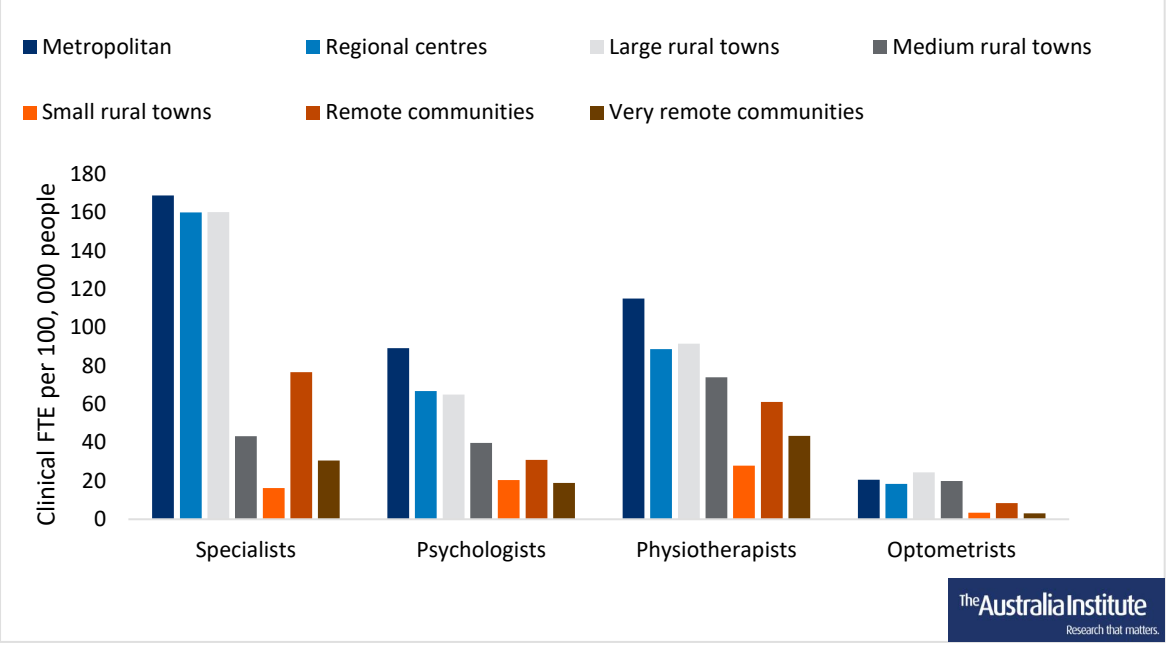
pursuit is that services are too far away or simply unavailable.[17] This creates barriers even to access medication needed to treat or manage disease.

The shortage of GPs in non-urban areas results in higher numbers of emergency presentations, and chronic or preventable conditions in remote residents often going unmanaged. Dealing with health problems this way is more expensive than treating them through a GP, especially if they are addressed before they become acute.[18]

SHORTAGE OF SPECIALISTS AND RURAL GENERALISTS

Remote and very remote areas also have disproportionately fewer specialist medical practitioners (**Figure 2**). This means that if remote residents need specialist care — for example, a heart specialist, oncologist, psychologist or physiotherapist — they need to travel to a regional hub or major city. This leads to a lack of early intervention; without local specialists or diagnostic tools like MRI and pathology labs, chronic diseases and cancers are often diagnosed at much later, less treatable stages.

Figure 2: Number of medical specialists per 100,000 people, by remoteness, 2023



Sources: Data from the Australian Institute of Health and Welfare, Rural and remote health. Table S8: clinical full-time equivalent rate (FTE) per 100, 000 people. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

[17] Australian Institute of Health and Welfare (2023) Access to services compared with need https://www.indigenoushpf.gov.au/measures/3-14-access-to-services-compared-with-need

[18] National Rural Health Alliance (2025) The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia, https://www.ruralhealth.org.au/the-forgotten-health-spend-report/

Rural Generalist (RGs) is a specialist field within general practice with specific expertise in providing medical care to rural and remote communities. RGs are essential to the stability of healthcare in non-urban regions, as they possess the specialised skills necessary to provide both primary care and specialist care in a single role. As shown in **Figure 2**, fewer medical specialists, psychologists, podiatrists and optometrists practice in non-urban communities. In the case of specialists, there are 10 times as many specialists in major cities as in small rural towns. In these communities, RGs could fill the vacuum left by the lack of specialist services. However, current Medicare funding models often do not suit this wide range of practice, which could explain why the Australian government took so long to recognise it as a specialty. In 2025, the Commonwealth government formally approved the National Rural Generalist Pathway.[19] But recognition alone is insufficient to incentivise and support doctors to train as RGs and practice in non-urban communities.

RECENT DEVELOPMENTS

Over the past few years, the Australian government, as part of its agenda to strengthen Medicare, has implemented several measures to address workforce shortages in rural and remote areas. These include:

- The 2024 Scope of Practice Review, which was an independent review of barriers that prevent health professionals, particularly those in rural and remote areas, from working to their full level of training and expertise.[20] One outcome of the Review is legislation that now allows endorsed registered nurses and nurse practitioners to prescribe certain medications, reducing the bottleneck caused by GP shortages.
- The 2022 Rural Bulk Billing incentive, which gave direct payments to doctors and practices to encourage long-term commitment to rural communities.[21]
- The 2020 Workforce Incentive Program, that provided additional payment for doctors working in regional, rural and remote communities.[22]

[19] Australian Government Department of Health, Disability and Ageing (Oct 2025) National Rural Generalist Pathway, https://www.health.gov.au/our-work/national-rural-generalist-pathway

[20] Australian Government Department of Health and Aged Care. (2024). Unleashing the potential of our health workforce: Scope of practice review – Final report. https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report

[21] Department of Health and Aged Care. (2021). Rural bulk billing incentive changes. Australian Government. https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-RBBI-Change

[22] Australian Government Department of Health, Disability and Ageing (2025) Workforce Incentive Program – Rural Advanced Skills Stream, https://www.health.gov.au/our-work/workforce-incentive-program/workforce-incentive-program-rural-advanced-skills-stream

While these changes may help, they will not overcome the fundamental problem, the complexities of operating health services in rural and remote areas, and the inappropriateness of the Medicare fee-for-service model in these contexts.

Rural areas have more need but get less health care

Despite having higher risk populations, more complex needs and higher costs of delivering healthcare, rural and remote areas do not receive more Medicare funding; often, they receive less.

Most Medicare spending broadly falls within funding for the Medicare Benefits Schedule (MBS), which covers health services, and the Pharmaceutical Benefits Schedule (PBS), which covers prescription medications. Under the MBS, funding generally flows in two ways. If the doctor (or relevant service) "bulk bills", the service is provided for free to the eligible Australian patient and the service receives payment from Medicare.[23] Under private billing, the total fee is paid by the person seeking the service, and (in some circumstances) the patient receives a rebate from Medicare to cover part of the cost. In cases of bulk billing or private billing with Medicare rebate, Medicare benefits are incurred.

The analysis below shows that non-urban areas receive less MBS benefits than urban areas, even accounting for population. This lower number of claims may create the false impression that demand for Medicare-subsidised services is lower in non-urban Australia. In reality, the lower rates of MBS benefit are likely driven by the difficulty of accessing healthcare in more remote areas. In fact, these areas actually have higher-risk populations than urban areas. As stated above, there is simply a shortage of healthcare workers in more remote areas.

Even when healthcare services are available, it is often more expensive. A 2025 study found that despite similar levels of coverage for subsidised services, out-of-pocket costs for non-bulk-billed GP services were higher in remote areas.[24]

RURAL AUSTRALIANS RECEIVE FEWER MEDICARE BENEFITS

The Australian Institute of Health and Welfare (AIHW) collects monthly data on the distribution of MBS funding across local government areas. By combining this data with the

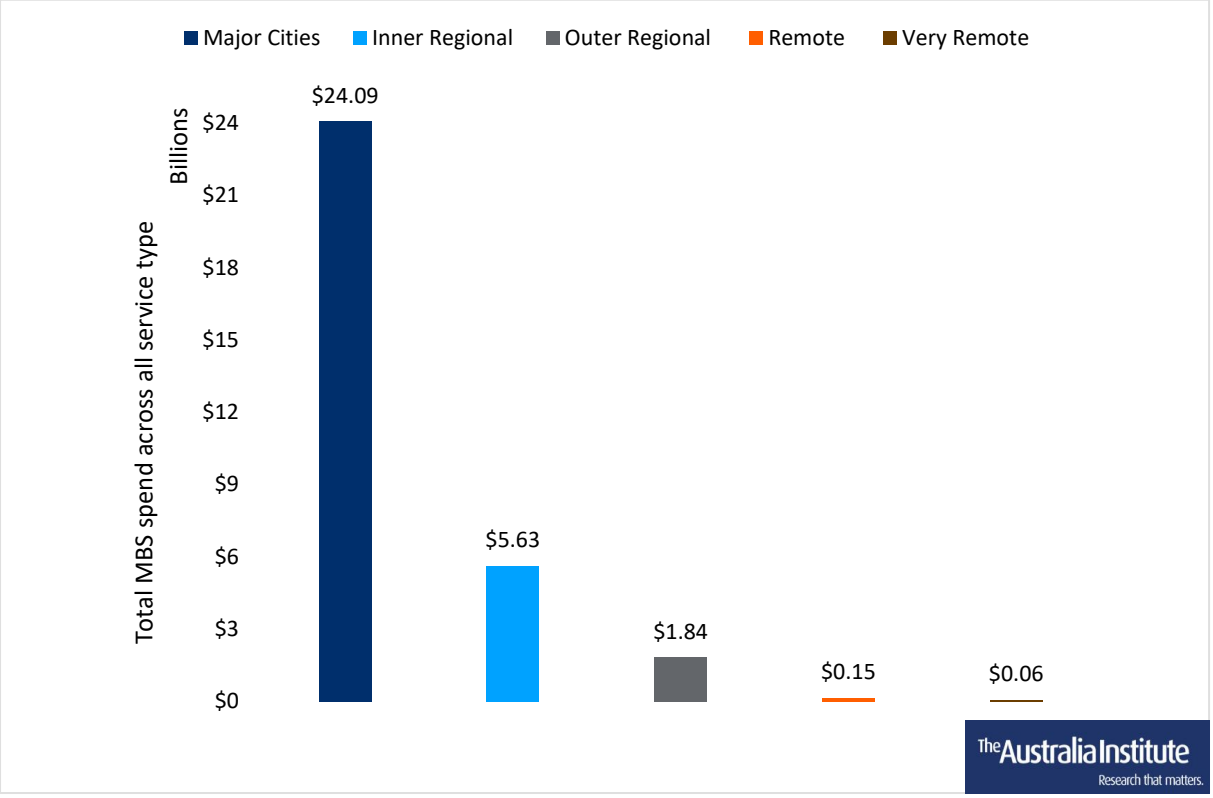
[23] Australian Government Department of Health, Disability and Ageing (n.p). Bulk Billing for all Australians. https://www.health.gov.au/bulk-billing

[24] Saxby & Zhang (2025). Bulk-billing rates and out-of-pocket costs for general practitioner services in Australia, 2022, by SA3 region: analysis of Medicare claims data. Medical Journal of Australia. https://doi.org/10.5694/mja2.52562

ABS remoteness classification, we can estimate the total amount of MBS benefit subsidies for a geographic area.

This analysis shows that outer regional, remote and very remote communities receive significantly less MBS benefits than communities in inner regional areas and major cities (**Figure 3**). Australians in major cities receive approximately $24 billion in MBS funding per year across all health services, while outer-regional, remote, and very remote Australians combined receive a mere $2 billion.

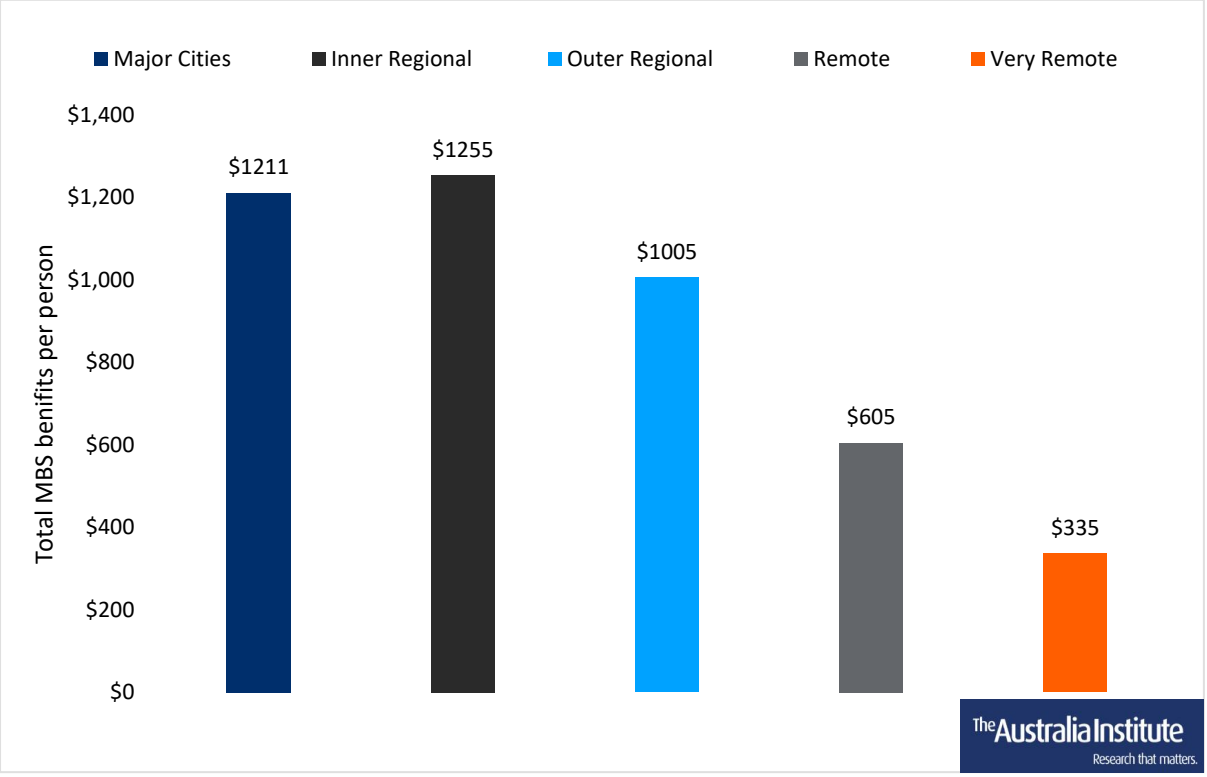
Figure 3: Total Medicare benefits across all services, by remoteness



Sources: Sources: Data from the Australian Institute of Health and Welfare, Medicare Benefits Scheme funded services monthly data, Table 6, https://www.aihw.gov.au/reports/medicare/mbs-funded-services-data/data. Australian Bureau of Statistics remoteness classification, https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3

After adjusting for population (**Figure 4**), this trend remains clear. There is a inverse relationship between MBS benefits and geographic remoteness, the more remote the area, the fewer MBS benefits. Every year, people living in major cities each receive $1211 in MBS benefits, whereas those in very remote areas get $335. This results in a nearly $880 per-person gap that these Australians are missing out on.

Figure 4: Total per person Medicare benefits across all services by remoteness

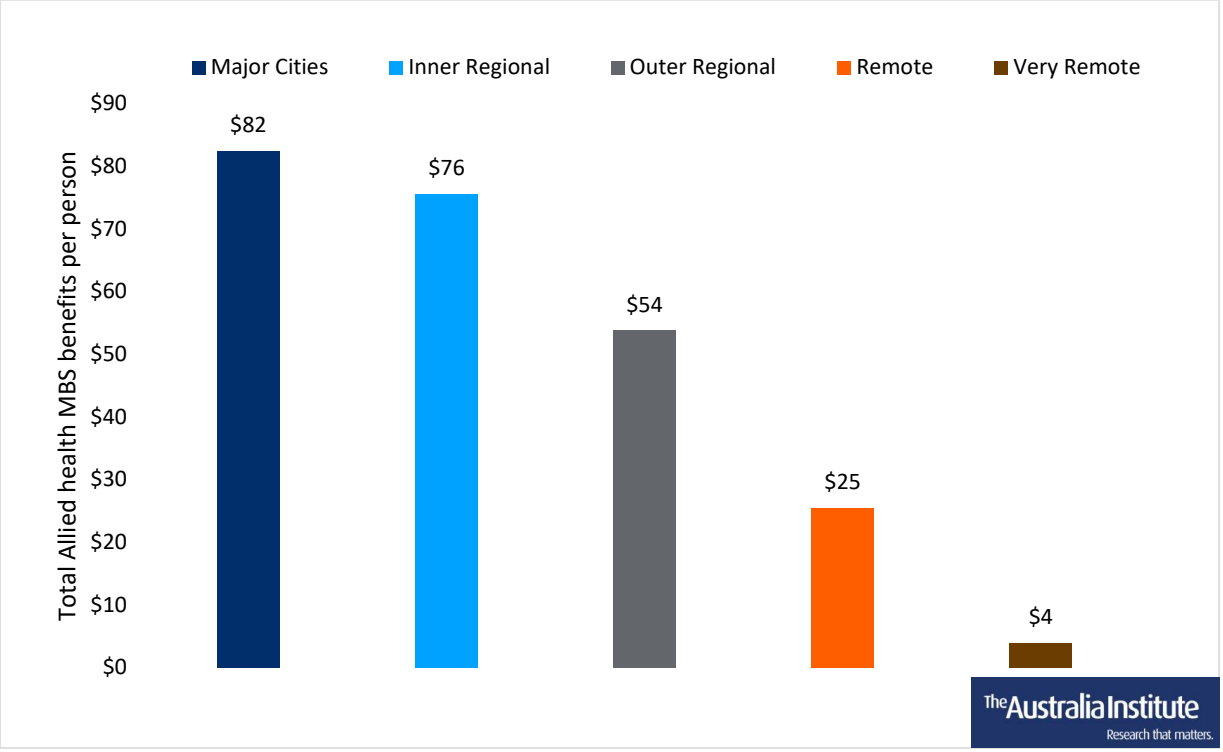


Sources: Data from the Australian Institute of Health and Welfare, Medicare Benefits Scheme funded services monthly data, Table 6, Nov 2024 – Oct 2025, https://www.aihw.gov.au/reports/medicare/mbs-funded-services-data/data. Australian Bureau of Statistics remoteness classification, https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3, ABS Population and people (data by region), https://digital.atlas.gov.au/datasets

This is the case across different services, including allied health, which encompasses a broad range of diagnostic, technical, and therapeutic services.[25] In major cities, the total per-person MBS benefit spent on allied health services is three times higher than in remote areas. When compared to very remote areas, that spending is twenty times higher (**Figure 5**). Those in major cities receive $82 per person for allied health services, while those in very remote areas receive $4. As detailed above, this difference is evident in the workforce shortage, where fewer allied health workers work in non-urban communities.

[25] Allied Health Professions Australia. (n.d.). What is allied health? https://www.ahpa.com.au/what-is-allied-health

Figure 5: Per person Medicare benefits across allied health services, by remoteness



Sources: Data from the Australian Institute of Health and Welfare, Medicare Benefits Scheme funded services monthly data, Table 6, Nov 2024 – Oct 2025, https://www.aihw.gov.au/reports/medicare/mbs-funded-services-data/data. Australian Bureau of Statistics remoteness classification, https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3, ABS Population and people (data by region), https://digital.atlas.gov.au/datasets

A 2025 report by the National Rural Health Alliance highlights just how stark this expenditure deficit is.[26] On average, rural Australians miss out on $1,090 per person in healthcare funding every year. For every dollar Medicare spends on GPs in cities, only about 72 to 85 cents is spent on residents in very remote areas.[27] For specialist services, the situation is much worse. For every dollar spent on city residents, only 30 to 50 cents is spent on remote residents.

[26] National Rural Health Alliance (2025) *The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia*, https://www.ruralhealth.org.au/the-forgotten-health-spend-report

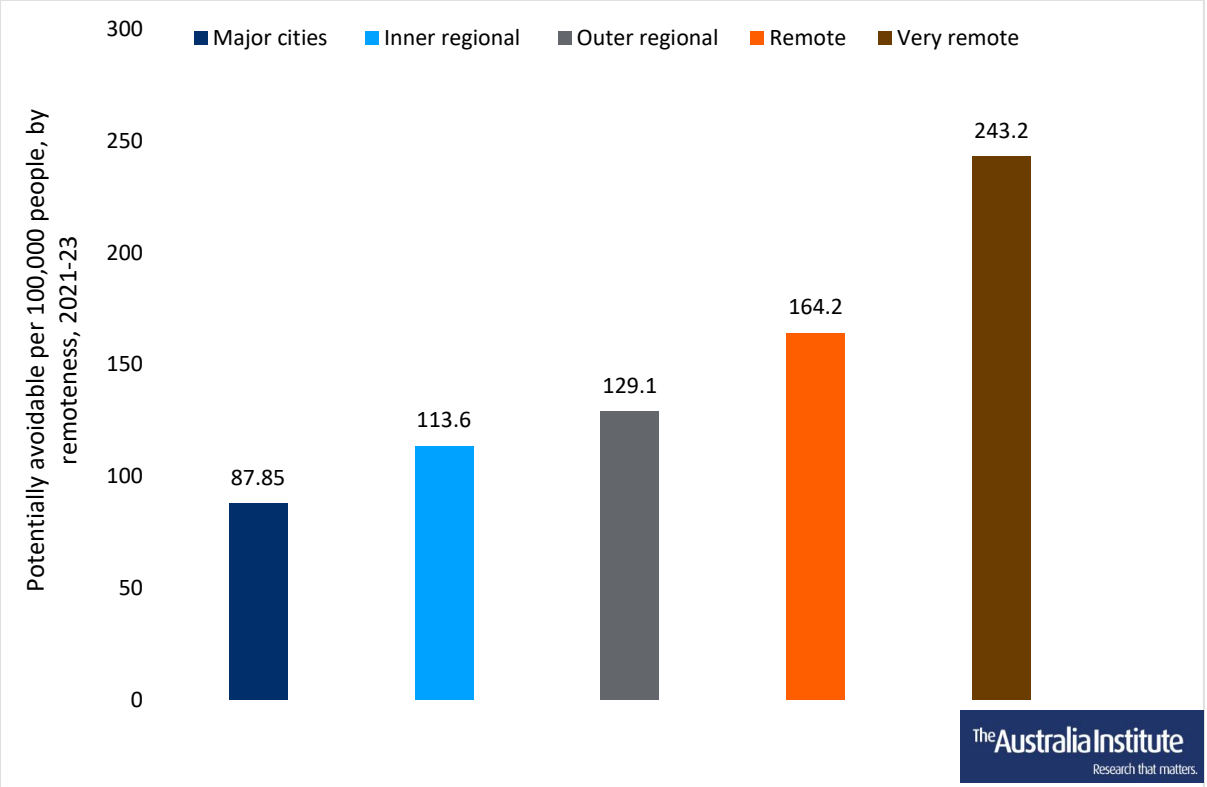
[27] Harris, Craike, Dunkin, & Calder (2019) *Is Medicare fair? The distribution of Medicare benefits across the cities and country*, https://www.vu.edu.au/sites/default/files/is-medicare-fair-cities-and-country-mitchell-institute.pd

This is a bad for human health and highly inefficient

The outcome of this system is that people in rural and remote areas are sicker for longer and die younger.[28] This is both a tragedy for the individuals involved and a highly inefficient use of public resources. People in these areas are more likely to wait until their condition becomes dire before seeking help. This means that when they finally do seek medical help, they often require complex, costly treatment.

For preventable conditions, people living in rural and remote areas are hospitalised at rates, two to three times higher than those in urban areas. They also have a higher incidence of dying from preventable conditions (**Figure 6**),[29] and are likely to have longer hospital stays.

Figure 6: Percentage of premature death (aged under 75), by remoteness, 2023



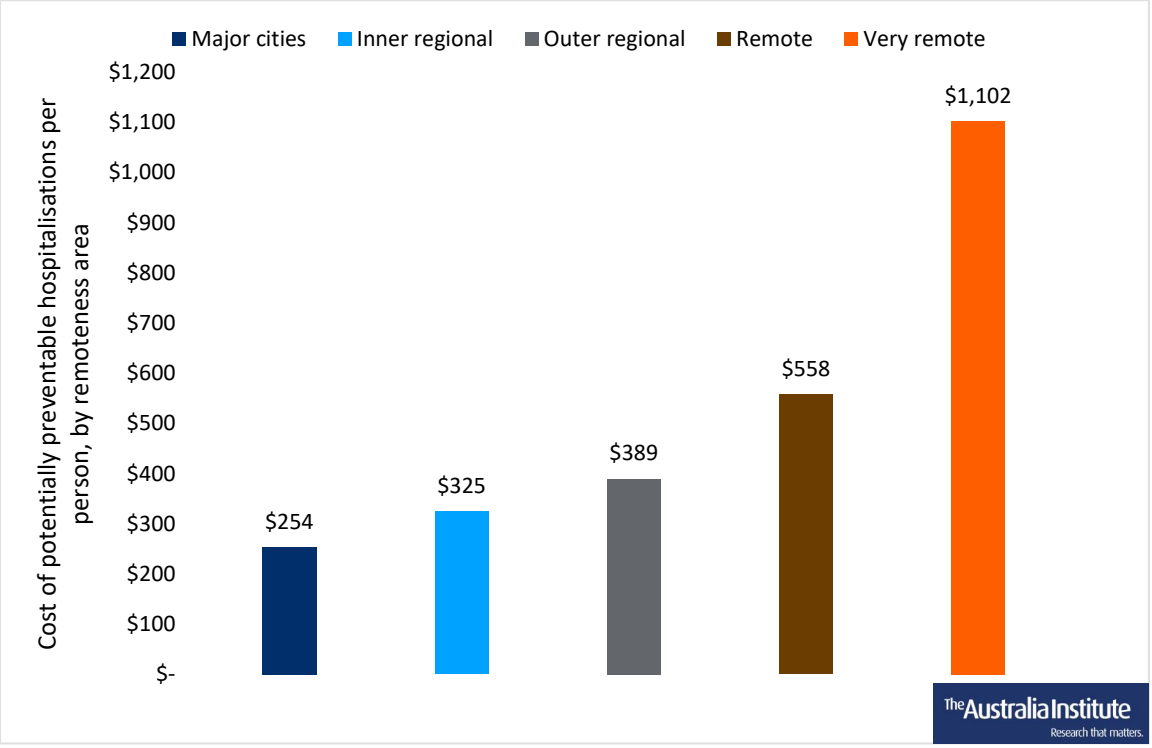
Sources: Data from the Australian Institute of Health and Welfare, Deaths in Australia, table 1, https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/data

[28] Australian Institute of Health and Welfare. (2025). *Rural and remote health*.

[29] National Rural Health Alliance. (2025). *Rural health in Australia: Snapshot 2025*. https://www.ruralhealth.org.au/rural-health-in-australia-snapshot/

These costs stack up. More geographically remote areas incur higher costs from potentially preventable hospitalisations (**Figure 7**). The cost of potentially preventable hospitalisations is four times greater in very remote communities than in major cities. This means that more money is spent in non-urban areas treating diseases and illnesses that could be prevented by vaccines, early treatment and lifestyle changes.

Figure 7: Cost of potentially preventable hospitalisations per person, by remoteness



Sources: Data from the Australian Institute of Health and Welfare, table 2, https://www.aihw.gov.au/reports/health-welfare-expenditure/cost-pph-in-australia-2014-15-to-2023-24/data

Rural Australians subsidise private health care for urban Australians

The Australian healthcare system currently relies on private hospitals to provide a number of services, including specialist care.[30] In metropolitan settings, GPs routinely rely on nearby private hospitals to secure timely specialist review and procedures. In rural and remote communities, that complementary system is often missing. Despite non-urban communities having higher hospitalisation rates than the rest of Australia, private hospitals are scarce and, in the most remote settings, non-existent.[31]

PRIVATE HOSPITALS

In 2003, The Australia Institute published research showing just how inequitable access to private healthcare was for Australians living in rural and remote areas. In particular, it detailed the lack of private hospitals outside major cities.[32] This remains true more than two decades later, with private hospitals concentrated in major Australian cities. In 1998, private hospitals accounted for 34% of the total number of hospital beds in urban areas. In contrast, they accounted for only six per cent of total hospital beds in rural and remote communities.[33] In 2024, less than one in ten private hospitals (8%) were in rural towns.[34]

The distribution of private hospitals in communities is deliberate. Operators in the private sector open private hospitals wherever they can make the most profit. There is little private-sector investment in non-urban areas because there are fewer people from whom to make a profit.[35] Because there are fewer people to profit from, it means that people in non-urban areas travel longer distances at their own expense to receive care – often hundreds of kilometres. This is despite the poorer health conditions and hospitalisation discussed above.

[30] Productivity Commission (2026) *Report on Government Services 2026: Public hospitals*, https://www.pc.gov.au/ongoing/report-on-government-services/health/public-hospitals/

[31] Australian Commission on Safety and Quality in Health Care (2021) *The Fourth Australian Atlas of Healthcare Variation*, https://www.safetyandquality.gov.au/our-work/healthcare-variation/fourth-atlas-2021

[32] Denniss, (2003) *Health spending in the bush: An analysis of the geographic distribution of the private health insurance rebate*, https://australiainstitute.org.au/report/health-spending-in-the-bush-an-analysis-of-the-geographic-distribution-of-the-private-health-insurance-rebate/

[33] Denniss, (2003) *Health spending in the bush: An analysis of the geographic distribution of the private health insurance rebate*

[34] Australian Government Department of Health and Aged Care. (2024) *Private hospital sector financial health check: Summary*, https://www.health.gov.au/resources/collections/private-hospital-sector-financial-health-check-resources

[35] National Rural Health Alliance (2025) *The Forgotten Health Spend*

The practical effect is a distance-based rationing of private care. Medicare's reliance on a coexisting private sector functions unevenly across geography: metropolitan residents can access two overlapping systems, while those in non-urban areas depend mostly on the public system. This exacerbates existing problems, including longer waiting times and higher acute admissions, and is a key structural factor in poorer outcomes in non-urban communities.

PRIVATE HEALTH INSURANCE

People living in non-urban areas are nevertheless subjected to the same pressures as all Australians to take out private health insurance, including the Lifetime Health Cover (LHC) loading and the Medicare Levy Surcharge (MLS). The LHC is a policy that pushes young people to take out private health insurance by penalising them with higher premiums for each year after age 30 without cover.[36] The MLS imposes an extra tax on higher-income earners who do not have suitable private health insurance.[37]

Both of these policies assume that buying private cover provides meaningful additional access to care. This might be true in urban areas where private hospitals, specialists, and day surgeries operate alongside the public system. However, in many non-urban areas, these services are scarce. Residents, therefore, pay higher premiums or tax penalties for a parallel system they cannot realistically use, unless they travel long distances.

Compared with residents of major cities, fewer non-urban residents have private health coverage. Even still, one in two people in non-urban areas (49%) have private health insurance.[38] This is despite limited access to private care in these areas.

This means that people with private health cover in non-urban areas are effectively subsidising the insurance of urban Australians, because they pay premiums without receiving effective benefits. If health outcomes for Australians living in non-urban areas are to improve, expectations of holding private health insurance must reflect the reality of service availability.

[36] Australian Taxation Office. (n.d.). *Lifetime health cover*, https://www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/private-health-insurance-rebate/lifetime-health-cover

[37] Australian Taxation Office. (n.d.). *Medicare levy surcharge*, https://www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/medicare-levy-surcharge

[38] Australian Bureau of Statistics. (2025*). Patient experiences, 2024–25 financial year*, https://www.abs.gov.au/statistics/health/health-services/patient-experiences/2024-25

Potential solutions

If Medicare is to provide universal high-quality health coverage for all Australians, reform must recognise geography as a determinant of access. Providing healthcare in rural and remote regions is inherently more challenging than providing care in cities. Medicare primarily rewards high-volume patient turnover, which simply does not apply in areas with less dense populations. Medicare does not effectively recognise or respond to the systemic hurdles that contribute to the rural health worker shortage and that make it hard for healthcare workers to operate in non-urban communities, such as health behaviours, low health literacy, transport barriers and geographic isolation.

AMENDMENTS TO THE EXISTING SYSTEM

One set of options would be to amend the existing Medicare system to better suit non-urban communities.

Medicare rebates could be increased for all healthcare services provided in regional and remote Australia. This could take the form of a remoteness loading, so that higher Medicare rebates are given for services in remote locations. This would mean the current rebates still apply in major cities, but they could be increased in more remote areas to cover the actual cost of providing services. Prioritising 'remoteness' in this way would reduce the financial burden on rural citizens and the doctors who treat them. This could secure more bulk-billed services and thus redistribute Medicare benefits more equitably. It would also have positive downstream effects by, for example, reducing the burden of preventable disease, as rural Australians could seek appropriate care before they become too sick or injured.

The Commonwealth has already moved towards similar models by introducing remoteness weighting for some Medicare items, such as standard GP consultations. However, this could be applied across all health and allied health services for every remote resident seeking health care. Applying a remoteness loading across the board would give remote residents parity with Australians in major cities in MBS benefits.

Recommendation 1: Apply a remoteness loading across all Medicare items and ensure they are specifically weighted to benefit individuals and healthcare providers residing in non-urban areas.

Medicare must explicitly recognise and remunerate advanced remote healthcare skills. Directing funding to specialised MBS items for rural generalist GPs performing obstetrics, anaesthesia, and emergency medicine in remote areas ensures these vital services remain locally available. Medicare must move beyond the current reliance on incentive payments, which only act as temporary top-ups to the fee-for-service system. Doctors and healthcare

workers practising in non-urban communities should not have to worry about where their income is coming from.

To prioritise stable rural practice, funding models must support service viability where patient volume is low and reduce individual risk to medical practitioners. By rural stress-testing every MBS item, including workforce incentives, and applying a fairness lens to how dollars are allocated across rural and remote areas, Australia can transform Medicare from a metropolitan-centric rebate system into a truly national health safety net.

Recommendation 2: Implement funding models that combine traditional Medicare fee-for-service billing with guaranteed base salaries and additional block funding for multidisciplinary teams.

DIRECT GOVERNMENT PROVISION

The other option is to recognise that providing healthcare in rural and remote communities through market mechanisms may inevitably lead to market failure. Australia Institute research has demonstrated the consistent failures of privatisation and market mechanisms in a range of social services and how these are predictable using basic economic concepts. Market failures are much more common in rural and remote communities due to the size of the market, with a small number of buyers and sellers.[39]

Fully remedying this market failure may require direct government provision of primary health services through government-owned clinics, government-employed GPs and specialists, and other programs. This direct provision of primary health services is unusual in Australia's current Medicare system; however, given the extent of market failure in health services in rural and remote communities, it can easily be justified. This could be directly run by the Commonwealth Government or in cooperation with the States and Territories.

Recommendation 3: Governments should directly provide primary health services in rural and remote communities. This could be directly controlled by the Commonwealth Government or via Commonwealth support for State and Territory Governments.

Exempting rural and remote populations from the pressures of private health insurance requirements – for example, the LHC – would address the gap between policy expectations and service availability.

Recommendation 4: Residents of rural and remote Australia should be exempt from private health insurance surcharges and forced coverage in areas where private hospital services are not reasonably accessible.

[39]Richardson, Denniss and Thrower (2024) *Privatised Failure*, https://australiainstitute.org.au/report/privatised-failure/

Conclusion

Medicare was built on the promise that access to healthcare in Australia would be universal. This promise has been broken. In practice, its structure distributes benefits according to the availability of providers, which are overwhelmingly concentrated in major cities. As a result, urban residents have disproportionate access to GP, specialist, and preventive care services, while people in non-urban areas face long travel distances, delays, and unmet needs. While all Australians fund Medicare, those in rural and remote communities do not fully share in its benefits.

Fee-for-service incentives encourage doctors to remain in high-volume urban markets, which perpetuates workforce shortages in rural and regional Australia. Compounding this inequity, private health insurance policy settings assume a parallel private system exists nationwide, but in reality, rural residents are penalised by paying surcharges even where no meaningful private care is accessible, effectively subsidising urban dwellers' access to these private services.

The rural divide is not a geographic inevitability; it is the predictable health outcome of Commonwealth policy. A universal insurance scheme, such as Medicare, cannot be considered universal if its use depends on where you live.

Medicare reform must therefore recognise these structural inequities. If Medicare funding formulas reflect access gaps, then workforce incentives could prioritise long-term rural practice rather than temporary placements. Similarly, if private health insurance requirements were exempted for non-urban residents who lack access to private health services, the residents would not be compelled to enrol in a system that does not benefit them. Alternatively, Commonwealth, State and Territory Governments could consider directly providing primary health services to these communities, stepping in where Medicare has consistently failed. Without these changes, Medicare will continue to provide equal entitlement but unequal care, leaving rural and remote Australians as second-class citizens.