Submission to the Rural and Regional Affairs and Transport References Committee for inquiry Rural, Regional and Remote Medicare Access and Funding Inquiry

Cancer Council Australia

The Clinical Oncology Society of Australia

Equitable Cancer Outcomes across Rural and Remote Australia Program

30th March 2026

We acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander Elders, past, present and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

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About Us

We welcome the opportunity to address the Rural and Regional Affairs and Transport References Committee consultation on changes to rural, regional and remote Medicare access and funding. We have welcomed the Australian Government's focus on strengthening Medicare and initiatives that aim to reduce the out-of-pocket costs Australians pay towards their healthcare, for example, through the Bulk Billing Incentive[1] and the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026.*[2] Through this submission, our organisations highlight the potential impact of recent changes to the MBS item rules, removing access for some Australians, including those who live regionally. This includes the 1 November 2025 changes to the MBS telehealth item requirements as they relate to Nurse Practitioners (NPs).[3] Cancer Council and COSA previously submitted to the Medicare Benefits Schedule Review Advisory Committee (MRAC) consultation on the Draft Report: *Post-Implementation of Telehealth Medicare Benefits Scheme (MBS) Items* in November 2023.[4] Our submission highlighted a concern that a shift from the flexible pandemic-era telehealth arrangements to more rigid requirements to meet 'eligible' telehealth practitioner criteria would significantly impact access to care for people affected by cancer living in regional, rural and remote parts of Australia.[5]

Cancer Council is the peak, non-Government cancer control organisation in Australia. As the national body in a federation of eight state and territory member organisations, Cancer Council works to make a lasting impact on cancer outcomes by: shaping and influencing policy and practice across the cancer control continuum; developing and disseminating evidence-based cancer information; convening and collaborating with cross sectorial stakeholders and consumers to set priorities; and speaking as a trusted voice on cancer control in Australia.

The Clinical Oncology Society of Australia (COSA) is the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients.

Embedded within the Institute of Health and Transformation at Deakin University, the **Equitable Cancer Outcomes Across Rural and Remote Australia (**ECORRA) Program represents a national, transdisciplinary effort to understand and reduce inequities in cancer outcomes across rural and remote areas.

Executive Summary

People living in remote areas are 1.3 times more likely to die from cancer and have a lower 5-year relative survival rate than people living in major cities.[6] The poorer cancer outcomes experienced by people living in rural and remote areas of Australia are partly explained by systemic inequities in access to high-quality cancer care, including clinical trials, diagnostic services, supportive care and palliative care.[7-9] People affected by cancer living in rural areas are also more likely to decline treatment or receive non-optimal treatment to avoid the need to travel or relocate.[10] Alongside geographic isolation, people in regional areas face additional challenges in accessing health services, including inadequate transport, higher out-of-pocket costs for services and to access services, lower availability of supportive services, and poor care coordination.[9] The utilisation of telehealth services helps to reduce the disturbance to family life and work, travel burden and costs associated with accessing specialist cancer services.[11]

For people with cancer living in the rural and remote areas, the best person or people to treat their condition may not be available locally, requiring them to travel significant distances to access appropriate treatment.[12] Telehealth has played a critical role in mitigating these barriers and supporting timely care for people living in regional, rural and remote areas.[13] It can bridge the gaps in accessing health services caused by distance and workforce by improving continuity of care and supporting healthcare professionals to deliver timely and efficient quality care locally.[14] Telehealth is not a substitute for face-to-face care, but a core access mechanism that supports continuity of care, multidisciplinary collaboration and timely follow-up, particularly for people with chronic, complex and cancer-related needs.

Medicare, as Australia's public health insurance program, must provide appropriate coverage of services and adequate rebates to enable Australians to access best cancer care. Health services in remote areas of Australia are characterised by limited local infrastructure, workforce shortages, and limited after-hours services.[12, 15] This impacts the availability and access to general practice, specialists, and publicly- funded pathology, diagnostics and radiology services which are critical in the diagnosis, management and monitoring of people affected by cancer.[16, 17] The availability of publicly funded, local services are limited, pushing people to use private services or travel distances to a public option. Alternative solutions are needed to improve access to health services for this population, including multi-disciplinary and nurse-led models of care, telehealth services and arrangements with private health services.[11, 14, 18] Additionally, improving Medicare eligibility to ensure all practitioners involved in providing care, either face-to-face, telehealth or as part of a team providing co-ordinated local and remote care, to claim rebates for their involvement in delivering care, supports achieving universal health coverage and equity. This is critical to ensure cancer care is delivered as per the Optimal Care Pathways and other national quality care standards.[19]

Telehealth is effective in enabling localised cancer care delivery for people living far from specialist cancer care services in remote or rural parts of Australia.[14, 16, 18, 20] Best practice is for people living in rural, regional and remote areas to have access to multidisciplinary cancer care that utilises telehealth to overcome geographic barriers. The advantages for people in rural, regional and remote parts of Australia include reduced burden of travel, associated costs and time away from family and work and the ability to receive care within their community. The current MBS requirement that patients must have had a face-to-face consultation with a practitioner in the preceding 12 months to access rebated telehealth services ("12-month eligible

telehealth practitioner rule") creates structural barriers to equitable health care access. This rule assumes that all patients can and need to access in-person care readily and regularly, an assumption that does not hold for many priority populations identified in the Australian Cancer Plan, including people living in rural and remote areas, Aboriginal and Torres Strait Islander people, people with disability and others experiencing structural disadvantage.[21] For many of these groups, access to face-to-face care is limited by workforce shortages, travel distances, costs, mobility constraints, and disability, which are central determinants of health equity and drivers of disparities in cancer care.

The final report from the Strengthening Medicare Taskforce included recommendations that equitable, person-centred primary care should be simple to navigate and accessible regardless of location.[22] It also recommended a focus on equity, including improved access for Aboriginal and Torres Strait Islander people, culturally diverse populations and residents of rural and remote communities. Towards this aim, we acknowledge the work of the Australian Government to improve healthcare outcomes for people living in remote and rural areas through initiatives such as expanded bulk-billing incentives scaled by remoteness and the reclassification of the Modified Monash Model (MMM) system to enable greater access.[23] Our submission makes recommendations that will further the existing achievements of the Australian Government of improving access to services and reducing out-of-pocket costs. The recommendations in our submission focus on providing place-based care as much as possible and clinically-appropriate, and where this is not possible, ensuring Australia's public health insurance program, Medicare, appropriately covers services and adequately rebates for best cancer care.

Recommendations

The recommendations made in this submission focus on ensuring Australian Government initiatives to enable Medicare to enable Australians to access publicly-funded best cancer care as close to home as possible.

To achieve this, we recommend:

- Remove the 12-month face-to-face requirement, allowing both GP and non-GP specialists (including NPs and allied health practitioners) to determine telehealth eligibility based on clinical judgement and patient need rather than a time-bound in-person attendance requirement. This approach would remove an unnecessary structural barrier for rural, remote, travel-restricted or mobility-constrained people.
- Extend telehealth flexibility across all clinician types, recognise the role of NPs, allied health professionals, Aboriginal and Torres Strait Islander health practitioners, and other non-GP specialists in delivering telehealth, ensuring that eligibility is not contingent on the 12-month rule unless clinically relevant.
- Reform to MyMedicare to enable accredited NP-led practices to access MyMedicare to strengthen sustainable and high-quality NP care models in cancer care in Australia.
- For MBS services delivered in primary care, extend eligibility to recognise the role of NPs, allied health professionals, Aboriginal and Torres Strait Islander health practitioners, and other non-GP specialists in delivering care, unless clinically-relevant, to increase the available workforce and access to timely primary care in rural, regional and remote areas.
- Improve availability of Australian Government initiatives aimed to financially support the operation of independently owned rural general practice to ensure local community access to primary care.
- Review the impact of the Bulk Billing Incentive Program and the Rural Bulk Billing Incentive annually, including Medicare data and through direct practice and patient experiences, to improve patient access to primary care.
- Review the impact of the introduction of Patient End Support MBS item numbers at 12 months in providing networked cancer care to boost adoption of these models and help ensure financial sustainability of local primary care services.
- Introduce a telehealth MBS item for telehealth supervision of chemotherapy comparable to the face-to-face MBS item (13950) and expanded eligibility to local NPs and doctors for providing support during treatment via telehealth.
- Expand eligibility for case conference MBS items (MBS items 871 and 872) to NPs and allied health practitioners, enabling participation in multidisciplinary care.
- Assess all Medicare reforms for appropriateness and effectiveness on the rural and remote community.
- Monitor and evaluate impact of Medicare, by implementing data-driven monitoring of use of Medicare services, telehealth uptake, quality of care and outcomes in priority populations to ensure Medicare policy contributes to closing the equity gap – consistent with Australian Cancer Plan equity metrics.
- Ensure availability of Medicare funded services, including diagnostics, radiology and pathology through the lens of Medicare caring for people as close to home as possible to receive care, by mapping services and demand to inform recommendations to enable the planning of publicly available services.

- Review availability and adequacy of financial support programs to identify appropriate programs models to better support people who are required to travel to receive best cancer care.
- Review the impact of the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill* 12 months after introduction to ensure Australians have information about out-of-pocket costs through the Medical Costs Finder website.
- Extend on the Australian Government's commitment to improved transparency of out-of-pocket costs and choice by investing in public education and awareness of informed financial consent, and resources which enable health professionals to have informed and supportive conversations with their patients.
- The Australian Government improve the function of the Medicare Safety Net of reducing out-of-pocket costs for people with cancer by moving to a rolling 12-month period of continuous assessment calculated from when an individual or family first accesses an eligible service.

Specific feedback based on the terms of reference

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

The specific changes that were implemented on 1 November 2025 that we will address in this section relate to the MBS telehealth 'eligible' practitioner requirements for nurse practitioners (NPs), including:

- MBS telehealth services must be delivered by an 'eligible' telehealth practitioner, unless an exemption applies. This is defined as the practitioner who performs the service, has provided a face-to-face service (that was billed to Medicare) to the person in the last 12 months, or is located at a medical practice where they have had a face-to-face service arranged in the last 12 months.
- The other eligibility pathway to access GP and prescribed medical practitioner (PMP) MBS telehealth services requires that the person is registered in MyMedicare, and the service is being performed by their registered practice.

Specialist cancer services are a significant service gap for people in regional Australia.[24] People in rural communities face a particularly high travel burden to access specialist care with experiences of travel times of five hours each way.[17] Attending in person involves significant challenges, including loss of income due to time off work, travel costs, childcare and logistical barriers and accommodation expenses.[9, 10, 25] The impact of these, both financial and time, affect not only a person diagnosed with cancer, but also their carer and family. These practical barriers amplify the importance of telehealth as a flexible and accessible option to receive specialist care closer to home.

Many rural, regional and remote communities rely on NPs to deliver aspects of their care, with around 30% of employed NPs working in these settings.[26] NPs develop, lead, and deliver tele-chemotherapy to these communities.[14, 18] NPs also often rely on the utilisation of telehealth to enable their involvement in follow-up, symptom assessment, and aspects of care coordination for people affected by cancer. This is acknowledged in the Nurse Practitioner Workforce Plan that states that telehealth can be used to strengthen support for safe, effective and sustainable NP services.[27] The 1 November 2025 MBS 'eligible' telehealth practitioner changes will impact NPs and their ability to provide flexible and efficient cancer care to people living in rural, regional and remote communities, with the greatest impact on NPs working in private practice across multiple sites to deliver care through rural or regional centres. This will impact their ability to deliver cancer care services in communities with people experiencing the poorest cancer outcomes, including Aboriginal and Torres Strait Islander peoples, which will increase existing equity issues.[21]

As a result of the 1st November 2025 changes, a NP who currently provides telehealth appointments to people they have not seen face-to-face in 12 months, which is common in long-term cancer survivorship or stable maintenance therapy, will no longer be eligible for the rebate. This will result in:

- People living in rural, regional and remote areas who rely on telehealth services for the delivery of aspects of their cancer care to travel to see an NP face-to-face before their

first appointment and every 12 months to retain access to Medicare-funded telehealth services even if it is not clinically necessary for the NP and patient to be face-to-face.

- People unable to travel or unable to afford the costs of travelling to attend appointments will experience inequity in their ability to access high-quality cancer care.
- For people affected by cancer, this will result in delays in symptom and treatment monitoring, contributing to further inequities in cancer outcomes.

The removal of the eligibility for this rebate undermines the role of NPs to deliver safe and efficient specialty cancer care for rural, regional and remote communities. This will result in people in these communities being disadvantaged financially and requiring them to travel to facilitate a "qualifying" face-to-face visit every 12-months.

The changes do not support the findings of the MBS Review Advisory Committee (MRAC). The MRAC review of the telehealth post-implementation, reported that telehealth can improve access to high-quality health care for some groups of people.[4] It acknowledged that MBS telehealth items and exemptions could enable access for people in rural and remote settings where the health care workforce may be limited and in situations when delayed access may result in adverse outcomes.[4] Current exemptions exist for vulnerable individuals, including children under 12 months, people who are homeless, affected by natural disasters, in COVID quarantine, or receiving specific services (like BBV/SRH from an Aboriginal Medical Service).[3] However, the current exemptions are limited and do not reflect Australians who are unable to, or not easily able to, access health services face-to-face. These people may avoid accessing care due to distance, financial constraints, or an inability to attend in person, including due to disability or trauma caused by previous experiences with the health system. Australians expect telehealth as an option for their care, where it is clinically appropriate, and models of care to deliver quality cancer services remotely have been developed as a standard of care.

Recommendations:

- Remove the 12-month face-to-face requirement, allowing both GP and non-GP specialists (including NPs and allied health practitioners) to determine telehealth eligibility based on clinical judgement and patient need rather than a time-bound in-person attendance requirement. This approach would remove an unnecessary structural barrier for rural, remote, travel-restricted or mobility-constrained people.
- Extend telehealth flexibility across all clinician types, recognise the role of NPs, allied health professionals, Aboriginal and Torres Strait Islander health practitioners, and other non-GP specialists in delivering telehealth, ensuring that eligibility is not contingent on the 12-month rule unless clinically relevant.
- Reform to MyMedicare to enable accredited NP-led practices to access MyMedicare to strengthen sustainable and high-quality NP care models in cancer care in Australia.

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

Independently owned rural general practices play a foundational role in community health systems and are often the primary, and sometimes sole, point of access for cancer diagnosis, chronic disease management, survivorship and palliative care support.[8, 28]

Current Medicare funding and incentive structures inadequately reflect:[29]

- Higher operating costs in rural settings, including workforce recruitment, accommodation and infrastructure
- Lower patient volumes combined with higher clinical complexity
- The essential non-billable roles rural practices perform, including care coordination, informal triage and community support.

Cancer Council Victoria consulted with their Clinical Network Executive Committee, including representatives with expertise in primary care, who shared that primary care providers and private practices operate as small to medium businesses that, to remain viable, require MBS rebates that is sufficient to cover the costs associated with salary, infrastructure and insurance. Without appropriate rebates, private fees will continue to exist alongside new Medicare incentives, as through the experience shared by primary care members of the Cancer Council Victoria Clinical Network Executive, do not cover the costs of running a practice. This is especially important in regional, rural and remote areas so that these general practices remain viable and sustainable to deliver primary healthcare services in these communities. Rural and remote primary care providers are important for providing localised continuity of care, which rural consumers consistently report as critical to quality safety and equity, particularly following a cancer diagnosis.[30]

Limited access to primary care can result in:[31]

- Delayed recognition and investigation or early symptoms
- Longer wait times for referrals to diagnostic services and specialists
- Fragmented follow-up and missed opportunities for early intervention

For cancer, these delays area associated with more advanced disease at presentation and poorer outcomes.

The Bulk Billing Incentive Practice Incentive Program that commenced 1st November 2025, is a positive step towards supporting eligible practices with financial incentives to enable more practices to provide free services to patients.[1] Ongoing review of the uptake and impact of this program, as well as the Rural Bulk Billing Incentive, is required to ensure financial support is appropriate for all practices, accounting for increased costs of providing care remotely and the different models primary care services operate in these areas.[23]

Recommendations:

- For MBS services delivered in primary care, extend eligibility to recognise the role of NPs, allied health professionals, Aboriginal and Torres Strait Islander health practitioners, and other non-GP specialists in delivering care, unless clinically-relevant, to increase the available workforce and access to timely primary care in rural, regional and remote areas.

- Improve availability of Australian Government initiatives aimed to financially support the operation of independently owned rural general practice to ensure local community access to primary care.
- Review the impact of the Bulk Billing Incentive Program and the Rural Bulk Billing Incentive annually, including Medicare data and through direct practice and patient experiences, to improve patient access to primary care.

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

Enhancing Medicare to improve telehealth access for people living in rural and remote areas' is a crucial component to reducing inequities in avoidable hospitalisations, and easing demand on emergency departments.[8, 32] This is due to telehealth's capability to enable remote monitoring, timely specialist access and virtual urgent care.[33] This leads to significant patient benefits, including improved symptom management, higher patient satisfaction, improved mental health, reduced pain, and promotes social connection among homebound people. [33-35]

People living in rural and remote areas have poorer access to and use of primary care services which can result in:[7, 31]

- Delayed recognition and investigation or early symptoms
- Longer wait times for referrals to diagnostic services and specialists
- Fragmented follow-up and missed opportunities for early intervention

For cancer, these delays area associated with more advanced disease at presentation and poorer outcomes.

ToR 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

Comprehensive quality cancer care involves interdependent and often complex networked pathways across multiple healthcare providers and settings. Multidisciplinary care, or mixed team models of cancer care, involve coordinated input from medical specialists (oncologists, surgeons), primary care providers (GPs), nurses, NPs, allied health professionals (physiotherapy, dietetics, psychology), and sometimes Aboriginal and Torres Strait Islander health workers — ideally incorporating supportive care, survivorship and palliative care. These models are internationally recognised as best practice for improved outcomes and continuity of care across the cancer continuum.[36] However, the current Medicare arrangements:[37]

- Remain overly GP-centric and episodic
- Do not adequately recognise and remunerate the roles of NPs, nurses and allied health professionals
- Provide limited support for supervision, mentoring and team-based care

As a result, rural services are constrained in their ability to deploy their workforce to their full scope of practice.[37] Medicare reform can better enable multidisciplinary, place-based models of

care that reflect how services are delivered in practice in rural and remote Australia. This would align with the recommendation of the Strengthening Medicare Taskforce to "Develop new funding models that are locally relevant for sustainable rural and remote practice in collaboration with people, providers and communities".[38] This requires new funding models designed to enable flexibility in delivery of care locally, accounting for local needs and availability of healthcare providers. New MBS item numbers introduced 1st March 2026, enabling GPs and NPs to claim a rebate for patient end support go some way towards improving accessibility of multidisciplinary care in rural areas.[39] This enables a patient and their local primary provider to videoconference with a non-GP specialist however, the patient and primary provider must be face-to-face. It is intended to improve communication between the patient, primary provider and specialist to share information about a person's care and make decisions.

Best practice is for people living in rural, regional and remote areas to have access to multidisciplinary cancer care that utilises telehealth to overcome geographic barriers.[36] Telehealth supports the multidisciplinary approach to cancer care by providing long-distance networked linkages, increasing the workforce capacity, and the secure, timely and accurate delivery of test results to clinicians. Shared care models utilising telehealth to support networked rural and remote cancer services enable specialist services and local health care providers to work collaboratively.[16] These models enable patients to access best cancer care services available to them in Australia while staying as close to home and their community as possible however, Medicare does not currently support all practitioners involved in delivering this model of care. Medicare funded services, and the availability of MBS rebates to practitioners, must be structured to keep rural and remote Australians as close to home as possible for their care, connecting them to their home and support networks.

Telehealth facilitates improve quality of care by allowing services in regional areas to link to metropolitan or other cancer centres for multidisciplinary care team discussions. The MBS 'eligible' telehealth practitioner requirement (face-to-face rule) limits access for new appointments or episodic care interactions that are often needed in multidisciplinary care models, where specialists, allied health or supportive care providers consult intermittently on care. Therefore, some allied health and multidisciplinary telehealth services are not eligible for MBS rebates, limiting the sustainability of this model of care.[14] The MBS includes specific case conference items (MBS items 871 and 872) that reimburse medical practitioners for participating or leading multidisciplinary cancer treatment planning meetings. These support a core component of multidisciplinary care planning but are limited to medical practitioner participation (specialists and GPs), not allied health.[3]

The Townsville Tele-oncology model demonstrates that telehealth can enable people affected by cancer to access care without the need to travel, through a multidisciplinary care approach.[18] This model of care enables people to access reviews with their oncologist via videoconferencing, but their treatment is managed in their community through local health professionals. This was found to be acceptable to people affected by cancer, rural-based health professionals and enabled the delivery of quality care.[18] Currently, this model of care does not receive Medicare support; clinicians can claim a rebate for telehealth consultations, but there is no specific rebate for telehealth supervision of chemotherapy comparable to the face-to-face MBS item (13950), and local NPs and doctors cannot claim MBS rebates for providing support during treatment via telehealth. This does not align with the needs of a networked model of care, where collaboration via telehealth between specialists and local practitioners is needed to deliver

care across the cancer continuum. People affected by cancer living in rural and remote areas are particularly disadvantaged, as joint consultations between specialists and local clinicians or NPs are not supported under current funding arrangements. Introducing rebates for these components would better facilitate such networked models of care and improve access for rural patients. Likewise, tele-trial models of care also lack Medicare support, and the introduction of specific rebates for local practitioner involvement and remote supervision of treatment delivery would encourage broader adoption.

Recommendations:

- Review the impact of the introduction of Patient End Support MBS item numbers at 12 months in providing networked cancer care to boost adoption of these models and help ensure financial sustainability of local primary care services.
- Introduce a telehealth MBS item for telehealth supervision of chemotherapy comparable to the face-to-face MBS item (13950) and expanded eligibility to local NPs and doctors for providing support during treatment via telehealth.
- Expand eligibility for case conference MBS items (MBS items 871 and 872) to NPs and allied health practitioners, enabling participation in multidisciplinary care.

ToR 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

A key strategic action in the Australian Cancer Plan (Action 4.5.2) is to expand access to digitally enabled cancer care, aiming to improve equity and access to quality cancer care, particularly in regional, rural, and remote areas.[21] It emphasised the importance of considering the funding mechanisms for telehealth services and enabling legislative and policy environments to support access for this priority population.[21] The Optimal Care Pathways are embedded in the Australian Cancer Plan to recognise the standard of care that all Australians should expect.[40] The Optimal Care Pathway for Rural and Remote Australians developed by ECORRA in partnership with Cancer Council Australia and in consultation with the sector, is expected to be realised mid-2026. This will set out the specific considerations to providing best cancer care for people living in rural and remote Australia.

The current MBS requirement that patients must have had a face-to-face consultation with a practitioner in the preceding 12 months to access rebated telehealth services ("12-month eligible telehealth practitioner rule") creates structural barriers to equitable health care access. This rule assumes that all patients can access in-person care readily and regularly, an assumption that does not hold for many priority populations identified in the Australian Cancer Plan,[21] including people living in rural and remote areas, Aboriginal and Torres Strait Islander peoples, people with disability and others experiencing structural disadvantage.

For many of these groups, access to face-to-face care is limited by travel distances, costs, mobility constraints, and disability, which are central determinants of health equity and drivers of disparities in cancer care.

The impact of the 12-month face-to-face rule to deliver telehealth services include:

- Limiting access to cancer care due to geographic barriers
- Increasing the need for costly travel to maintain eligibility for MBS telehealth rebates
- Worsening disparities in communities with the poorer cancer outcomes in Australia due to structural barriers
- Increasing financial and logistical burdens to accessing cancer care.

The expansion of MBS telehealth items during the COVID-19 pandemic broadened access to the best care regardless of where people live.[20] Telehealth has enabled the development of models of care that supported expanded access to care for people living in parts of Australia with limited access to specialty care.[14] Providing cancer care remotely (via telephone or videoconferencing), for treatment that isn't required in person or can be delivered via local health professionals connected to specialist sites, has become an accepted model of care.[14, 18, 41] This is supported by the Primary Health Care 10 Year Plan that recognises the importance of MBS telehealth provisions for GPs, NPs, allied health providers and non-GP specialists.[28]

Telehealth is effective in enabling localised cancer care delivery for people living far from specialist cancer care services in remote or rural parts of Australia.[14, 16, 18, 20] Telehealth offers benefits regarding choice, convenience and safety for both the person affected by cancer and their clinician, and can potentially reduce geographic disparities in cancer.[14, 36, 41] Telehealth also facilitates improved quality of care by allowing regional sites to link to tertiary metropolitan centres for multidisciplinary team discussion and access to clinical trials. Telehealth has been shown to reduce patient travel burden and increase access to specialised care.[14, 17] In a survey of people living in regional NSW, 83% (n=289) of respondents stated that it was important to have telehealth available as an option to consult with health professionals.[17]

To support these benefits, expanded access to MBS telehealth items to enable both GP and non-GP specialists (including NPs and allied health professionals) is needed to provide ongoing flexible arrangements to telehealth consultations. This would put the needs of people affected by cancer at the centre of care delivery. This flexibility would extend access to telehealth for all Australians affected by cancer living in rural, regional and remote areas, based on clinical judgement and patient preference, or feasibility. Decisions regarding the suitability of telehealth to deliver cancer care must consider the implications for communities with poor cancer outcomes, including Aboriginal and Torres Strait Islander peoples and people from lower socioeconomic areas, to reduce the existing equity issues and improve cancer outcomes for all Australians.[21]

Currently, only GP practices can register for MyMedicare and healthcare providers within these practices can access these benefits. Expanding access to MyMedicare for other health practitioners could support more patients to register for MyMedicare, including people affected by cancer as an enabler to help people access ongoing telehealth services that support a multidisciplinary care approach to cancer care. This would enable people affected by cancer to have their care better coordinated by a multidisciplinary care team, especially if they are required to undertake care between different locations or health professionals. Routine reporting of Medicare impacts by rurality is required to identify unintended consequences early and support course correction, this includes engagement with services and patients to understand the real-life impacts of MBS arrangements. The introduction of Medicare reforms requires assessment of local workforce availability, travel requirements, service sustainability, digital access, unintended financial impact on practices and impact on access for priority populations who have poorer cancer outcomes. This requires direct testing of reforms with people, providers and communities.

The ability to develop evidence-informed Medicare reforms for rural and remote communities is constrained by critical gaps in research and data relating to cancer inequities experienced by this population. Australia's data infrastructure remains limited, with people living in rural and remote areas travelling for cancer treatment being lost within large metropolitan datasets.[9] This restricts the capacity to determine effective service types or locations for cancer treatment in rural and remote areas, and their reliance and uptake of telehealth services.[9] Strengthening the monitoring of telehealth access for these communities, and the impact of these services on quality of care and outcomes, will require improved access to nationally linked datasets and gathering experiences directly from healthcare providers and patients. Medicare must contribute to multisectoral collaboration to enhance the evaluation of telehealth services for these communities and ensure alignment with the Australian Cancer Plan equity metrics.

Improving Medicare access and funding for people in rural, regional and remote areas is a key recommendation of the Strengthening Medicare Taskforce and is key to Australia meeting its commitments to achieving universal health coverage and its obligations under international human rights law, regarding The Right to Health.[38, 42] This also aligns with the Australian Government's commitments to the National Agreement on Closing the Gap, which commits it to partnering with Indigenous leaders to achieve health equity by 2030. [43] A key action is to empower Aboriginal Community Controlled Health Organisations (ACCHOs) to lead service delivery in rural and remote communities. Therefore, any planned reforms should be done in consultation and collaboration with ACCHOs to ensure they meet the needs of their communities and address health inequities for Aboriginal and Torres Strait Islander peoples.

Recommendation:

Assess all Medicare reforms for appropriateness and effectiveness on the rural and remote community.

Recommendations reflected earlier in submission:

- Expand access to MBS telehealth items to enable both GP and non-GP specialists (including NPs and allied health practitioners) to provide ongoing flexible arrangements to telehealth consultations by removing the 12-month eligible telehealth practitioner rule.
- For MBS services delivered in primary care, extend eligibility to recognise the role of NPs, allied health professionals, Aboriginal and Torres Strait Islander health practitioners, and other non-GP specialists in delivering care, unless clinically-relevant, to increase the available workforce and access to timely primary care in rural, regional and remote areas.
- Reform to MyMedicare to enable accredited NP-led practices to access MyMedicare to strengthen sustainable and high-quality NP care models in cancer care in Australia.
- Monitor and evaluate impact of Medicare, by implementing data-driven monitoring of use of Medicare services, telehealth uptake, quality of care and outcomes in priority populations to ensure Medicare policy contributes to closing the equity gap – consistent with Australian Cancer Plan equity metrics.

ToR g. Any other related matters

Improving accessibility of publicly funded services and national financial support for people required to travel for best cancer care.

A reformed Medicare system should enable people with cancer to access the best possible care closer to home, supported by strong primary care, multidisciplinary shared care models, and fit-for-purpose telehealth. Medicare should reduce avoidable travel by supporting high-quality local care where clinically appropriate, including care coordination, survivorship, supportive, and follow-up care delivered through primary care and regional services. Travel to metropolitan or tertiary services should occur only when there is a clinical need, and where this is required, patients must be adequately supported to access care without undue financial or logistical burden.

Despite this, inadequate support for transport and accommodation when requiring care away from home continues to undermine equitable access to cancer care, particularly for people living in rural, regional and remote Australia. In regional areas, transport for cancer treatment without a private vehicle can be challenging due to limited public transport options. If public transport is available, the limited reach of services, infrequent services, long wait times, and poor connections make it a challenging experience for people already under significant physical and emotional strain.[17] Through the National Healthcare Reform Agreements, there is shared responsibility between the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians, including accessibility of publicly available care.[44] This includes providing support for people required to travel to access non-GP specialist services with financial support towards travel expenses.

Travel to access healthcare is a significant burden in terms of financial costs for transportation, accommodation, time away from work and puts a financial strain on people undergoing cancer care.[9, 10, 25] People travelling more than two hours for treatment report significantly greater financial strain.[25] People living in regional NSW reported that, despite 75% (n=261) of survey respondents having access to a cancer treatment centre in their local area, 53% still had to travel over 100km to access cancer services.[17] Access to cancer care for people living in regional areas is not entirely dependent on proximity to services, but also whether available care is culturally appropriate, affordable and can be accessed when needed. One in four people affected by cancer in Australia experience out-of-pocket costs >AU$10,000, and rurality is a risk factor for greater financial burden.[25] People living in regional, rural or remote parts of Australia may decline recommended treatments if it requires travel over two hours.[9, 45] 1 in 5 people reported skipping appointments or treatment due to the costs.[17] Travelling and living away from home for cancer treatment can also impact a person's and/or their carers' ability to work and pose challenges to caring responsibilities and childcare. Travelling also removes people from their families, communities and broader support networks.

Additionally, the Australian Government should review the availability of publicly funded services to reduce inequities in access experienced when local care options are only available in the private sector, or publicly available services do not match demand. The availability of public imaging, pathology and diagnostic services has been a longstanding issue for regional patients. These services are critical for diagnosing, treatment planning and monitoring however, many patients are required to pay out-of-pocket for private services. Similarly, there is a gap in access to clinically indicated prostheses for public or patients without private health insurance, with this depending on The Prescribed List (formally the Prostheses List) or through local hospital budgets.

Recommendations:

- Ensure availability of Medicare funded services, including diagnostics, radiology and pathology through the lens of Medicare caring for people as close to home as possible to receive care, by mapping services and demand to inform recommendations to enable the planning of publicly available services.
- Review availability and adequacy of financial support programs to identify appropriate programs models to better support people who are required to travel to receive best cancer care.

Supporting informed financial consent

The financial costs of cancer are substantial and varied, including direct medical bills (private healthcare costs, non-Medicare subsidised services, imaging, pathology and medicines) and indirect costs, leading to financial toxicity.[46] These indirect costs are often unexpected and vary significantly, including parking, transport and accommodation. The impact of out-of-pocket costs is greater as a cancer diagnosis often results in reduced capacity to work, the need to access retirement funds and savings, reduced income and caregiver expenses. The Medicare Taskforce Review report, recommendation 3 is to *Develop and mandate a consistent documented procedure with appropriate provision of information to assist providers in explaining costs to consumers prior to a course of treatment.* To begin delivering on this recommendation, the recent introduction of the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill* is good progress towards improving transparency by enabling the Department of Disability, Health and Ageing to publish specialist fees on the Medical Costs Finder website, moving specialist's involvement on the website from an opt in model.[2] Further opportunities for an active approach to ensuring informed financial consent is achieved, requires the Australian Government to develop, support, and implement a consistent documented procedure to assist healthcare service providers in explaining the costs associated with care (i.e., informed financial consent). Cancer Council Australia, with organisations in the sector, developed the Standard for Informed Financial Consent as a guide for healthcare service providers to conduct discussions around the costs, risks and benefits of treatment, to enable individuals and families to better understand the financial impact.[46] This is especially important for people living in rural, regional and remote areas, as accessing specialist cancer services often involves travel, accommodation, and additional, often hidden, costs.[45]

Recommendations:

- Review the impact of the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill* 12 months after introduction to ensure Australians have information about out-of-pocket costs through the Medical Costs Finder website.
- Extend on the Australian Government's commitment to improved transparency of out-of-pocket costs and choice by investing in public education and awareness of informed financial consent, and resources which enable health professionals to have informed and supportive conversations with their patients.

Improving access to the Medicare Safety Net

The Medicare Safety Net (MSN) in Australia is designed to reduce out-of-pocket costs for high-volume users of medical services.[47] While this is a good initiative to reduce out-of-pocket costs, it operates on a strict calendar year basis (1 January to 31 December), which can disadvantage people diagnosed with chronic conditions or requiring intensive treatment later in the year. The MSN also requires patients to pay a substantial "gap" amount upfront before they are eligible for

higher rebates. This can lead to inequity of access to health care for people diagnosed with chronic conditions, where the timing of the diagnosis dictates the level of financial assistance, rather than the severity of the disease or total cost of care. Cancer Council Australia has previously recommended a review of the current calendar year structure and moving to a rolling 12-month period of continuous assessment, in our 2024 submission to the Medicare Safety Net Reform Working Group (MSNWG) of the Australian Department of Health and Aged Care and suggested by the Royal College of General Practitioners and the Australian Medical Association.[48] [49, 50]

Recommendation:

The Australian Government improve the function of the Medicare Safety Net of reducing out-of-pocket costs for people with cancer by moving to a rolling 12-month period of continuous assessment calculated from when an individual or family first accesses an eligible service.

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