# SUBMISSION ON

# RURAL, REGIONAL AND REMOTE MEDICARE ACCESS AND FUNDING

OTSi

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# 1. Executive Summary

The Occupational Therapy Society for Hidden and Invisible disabilities (OTSi) welcomes the opportunity to contribute to this consultation. OTSi member contributions offer a consistent and evidence-informed message: current Medicare settings are misaligned with the realities of rural mental health need, workforce distribution and contemporary allied health capability. Allied health, including occupational therapy, remain an under-utilised workforce within Medicare, despite its critical role in delivering care in rural and remote communities.

Members report tangible and immediate consequences of late 2025 Medicare policy setting changes, including cancelled telehealth clinics, disrupted continuity of care, increased travel burdens for consumers, financial instability among small community-based practices, and predictable escalation to crisis care and avoidable emergency department presentations. These impacts are experienced daily across rural Australia.

Small, community-embedded allied health practices are central to the functioning of rural health systems. These services hold deep local knowledge, long-standing therapeutic relationships and cultural understanding that cannot be replicated by large, centralised or corporate providers. However, current Medicare arrangements are placing these practices under increasing strain, threatening their sustainability and, by extension, the communities they serve.

At the same time, impending reductions and reforms within the National Disability Insurance Scheme (NDIS) are expected to shift significant unmet need back into the Medicare system. This will increase pressure at both ends of the care spectrum, on primary care services attempting to absorb unmet demand, and on emergency services managing escalating crises, further exposing the limitations of current funding models.

This submission proposes a targeted reform platform to ensure Medicare remains fair, accessible and sustainable for rural Australians, with a strong focus on strengthening allied health, supporting community-based practice and ensuring equitable access to telehealth.

# 2. About OTSi

OTSi is a national society whose purpose is to enable occupational therapists who work alongside people with invisible and hidden disabilities, to reduce barriers to full participation as active citizens of Australia. OTSi has a strong voice in systemic advocacy and policy direction, as well as enabling individuals to build better lives. Currently, over 70% of OTSi members identify as having a disability and/or as carers. Occupational therapists play a fundamental role within primary care and preventative health systems.

# 3. Impact of the 1 November 2025 Medicare Changes on Access to Care, Including Telehealth

The Medicare changes introduced on 1 November 2025 have reinforced continuity-of-care requirements by linking eligibility for services, including Better Access mental health care, to MyMedicare registration or a relationship with a usual medical practitioner (Department of Health and Aged Care, 2025a; MBS Online, 2025). While continuity is an important principle, its current implementation does not reflect the realities of rural service access.

In practice, these changes have created a two-tier system that advantages patients connected to large, MyMedicare-registered practices, while disadvantaging those who rely on allied health-led services, visiting providers or community-based clinics. In rural and remote areas, where general practice access is often limited, unstable or unavailable, many patients are unable to meet these requirements despite clear clinical need (AIHW, 2025; NRHA, 2023).

Members report that these changes have already resulted in cancelled telehealth sessions, reduced service availability and increased travel burdens for consumers. Telehealth is not a convenience in rural Australia; it is a critical access mechanism. Any policy settings that restrict telehealth access risk further isolating communities that are already underserved.

A further barrier is the absence of a practical mechanism for allied health providers to verify MyMedicare registration or continuity eligibility. This creates administrative inefficiencies, delays access to care and shifts time away from clinical service delivery. These cumulative effects are particularly burdensome for small, community-based practices.

# 4. Medicare Settings, Unmet Need and Escalation to Crisis Care

As an unintended consequence, Medicare settings that commenced in late 2025, may contribute to avoidable emergency department presentations and preventable hospital admissions by limiting access to timely, community-based allied health care. When early intervention is unavailable, individuals are more likely to deteriorate and present in crisis, including for acute mental health episodes, suicidal distress and complex psychosocial needs (AIHW, 2022; AIHW, 2023).

This issue is likely to be significantly exacerbated by recent and proposed changes to the NDIS. As eligibility tightens and supports are reduced, many individuals with psychosocial disability and functional needs may no longer be eligible for the NDIS. This unmet need will not disappear; rather, it will shift into Medicare, likely back to primary care and, when needs escalate, into emergency departments.

This creates a “squeezing effect” across the system, where demand increases simultaneously at both ends of the care continuum. Primary care services, including allied health providers, will face increasing demand without corresponding funding increases, while emergency services will continue to absorb the consequences of delayed and inadequate early intervention.

Occupational therapists play a critical role in addressing functional decline, supporting daily living, and preventing escalation to crisis. However, without appropriate Medicare support, this preventative capacity remains underutilised.

# 5. Adequacy of Medicare Support for Allied Health and Community-Based Care Models

Allied health professionals, including occupational therapists, are an under-utilised workforce within Medicare. Despite their capacity to deliver effective, evidence-based mental health, preventative and functional interventions, current funding arrangements do not adequately support their integration into primary care.

In rural and remote communities, healthcare delivery is inherently multidisciplinary and adaptive. Small, community-based allied health practices are often the most stable and accessible providers of ongoing care. These practices develop deep local knowledge, maintain long-term therapeutic relationships and provide flexible, context-responsive services that are essential to effective care.

However, Medicare settings remain poorly aligned with these realities. Funding structures are fragmented, rebates are insufficient, and there is limited recognition of the complexity and scope of allied health practice. This restricts service capacity and undermines the sustainability of local providers.

The current telehealth restrictions for group-focussed psychological focused strategy services create unintended inequities for both metropolitan and rural participants seeking occupational therapy (OT). Requiring individuals to be located in Modified Monash Model (MMM) areas 4–7, and prohibiting access if they are within 15 kilometres of the clinician, excludes people living in cities from participating in virtual groups—even where in-person attendance is not feasible due to disability, fatigue, transport barriers, or sensory needs. This disproportionately affects individuals whose conditions limit community access, effectively reducing service availability despite workforce capacity. Conversely, the rule also restricts rural participants from joining city-based telehealth groups, even when these groups offer specialised expertise that is unavailable locally. This is particularly problematic for people with less common or complex conditions, such as Functional Neurological Disorder, where suitably trained clinicians and peer groups are often concentrated in metropolitan areas. Preventing rural participants from accessing these groups limits both clinical effectiveness and opportunities for meaningful peer connection. Overall, the policy creates artificial geographic barriers that are not aligned with contemporary models of care, including telehealth delivery, interdisciplinary practice, and the need for condition-specific group interventions.

Group focussed psychological strategies services - telehealth (video) requirements: Group therapy mental health treatment services may only be delivered via video in certain circumstances. To be eligible for group therapy mental health treatment services via video, the patient must be located in a Modified Monash Model area 4-7 at the time of the consultation, and at least 15 kilometres apart by road from the eligible allied health professional delivering the service. The patient or eligible allied health professional is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation item.

More information about the Modified Monash Model, including a search tool to identify the classification of a specific location, is available at:
https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=MN.7.4&qt=noteID&criteria=MN%2E7%2E4

Field Code Changed

In addition, the disparity in Medicare rebates between disciplines creates a further structural disadvantage for clients seeking occupational therapy (OT) mental health services. Under current arrangements, services delivered by clinical psychologists attract substantially higher Medicare rebates of $145.25 than those delivered by occupational therapists providing equivalent psychological strategies, with OT sessions rebated at approximately $87.25. This gap increases out-of-pocket costs for clients who choose to engage with an OT, despite OTs offering evidence-based, psychologically focused interventions and may have more availability in some areas eg rural and remote. As a result, clients may be financially incentivised to access clinical psychology services over OT, even where OT is more clinically appropriate to their needs or available locally. This undermines principles of client choice and interdisciplinary care. Providing a similar rebate for Psychologists, Occupational Therapists and Social Workers would be beneficial for the reasons outlined.

Stronger investment in allied health would enable earlier intervention, reduce system pressures and improve long-term outcomes. In particular, occupational therapy offers a unique focus on function and participation, enabling individuals to participate in daily life and maintain independence within their communities.

# 6. Sustainability of Small, Community-Based Practices

Small, community-embedded practices are central to rural health systems. They are not simply service providers; they are part of the social and cultural fabric of their communities. These practices often operate with limited resources while absorbing significant administrative, financial and workforce pressures.

Current Medicare rules and compliance requirements disproportionately burden these small providers, who lack the infrastructure and economies of scale available to large corporate organisations. Members report increasing difficulty in maintaining financial viability under current funding arrangements, particularly in the context of rising operational costs and workforce shortages.

These pressures are compounded by the unique challenges of rural practice, including recruitment and retention difficulties, housing shortages and professional isolation (NRHA, 2021; National Rural Health Commissioner, 2022). Without targeted support, there is a real risk that these locally embedded services will be lost, further reducing access to care.
Primary Health Networks (PHNs) have a critical role to play in addressing this issue. A core function of PHNs should be to actively support and sustain small, community-based practices, recognising their value as holders of local knowledge and as essential infrastructure within rural health systems. This includes targeted commissioning, flexible funding models and investment in practice sustainability.

# 7. Reforms to Ensure Medicare is Fair, Accessible and Sustainable

To address these challenges, Medicare reform must prioritise equity, flexibility and sustainability. Increasing rebates for occupational therapists under Better Access is a necessary first step to reflect the complexity and value of their work. In addition, the introduction of rural complexity loadings, telehealth top-ups and blended or bundled payment models would better align funding with real-world service delivery.

Accessible telehealth must be protected and strengthened as a core component of rural healthcare. Policy settings should enable, rather than restrict, telehealth access, particularly for populations with limited local service availability.

There is also a need to introduce funded telehealth follow-up for individuals at high risk and those discharged from emergency departments, supporting continuity of care and reducing the likelihood of crisis escalation. All future Medicare reforms should be subject to mandatory Rural Impact Statements to ensure that unintended consequences for rural communities are identified and addressed.

Finally, in the context of NDIS reform, a new Medicare item for Focused Functional Interventions should be introduced. This would enable allied health providers, including occupational therapists, to deliver targeted, early interventions that address functional needs and reduce reliance on crisis-based care (See Appendix 1).

# 8. Conclusion

The current Medicare framework does not adequately reflect the realities of rural healthcare delivery or the critical role of allied health in supporting community wellbeing. Without reform, existing inequities will deepen, small community-based practices will become increasingly unsustainable, and pressure on emergency services will continue to grow.

Strengthening allied health, supporting locally embedded providers, investing in telehealth and aligning funding with real-world practice are essential steps toward a fair, workable and sustainable Medicare system for rural Australians.

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# Appendix 1

## Access to Function-Focused Allied Health Interventions Outside the NDIS

### Overview

Many people with disability require timely, effective, and targeted capacity-building supports to participate in daily life, education, work, and community. Under the National Disability Insurance Scheme (NDIS), occupational therapists and other allied health professionals have delivered evidence-based interventions that significantly improve functional ability and participation. However, a substantial cohort of people with disability across the lifespan either cannot access the NDIS or are losing access as eligibility thresholds tighten.

These individuals continue to experience significant functional impacts associated with developmental, psychosocial, cognitive, physical, sensory, and neurological disabilities, yet currently have limited or no access to funded, function-focused allied health intervention. This gap results in preventable declines in participation, independence, and wellbeing, and increases the likelihood of escalation into more intensive and costly service systems.

There is a strong and urgent need for accessible, function-focused intervention pathways outside the NDIS, including for people who can no longer access the Scheme.

### The Problem

Significant numbers of children, young people, and adults with disability are unable to access evidence-based interventions that build functional capacity and address disability-related participation barriers. This unmet need is driven by:

- High and increasing thresholds for NDIS access
- The absence of community-based, function-focused foundational supports

- The limited scope of existing Medicare and primary care items, which are largely diagnosis- or symptom-focused and do not adequately address functional capacity, daily routines, executive functioning, sensory regulation, or participation
- The cost-prohibitive nature of Medicare co-payments for many individuals and families

As a result, people with disability outside the NDIS often receive fragmented, insufficient, or no intervention, despite having clear functional needs that are amenable to allied health support.

### Impacts of Unmet Functional Need

The lack of access to function-focused intervention has significant personal, social, and economic consequences, including:

- Reduced participation in education, employment, and community life
- Barriers to independent living and daily functioning
- Increased reliance on families and carers
- Earlier and greater demand for intensive mental health, health, and disability supports

Without early and targeted functional intervention, many individuals experience avoidable escalation of need, leading to poorer outcomes and higher downstream system costs.

### Focused Functional Interventions (FFI)

Focused Functional Interventions (FFI) are proposed as a structured, time-limited model of allied health support designed to address this service gap.

FFI are:

- Grounded in functional goals rather than diagnosis alone
- Delivered through structured packages (e.g. 4–10 sessions)
- Individualised and contextualised to daily life demands
- Explicitly focused on improving participation in home, education, work, and community settings

FFI sit between:

- Intensive, ongoing NDIS-funded supports, and
- Mainstream services that lack capacity to address functional participation

They are not crisis services or open-ended therapy. Instead, they provide targeted, evidence-based functional intervention at critical points to prevent deterioration, disengagement, or system escalation.

For occupational therapy, FFI may include:

- Functional skill development and daily living supports
- Executive functioning and cognitive strategies
- Routine development, time use, and occupational balance
- Sensory-based regulation and participation strategies
- Parent and carer coaching
- Environmental modification and adaptation
- Participation supports for learning, work, and community engagement

A strong and growing evidence base supports these intervention domains across age groups and disability types.

### Target Cohorts

Focused Functional Interventions are required across the lifespan for people with a wide range of disabilities, including:

- Severe mental illness and psychosocial disability
- Autism and other neurodivergences
- Developmental delay
- Cognitive disability
- Physical disability
- Sensory disability
- Neurological disability

These cohorts include individuals who have never met NDIS eligibility criteria, as well as those who previously accessed the NDIS but no longer qualify despite ongoing functional need.

### Workforce Capacity and Sustainability

Occupational therapy is a participation-focused, outcomes-based profession with national reach and expertise in supporting people with disability across the lifespan. Occupational therapists are AHPRA-registered, degree-qualified professionals with strong capability in delivering functional, context-based interventions.

As NDIS demand contracts and eligibility narrows, a significant number of experienced occupational therapists will no longer be required within the Scheme and will be available to deliver Focused Functional Interventions through alternative funding pathways. FFI models support:

- Workforce retention and redeployment
- Flexible, local service delivery
- Participation by experienced clinicians, including those requiring flexible work arrangements

- Improved geographic and service coverage

This approach aligns workforce capacity with unmet community need.

### Funding and Delivery Options

A range of funding and delivery mechanisms could support the implementation of Focused Functional Interventions outside the NDIS, including:

1. **Commissioned delivery through Primary Health Networks**, using panelled allied health providers
2. **A nationally funded foundational support package**, separate from Medicare and the NDIS
3. **Escalation or referral pathways embedded in mainstream systems**, targeting people at risk of functional decline
4. **A statutory, entitlement-based funding model**, similar to WorkCover or Victims of Crime schemes, with time-limited, needs-based access

Each option enables structured access to function-focused allied health intervention without requiring ongoing scheme membership, and supports cost containment through early intervention and prevention.

### Key Recommendations

- Develop and cost Focused Functional Interventions to provide structured access to allied health supports for people with disability outside the NDIS
- Ensure FFI are available across the lifespan and across a broad range of disability types
- Prioritise access for individuals who can no longer access the NDIS but continue to experience significant functional impacts
- Deliver FFI through AHPRA-registered allied health professionals using evidence-based, goal-directed practice
- Position FFI as a formal complement to the NDIS, strengthening system coherence while addressing critical service gaps