

# Rural, regional and remote Medicare access and funding

Submission by **Australian Physiotherapy Association (APA)**

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### **Acknowledgement of Traditional Owners**

The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

## About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 35,000 members. The APA corporate structure is one of a company limited by guarantee and is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association. Of the potential nine Directors, seven must be financial members of the APA, and up to two may be external, non-physiotherapist Directors.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas and are committed to embedding cultural safety within the organisation, policy and education programs.

## 1. Executive Summary

The Australian Physiotherapy Association (APA) welcomes the opportunity to contribute to the Rural and Regional Affairs and Transport References Committee (the Committee) examination into Rural, Regional and Remote Medicare Access and Funding.

The 1 November 2025 Medicare reforms did not result in greater access to physiotherapy for chronically underserved rural, regional and remote Australians.

Medicare reform should shift from a one-size-fits-all, fee-for-service model to blended, place-based funding that reflects higher burden of disease, service gaps and the cost of delivering team-based care in rural, regional and remote communities, particularly for First Nations people and those with chronic and complex conditions. This means combining flexible block funding, tailored MBS items and enhanced telehealth and outreach funding tied to local population need, not just throughput.

There are 7.3 million people—more than 27 per cent of the total population—living in rural, regional or remote Australia. However, the distribution of the healthcare workforce does not align with geographical distribution of the population<sup>1</sup>. They face the greatest barriers to physiotherapy and continue to miss out on early intervention to restore function, protect independence and reduce hospitalisation, pharmacological dependence and long-term costs.

The APA Workforce Census 2025 identified that there is a strong intention from physiotherapists to work rurally with 32% stating they would consider moving to a rural location. However, barriers to rural practice include the high costs of moving, lack of professional networks, and lack of professional development and support opportunities. Nearly two-thirds (65%) of respondents said higher remuneration would support them to undertake rural employment, followed by relocation support (52%), and opportunities for skill development and career advancement (31%).

Medicare access and funding must be framed to recognise that primary care extends beyond general practice, and must integrate other healthcare professions, including physiotherapy.

Access to physiotherapy deficits in rural, regional and remote areas can be addressed by:

- Expanding publicly funded First Contact Physiotherapy (FCP) to enable patients to access physiotherapists directly in primary care and urgent care clinics for faster, more affordable and effective treatment of musculoskeletal conditions;
- Empowering physiotherapists to make direct referrals to specialists and request diagnostic imaging, streamlining patient care and reducing delays in treatment pathways;
- Strengthening multidisciplinary care by embedding physiotherapists in multidisciplinary models to ensure integrated, patient-centred care;
- Prioritising non-surgical pathways and early intervention by expanding physiotherapy-led management and blended model addressing high burden conditions; and
- Improving community access to physiotherapy by investing in physiotherapy strategies that reduce the reliance on high-cost interventions and prolonged use of medications;

It must be noted that the Terms of Reference of this examination lack direct focus on the patient care journey, practice viability beyond medical clinics; and preventative and early intervention that are critical factors in reducing hospitalisations and downstream costs. This submission addresses the Terms of References and we welcome the opportunity to provide further detail to the Committee.

## 2. Recommendations

<b>Recommendation 1</b>	Expand Medicare GP Chronic Condition Management Plan items beyond the capped five sessions to ensure evidence- and needs-based provision of physiotherapy and multidisciplinary care.
<b>Recommendation 2</b>	Ensure The Medicare Benefits Schedule Review Advisory Committee (MRAC), through the Allied Health Chronic Disease Management Services Review, increases allied health access—consistent with sector calls for higher annual session limits—to enable physiotherapy-led multidisciplinary models for priority chronic conditions.
<b>Recommendation 3</b>	Extend the Medicare Benefits Schedule benefits to include physiotherapy-requested MRI to supports both the patient and the healthcare system in rural, remote and regional Australia.
<b>Recommendation 4</b>	Enable physiotherapists to make direct referrals to specialists, such as orthopaedic surgeons.
<b>Recommendation 5</b>	Introduce targeted incentives to attract and retain physiotherapists and address workforce shortages.
<b>Recommendation 6</b>	<p>Support student physiotherapists to ensure a strong workforce pipeline in rural and regional remote Australia, including by:</p> <ul style="list-style-type: none"> <li>• Expanding the Commonwealth Prac Payment to include allied health students to reduce the financial barriers of undertaking student placements in rural, regional and remote areas</li> <li>• Amending legislation to allow billing for services delivered by physiotherapy students under supervision, as recommended in the Scope of Practice Review (Recommendation 5).</li> <li>• Investing in placement capacity across all settings, including incentives to keep practices viable while hosting students.</li> </ul>
<b>Recommendation 7</b>	Develop a National Allied Health Workforce Strategy that defines the capabilities, training pathways and incentivised supports required to build and retain a sustainable rural workforce. The strategy should recognise the role of APA rural generalist professional development in supporting physiotherapy capability in rural and regional settings, while acknowledging the relevance of rural practice to future titling and specialisation pathways within the broader Career Pathway Framework. It should also consider insights from sector-led models such as the AHRGP, including the importance of dedicated rural physiotherapist positions in shaping future pathway design.

<b>Recommendation 8</b>	Reform the Workforce Incentive Program to address workforce shortages and sustainability by incentivising physiotherapists rather than funnelling more dollars to general practice, which affects thin markets.
<b>Recommendation 9</b>	Establish access to Medicare funded First Contact physiotherapy for rural, regional and remote Australians for face-to-face and telehealth consultations.
<b>Recommendation 10</b>	Introduce travel payments for healthcare practitioners conducting home visits in recognition of the distance and time required in rural, regional and remote areas.
<b>Recommendation 11</b>	Embed physiotherapy within ACCHOs and multidisciplinary First Nations health teams to address access inequity.
<b>Recommendation 12</b>	Extend Higher Education Loan Program (HELP) debt relief to rural physiotherapists to align with assistance available to GPs and nurses.
<b>Recommendation 13</b>	Enable bundled funding models supporting PHNs to package multidisciplinary care prioritising rural, regional and remote communities for high priority clinical need in knee osteoarthritis, falls prevention, back pain and women's health.
<b>Recommendation 14</b>	Review the Rural Health Outreach Fund to ensure it is community-led and accessible, supporting local practitioners and local capacity building.
<b>Recommendation 15</b>	Adequately fund the Rural Locum Assistance Program to support permanent practitioners in rural, regional and remote places with clear understanding that where and when leave is required it can be accessed without negatively impacting the community.
<b>Recommendation 16</b>	Accelerate expansion of Endometriosis and Pelvic Pain clinics, and subsidised access to physiotherapy for women in rural, regional and remote areas.
<b>Recommendation 17</b>	Introduce Medicare/blended funding to increase access to pre- and post-natal physiotherapy to prevent, manage and treat birth trauma.
<b>Recommendation 18</b>	Review the Rural Health Outreach Fund contracting and procurement mechanism to build capacity in the rural, regional and remote healthcare workforce and local economies.

### 3. Addressing the Terms of Reference

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

**There has been no improvement in access to physiotherapy as a result of the 1 November 2025 Medicare changes.**

Primary care reform must address the first point of contact across all care pathways, especially for people with musculoskeletal injury and persistent pain. Physiotherapists working to full and advanced scope are a critical, immediately available solution to pressure on GPs and emergency departments. Federal recognition of physiotherapists as publicly funded First Contact physiotherapists—via dedicated Medicare-rebated primary care items that do not require GP referral and are allocated according to patient need—is essential to improve timely access to evidence-based care, particularly in rural, regional and remote areas. This reform will cut unnecessary GP appointments, imaging, opioid prescribing and low-value surgical referrals, reducing costs for both patients and the health system.

Further Medicare reform must guarantee direct access to appropriately skilled physiotherapists in primary care and urgent care clinics, eliminating avoidable delays and duplication. First Contact physiotherapists can safely assess, diagnose and manage most musculoskeletal conditions, determining the right care pathway and freeing GPs to focus on complex and multi-morbid patients. For rural, regional and remote communities, direct physiotherapy access must be backed by stronger, better-targeted workforce incentives—expanded rural loadings, relocation support, housing subsidies and structured professional support such as supervision, mentoring and funded continuing professional development—to attract, retain and sustain a highly skilled physiotherapy workforce in the places that need it most.

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

The APA is disappointed the examination of practice sustainability has not been extended to physiotherapy. The importance of physiotherapy and the need for affordable access to the comprehensive clinical care physiotherapy provides is essential to ensuring access to evidence- and needs-based care for rural, regional and remote Australians. Improvement in healthcare can't occur without inclusion of physiotherapy in rural health reform.

Physiotherapy practices, often central to their local communities, face the same challenges as their medical counterparts. Targeted incentives and flexible commissioning that make rural physiotherapy viable and sustainable are lacking.

Medicare and broader funding reform must include:

- targeted incentives to attract and retain rural physiotherapists;
- expansion of the Primary Health Network commissioning to fund local physiotherapy solutions;
- rural funding programs to directly support physiotherapy; and
- extension of Extend Higher Education Loan Program (HELP) debt relief to rural physiotherapists to align with assistance available to GPs and nurses.

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

Without affordable access to physiotherapy, the impact on rural and remote communities and health outcomes can be significant, including:

- Rural communities wait longer and travel further for basic physiotherapy services.
- Delayed care leads to preventable hospitalisations and costly retrievals.
- Workforce shortages limit early intervention and drive up acute care demand.
- Local physiotherapy services reduce hospitalisations and keep regional communities working.
- Not promoting preventive and early intervention increases the risk of chronic conditions and avoidable admissions.

**Physiotherapists are a first-contact professionals and play a vital role in the Australian healthcare system, particularly in the diagnosis and management of musculoskeletal conditions. The current funding system underutilises this resource.**

With expertise in anatomy, biomechanics, and clinical reasoning, they are well-equipped to assess, diagnose, and treat a wide range of injuries and disorders. Their ability to identify red flags and formulate evidence-based treatment plans positions them at the forefront of early intervention and care. Current systems that require general practitioner (GP) referrals for diagnostic imaging create unnecessary duplication and delays. Physiotherapists are trained to assess and determine appropriate imaging. There is an opportunity to build on existing professional service delivery models with GPs and specialists in the first contact practitioner space. This must be funded to ensure the patients that need the service are able to access it.

#### **Imaging and direct referral to specialists**

**Physiotherapist must be allowed to refer patients directly to specialists and request diagnostic imaging, streamlining patient care and reducing delays in treatment pathways.**

A MBS-subsidised referral pathway to allow physiotherapists to directly refer to imaging for musculoskeletal conditions is critical to reduce patient wait times and costs, and the cost to taxpayer by reducing Medicare GP consultation rebates.

Expanding physiotherapists' rights to request rebated diagnostic imaging will deliver significant benefits for patients and the healthcare system.

An analysis by the Nous Group estimated cost savings of \$64.1 million through reduced GP consultations and lower out-of-pocket expenses for patients. Streamlining this process would improve timely access to care, reduce administrative burden, and enhance patient outcomes—particularly in rural and remote areas where access to GPs is limited. Empowering physiotherapists to request imaging aligns with national workforce reform priorities and ensures patients receive efficient, evidence-based care from the most appropriate practitioner.

To fully realise the benefits of granting physiotherapists rebated MRI referral rights, complementary reforms are necessary. Currently, patients still face inefficiencies as physiotherapists are unable to provide a Medicare rebated referral to orthopaedic specialists. Therefore, should a physiotherapy-requested MRI suggest the need for specialist review, the patient will still be required to seek this referral from their GP, undermining the intended improvements in access and timeliness of care.

Physiotherapists also require comprehensive plain film (X-ray) requesting rights, as these are often the first-line investigations required by orthopaedic specialists. Limiting physiotherapists to MRI requests creates unnecessary fragmentation in patient care.

It is essential that imaging requested by physiotherapists attracts the same Medicare rebate as imaging requested by GPs. This ensures patients are not placed at a financial disadvantage and promotes equitable access to necessary diagnostic services.

**Direct referrals to specialists such as orthopaedic surgeons by physiotherapists is another straightforward improvement that must be actioned to reduce the need for patients to return to GPs for referrals and reduce the cost to the taxpayer of unnecessary consultations.**

### **Non-surgical pathways, prevention and early intervention**

Rural Australians face long waits, long travel distances and limited local services, which means that many people miss early treatment altogether. These gaps drive higher hospital use, more retrievals and poorer recovery.

#### **Knee osteoarthritis**

Strengthening Medicare means backing full recovery pathways. Prehabilitation should drive MDT reform and physiotherapy-led, non-surgical pathways cut surgical demand and ease system pressure.

Patients are often left waiting years for knee surgery. During this time, GPs struggle to keep them active, manage their pain and prevent their condition from worsening. Without a clear injury-to-recovery pathway, patients miss timely physiotherapy, leading to deterioration, harder recoveries and increased hospital strain.

Physiotherapy-led osteoarthritis programs for the knee and hip deliver a \$3772 net benefit per episode and can help nine in 10 Australians with knee OA avoid surgery.<sup>2</sup> <sup>3</sup>With knee and hip replacement costs projected to reach \$5.32 billion, early physiotherapy offers substantial savings and better outcomes.<sup>4</sup> It prevents deterioration, reduces pain and can help patients avoid surgery altogether. When surgery is required, physiotherapy shortens hospital stays and speeds recovery. Preoperative

physiotherapy reduces postoperative care by nearly 30 per cent,<sup>5</sup> saving costs and improving outcomes.<sup>6 7</sup>

A Medicare-backed blended model, similar to those used in diabetes and mental health, would enable earlier access to physiotherapy. Programs like GLA:D® show that physiotherapy can cut reliance on surgery and medication, providing a proven, scalable pathway.

## Falls

Falls are the leading cause of morbidity and mortality in older Australians, accounting for 43 per cent of injury hospitalisations and 40 per cent on injury deaths in Australian over 65s<sup>8</sup> Of all hospitalisations due to falls, more than half (53 per cent) occur at home.<sup>9</sup>

People living in very remote areas have higher age-standardised hospitalisation rates for falls compared with major cities experiencing about 1,070 hospitalised falls per 100,000 population compared with 793 per 100,000 in major cities.<sup>10</sup> Mortality rates in older Australians following falls is slightly higher in inner regional areas compared with other areas.<sup>11</sup>

**Falls are a significant issue for older people admitted to regional Australian hospitals with 1.28 per cent of inpatients aged 65 and over experiencing a fall during hospitalisation and the incidence increasing with age.**<sup>12</sup>

Patients who experience falls in hospital have significantly longer hospital stays and higher associated costs<sup>13</sup> with studies finding stays 4 to 15 days longer in patients who experienced a fall compared to those who did not. Hospital stays increase the risk of early admission to residential aged care. About 15 per cent of older adults sustain a fall within one month of discharge from hospital.<sup>14</sup>

Physiotherapists are experts in maintaining and improving mobility, falls prevention and reduction, and minimising harm from falls. They also provide high-value care, managing comorbidities that contribute to falls such as incontinence and dizziness.

Physiotherapy-led balance and progressive resistance exercise programs are demonstrated to reduce the number of falls and falls-related injuries by 55 per cent in residential aged care. In the community, a program aimed at functional mobility and balance reduced falls by 24 per cent and programs that included these exercises for three hours per week reduced falls by 42 per cent.<sup>15</sup>

Reform must focus on targeted, physiotherapy-led falls prevention to reduce preventable injury, hospitalisation and mortality in older people living in rural, regional and remote areas via a nationally consistent and funded program.

## Women's health

Women in rural, regional and remote Australia face significant barriers to accessing timely and ongoing care to prevent, treat and manage common conditions and symptoms such as a birth trauma, endometriosis and pelvic pain. The travel burden required for pelvic pain care among rural women, sometimes exceeding hundreds of kilometres per appointment, can lead to financial, emotional, and care-continuity costs.

Rural women in outback regions report amplified isolation and lack of local treatment services, which are concentrated in metropolitan centres, compounding access disparities.

Physiotherapists provide care during all stages of pregnancy, including pelvic floor muscle training in both antenatal and postnatal care, preparing for childbirth, promoting recovery and prescribing appropriate exercises during pregnancy and at birth. The Australian Commission on Safety and Quality in Health Care's national standard on third- and fourth-degree perineal tears recognises the role of physiotherapy in the best practice care pathway for the management of perineal tears.<sup>16</sup> The UK's National Institute for Health and Care Excellence guideline Pelvic floor dysfunction: prevention and non-surgical management recommends supervised pelvic floor muscle training before and after pregnancy to prevent symptoms of pelvic floor dysfunction.<sup>17</sup>

In Australia, there is currently no government funding for antenatal physiotherapy-led pelvic health assessment and individualised pelvic floor muscle training as preventative approaches.

There is no Medicare-funded antenatal physiotherapy assessments and postnatal treatment for physical birth trauma, as well as limited funding for telehealth and workforce development.

Unresolved symptoms of incontinence and pelvic organ prolapse can lead to costly and invasive downstream treatments for these conditions including surgery and, in many cases, repeat surgeries.

While women can access post-natal physiotherapy in hospital outpatient clinics, this is not always feasible for women outside metropolitan areas, who need to travel significant distances following childbirth for these services.

A new Medicare-funded or blended funding model must be introduced to address this unmet need in pre- and post-natal and ongoing care.

Physiotherapy has been widely studied and recognised as an effective treatment modality for pelvic pain in Australia, encompassing various conditions including those related to endometriosis with demonstrated sustainable clinical benefits.<sup>18</sup>

**Australian research consistently reports that diagnostic delays for endometriosis in Australia average ~6–8 years, with rural and regional women facing even longer delays and poorer access to specialist care due to workforce shortages and travel burdens.**

Endometriosis, a condition often associated with chronic pelvic pain, affects about 1 in 9 women in Australia, leading to about 34,200 hospitalisations (in 2016-2017)<sup>19</sup>.

The economic burden of endometriosis is significant costing the Australian economy about \$7.4 billion annually, with most of the costs arising from lost productivity and reduced quality of life. In the healthcare sector, it is estimated that \$247.2 million was spent on endometriosis-related healthcare in 2020-21, with a substantial portion of this expenditure attributed to hospital service.<sup>20</sup> Individuals with endometriosis face considerable personal financial burdens.

The direct costs include expenses for surgeries, medications, general practitioner consultations, and various treatments such as acupuncture and iron infusions. Many patients report spending between \$300 to \$400 per month on managing the condition with some incurring thousands of dollars in out-of-pocket expenses for surgeries.<sup>21</sup>

Physiotherapy is a beneficial adjunctive treatment for managing endometriosis-related symptoms through interventions targeting pelvic floor dysfunction, pain management, and overall rehabilitation. Such treatment can effectively complement traditional medical treatments in alleviating symptoms and improving the quality of life for women with endometriosis.

The APA welcomes the establishment of 33 dedicated Endometriosis and Pelvic Pain Clinics predominantly through the PHN health and medical centre network. This network needs to be expanded to ensure access for women in rural, regional and remote areas with consistently applied subsidies to support access to physiotherapy.

### **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**

**An integrated, comprehensive healthcare system that delivers best care needs the skills of the entire health workforce and multidisciplinary care teams can provide the most comprehensive care possible, at the right place and time for each patient.**

Ineffective management of chronic conditions in primary care leads to worse health outcomes and higher costs. The current system prioritises referral over integration, which is limiting the potential for active team management. Prevention and early intervention, in addition to the management of conditions, are key to addressing the chronic disease burden.

GP Chronic Conditions Management Plan (GPCCMP) items are not used to their full capacity for a range of conditions, including chronic musculoskeletal pain and conditions such as osteoarthritis, rheumatoid arthritis, juvenile arthritis and back problems.

Five sessions to meet all the allied health needs of a chronically ill or physically deconditioned person have never been enough to provide access to essential care. The five available Medicare-subsidised sessions limit evidence- and needs-based care. For example, in the case of a newly diagnosed Type 2 diabetes patient, requiring education, nutritional advice, foot care and exercise, the GPCCMP does not enable ongoing care, following initial consultations with podiatry, dietetics and physiotherapy.

Operationally, physiotherapists referred to by GPs often have no visibility of the overall plan for the patient or the number of visits they may already have accessed. Without reform to support digital system integration for physiotherapists, these handover issues are likely to remain.

Primary care extends beyond general practice, relying on the integration of nurses, physiotherapists, psychologists, and pharmacists.

Shifting towards evidence-based, timely primary care interventions is crucial to preventing costly medical procedures and surgeries. Our health workforce faces complex challenges, including a rising disease burden and increasing service demand due to population growth and ageing. We need a

stronger focus on sustainable workforce supply and distribution to optimise access and meet needs. Demand for allied health services is growing across disciplines and roles, with key drivers shaping physiotherapy demand already identified.

Rural Australians need accessible physiotherapy to cut delays, travel and preventable hospitalisations. Targeted incentives, flexible commissioning, funded telehealth models and direct support for physiotherapy will sustain rural care.

### **Culturally safe and First Nations healthcare**

Expansion of culturally safe physiotherapy and growth of a workforce that supports long-term community health. First Nations peoples continue to experience higher rates of chronic disease, pain and disability, yet many communities still lack reliable access to culturally safe physiotherapy. Care often arrives late, if at all, because services are thin, transient or not culturally grounded. This drives avoidable deterioration, preventable hospital use and poorer long-term outcomes. Strengthening First Nations-led health services and developing the First Nations physiotherapy workforce are essential to delivering care that is trusted, continuous and effective.

First Nations communities face the greatest inequity in access to physiotherapy recognising that:

- Delayed care leads to avoidable deterioration and higher acute care use.
- Culturally safe, community-based physiotherapy improves participation and outcomes.

The APA is calling for investment in First Nations-led physiotherapy services to expand culturally safe, local care; cultural capability and pathways to grow the First Nations physiotherapy workforce.

Physiotherapy must be embedded within ACCHOs and multidisciplinary First Nations health teams to bridge the gap.

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

The APA Workforce Census 2025 identified that there is a strong intention from physiotherapists to work rurally with 32% stating they would consider moving to a rural location with a further 17% unsure.

However, barriers to rural practice include the high costs of moving, lack of professional networks, and lack of professional development and support opportunities. Nearly two-thirds (65%) of respondents said higher remuneration would support them to undertake rural employment, followed by relocation support (52%), and opportunities for skill development and career advancement (31%).

Incentives that would encourage physiotherapists are:

- Higher remuneration; in recognition of increased operational costs of providing service in rural, regional and remote areas

- Financial support to relocate;
- Career progression opportunities with advanced skill acquisition;
- Professional support and mentoring; and
- Reduction in Higher Education Loan Program (HELP) fees to align with current assistance available to GPs and nurses.

Reform must incentivise a strong, viable physiotherapy workforce in rural, regional and remote Australia including students and community-based practices. Such incentives should include:

### **Physiotherapy students**

Physiotherapy students currently must complete hundreds to over a thousand hours of mandatory unpaid clinical placements as part of their degrees. This has led to widespread financial hardship or “placement poverty” --students lose income from part-time work, incur travel and accommodation costs, and sometimes face housing and food insecurity while on placement.

This financial strain disproportionately affects students from low-income, rural, mature-age and diverse backgrounds and can force some to defer, drop out, or limit where they undertake placements, threatening the pipeline of allied health professionals needed to address workforce shortages.

The Commonwealth Prac Program provides financial support to domestic students in teaching, nursing, midwifery, social work (Bachelor/Master's), or Diploma of Nursing (VET) who are undertaking mandatory, unpaid placements – but excludes allied health students, including physiotherapy students.

Physiotherapy students must be supported to ensure a strong workforce pipeline in rural and regional remote Australia, including by:

- Expanding the Commonwealth Prac Payment to include allied health students, such as physiotherapy students, to reduce the financial barriers of undertaking student placements in rural, regional and remote areas
- Amending legislation to allow billing for services delivered by physiotherapy students under supervision, as recommended in the Scope of Practice Review (Recommendation 5); and
- Investing in placement capacity across all settings, including incentives to keep practices viable while hosting students.

### **Workforce Incentive Program**

The Workforce Incentive Program (WIP) must be expanded to directly support physiotherapy practices in rural, regional and remote communities.

The WIP does not materially improve access to physiotherapy because it is structurally designed to support general practice employment models rather than independent or community-based allied health service delivery.

Incentive payments are directed to eligible GP practices, not to physiotherapists, and are contingent on employment arrangements that are uncommon in physiotherapy, particularly in rural, regional and private practice settings where most physiotherapists operate as small businesses or sole traders

The program does not address the primary barriers to physiotherapy access--namely inadequate and capped rebates, travel time and costs, workforce shortages, and the absence of viable funding for outreach and multidisciplinary care--nor does it incentivise service provision in high-need or underserved locations.

As a result, WIP funding may increase practice revenue without translating into additional physiotherapy capacity, availability, or affordability for patients, limiting its effectiveness as an access-enhancing workforce measure for physiotherapy.

## **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; and**

**The number of recommendations made by the APA in this submission reflects the scale of the systemic failures in enabling affordable local, culturally safe and evidence-based physiotherapy for regional, rural and remote Australians.**

There are few incentives to attract and retain highly qualified physiotherapists to non-metropolitan areas, and where they do exist, they are funnelled via GP practices (Workforce Incentive Program) or inadequately funded to support the workforce (Rural Locum Assistance Program).

Access to MBS subsidised services are limited and do not support evidence-based care.

A national strategy to address allied health workforce shortages must be prioritised to support attraction and retention of qualified physiotherapists across geographical areas.

The removal of the GP as a gatekeeper model to reduce out-of-pocket cost and time imposts for regional, rural and remote Australians--many experiencing socio-economic disadvantage--is key to a streamlined patient journey. This would include funding First Contact Physiotherapy and direct referral to diagnostic imaging by physiotherapists; and expansion of the Workforce Incentive Program to include physiotherapy practices.

The system currently fails to address workforce shortages with a lack of support and incentives the physiotherapy workforce in regional, rural and remote areas. Funding physiotherapy student Prac payments to address "placement poverty"; introducing adequate travel payments in recognition of the distances required to provide care; ensuring fair and sustainable remuneration to support service viability; and creating clear rural training and career pathways would strengthen recruitment, retention and access to care in underserved communities.

## g) Other matters

### Rural Health Outreach Fund

While the APA supports initiatives to fund multidisciplinary healthcare in rural areas, there are key issues that must be addressed to ensure the Rural Health Outreach Fund (RHOF) is not a missed opportunity to build local economic and workforce capacity and ensure long-term health outcomes. These issues include:

- RHOF procurement, contracting, and reporting requirements favour large organisations
- “Fly-in, Fly-out” Service Models Displacing Local Capacity
- Limited Genuine Community Co-Design meaning services may technically “service” a community but not reflect its priorities, cultural context, or preferred models of care;
- Short-term outreach vs long-term community health outcomes

Large corporate providers frequently operate FIFO outreach models that deliver episodic care, have limited continuity of clinicians and prioritise volume and coverage metrics over relationship-based care. When RHOF funding flows to these models, it can undermine investment in local workforce development, disincentivise permanent or long-term rural practice and reduce mentoring and skills transfer to local clinicians.

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