Inquiry into Rural, regional and remote Medicare access and funding

Joint Submission to Senate Standing Committees on Rural and Regional Affairs and Transport

March 2026

About

The Federation of Ethnic Communities' Councils of Australia (FECCA) is the national peak body representing people from culturally and linguistically diverse (CALD) communities and their organisations across Australia. Through its membership of state, territory and regional ethnic communities' councils, FECCA represents more than 1,500 multicultural community organisations nationwide and provides a collective national voice on issues including migration, settlement, workforce participation, skills recognition, social cohesion and equity.

FECCA's work is informed by its work as a peak body of multicultural organisations, peak body in ageing and aged care, and through its two initiatives:

1. the Australian Multicultural Women's Alliance (AMWA), the national voice for multicultural women, and
2. the Australian Multicultural Health Collaborative (the Collaborative), the multicultural health peak.

AMWA, in strategic partnership with SSI and Media Diversity Australia, is the national voice for migrant and multicultural women. It brings lived-experience insights from migrant, refugee and multicultural women, highlighting barriers such as visa insecurity, racism, language, digital exclusion and system navigation that must be addressed in reform design. It aims to empower women from all multicultural backgrounds to thrive and contribute fully to Australia's prosperity.

The Collaborative provides a national voice, leadership and advice on policy, research, data, and practice to improve access and equity, address systemic racism, and achieve better health and wellbeing outcomes for Australians from multicultural backgrounds.

Executive Summary

FECCA, AMWA and the Collaborative welcome the opportunity to contribute to the Senate Standing Committees on Rural and Regional Affairs and Transport's Inquiry into Rural, regional and remote Medicare access and funding.

Multicultural communities are an increasingly significant part of rural, regional and remote Australia. 2023-24 ABS population figures indicate that net overseas migration has contributed to more than 59% of regional growth in recent years.[1] However, regional migration has not been matched by proportional investment in culturally safe, linguistically accessible and equitable primary health care services.

People from multicultural communities in rural and regional Australia experience compounded barriers to accessing primary care within a system that is already structurally under-resourced. Evidence indicates that rural health systems operate with a significant funding shortfall, with Medicare utilisation substantially lower in more remote areas despite higher health needs. This reflects a broader reality that Medicare, in its current form, does not function as a truly universal system outside metropolitan context. This is especially true for multicultural communities living in rural and regional areas.

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[1]Australian Government Centre for Population. (2025). Regional Population, 2023-24. https://population.gov.au/data-and-forecasts/key-data-releases/regional-population-2023-24#_ftn1

For multicultural communities, systemic gaps are further compounded by barriers such as language, health literacy, visa-related exclusion from Medicare, and low trust in institutions. As a result, many individuals experience layered disadvantage, facing not only geographic inequities, but also a system that often lacks the capacity to accommodate the time, complexity, and cultural considerations required for safe and effective care.

While recent Medicare reforms aim to improve affordability and access to primary care, the benefits of these reforms may not be fully realised by multicultural communities without deliberate policy design that addresses structural barriers. Medicare reform must ensure investment supports equity, cultural safety and language access by design to ensure fair and consistent access across rural, regional and remote Australia.

To complement this submission, the Collaborative consulted our network to capture the lived experiences of multicultural people living and working in these areas. We received responses from healthcare professionals, consumers, carers, and representatives from community organisations. While not representative, responses provide valuable illustrative insights into how systemic barriers are experienced in practice.

Key Recommendations:

1. Expanded pathways to Medicare access for temporary visa holders, people seeking asylum and others with insecure migration status.
2. Increased Medicare support for long consultations addressing complex health needs.
3. Improved Patient Assisted Travel Schemes to reduce barriers to specialist care in rural and remote areas.
4. Expand and appropriately target block funding to support primary care delivery servicing multicultural communities.
5. Multilingual and culturally safe support for MyMedicare enrolment and telehealth access.
6. Reinstate telehealth exemptions for Mental Health Treatment Plan reviews and referrals.
7. Medicare funding and incentives that recognise and improve the quality of interpreter-supported consultations.
8. Funding for community-led health literacy and health system navigation initiatives
9. Greater support for multidisciplinary models of care, including bicultural health navigators and community connectors.
10. Equity monitoring and stress testing of reforms to assess impacts on multicultural communities in rural and regional areas

Background

Australia's migration policy has 'regionalised' migration, increasing the proportion of multicultural populations living in rural and regional areas. However, this shift reflects a broader structural pattern: population growth has not been matched with proportional investment in culturally responsive health services. This misalignment reflects a structural policy gap, where migration settings are not adequately integrated with health system planning, resulting in inequitable access to essential services for multicultural communities in regional Australia.

FECCA, the Collaborative and AMWA's national consultations and policy work have consistently identified that multicultural communities, especially in rural and regional Australia, experience compounded barriers to care. The intersection of rurality with cultural and linguistic diversity creates a "double disadvantage," including lower rates of health literacy, limited English proficiency and greater socioeconomic disadvantage. This intersectional disadvantage is well documented across national and international research, which shows that culturally and linguistically diverse populations in rural areas experience significantly poorer access to care and worse health outcomes compared to both metropolitan multicultural populations and the broader rural population.

Barriers are further heightened for specific groups, including multicultural women, people with disability, older migrants, and people with insecure migration status. Multicultural women experiencing domestic and family violence experience further vulnerabilities, particularly where visa status, financial control and language barriers intersect, further reducing access to culturally safe services and limiting independent access to care.

Multicultural communities in rural and regional areas include temporary migrants, international students, refugees, asylum seekers, and permanent residents, with varying levels of Medicare eligibility. Some temporary visa holders and people with insecure migration status may experience limited, delayed or no effective access to Medicare despite often having complex health needs.

Structural disadvantages, not service design alone, shape health outcomes. Experiences of racism and discrimination within the health system, low trust in institutions, and fears of not being understood or treated fairly can deter multicultural communities from seeking care or maintaining continuity of care. These challenges are compounded by broader social determinants such as housing insecurity, precarious employment, transport barriers and long distances to services, contributing to poorer health outcomes. Greater targeted investment in overcoming these barriers will support a more equitable health system for multicultural communities.

Recommendation 1: Expanded pathways to Medicare access for temporary visa holders, people seeking asylum and others with insecure migration status.

Some temporary visa holders, people seeking asylum and others with insecure migration status may experience limited, delayed or no effective access to Medicare, despite often facing complex health needs. Improving access would reduce delays in care and pressure on hospital services.

Recommendation 2: Increased Medicare support for long consultations

Medicare rebates should recognise the additional time required for consultations with complex health needs, which disproportionately impacts multicultural communities. Expanding Medicare support for longer consultations would reduce out-of-pocket costs for patients already facing significant barriers to care.

Recommendation 3: Improve the Adequacy and Consistency of Patient Assisted Travel Schemes

Improving the adequacy and consistency of patient travel subsidy schemes would reduce barriers to specialist care for multicultural communities in rural and regional areas, particularly for women with caregiving responsibilities or limited financial resources.

Impact of 1 November 2025 Medicare changes

Bulk Billing Incentive Expansion

From November 2025, bulk billing incentives expanded to all Medicare card holders. However, the impact for multicultural patients in rural and regional areas may be limited due to provider shortages and Medicare eligibility barriers.

Many multicultural groups, especially people seeking asylum and refugees in early settlement stages, have complex health needs but are afforded limited or no Medicare coverage. FECCA's work on migration and settlement has highlighted how visa status and prolonged processing times can create sustained exclusion from essential services, including healthcare. During lengthy protection visa processes, some applicants remain ineligible for Medicare. For these groups, affordability remains a major barrier, regardless of incentives.[2] Medicare reforms should also recognise the heightened vulnerability of women on temporary visas experiencing domestic and family violence, particularly where visa status, financial control and language barriers intersect to limit independent access to care. Ensuring that access to Medicare, interpreter support and health navigation is trauma informed irrespective of visa status is paramount to providing equitable healthcare. Without targeted policy responses, current reforms risk reinforcing existing inequities rather than addressing them.

For Medicare-eligible multicultural patients, expanded incentives may still be insufficient. Cost remains a barrier to accessing health services for multicultural patients in rural and regional areas, particularly when bulk billing rates among rural GP clinics are already low. This was echoed by consultation participants, who cited the cost of care, combined with long wait times, limited service availability, transport challenges and lower health literacy further restricting access (see Consultation Question 1).[3]

Many multicultural patients require longer consultations due to interpreter use, higher rates of chronic disease and mental health needs, and complex health histories linked to trauma or disrupted care. These consultations are not adequately reimbursed under current Medicare settings. This creates a misalignment between funding incentives and patient need, ultimately shifting costs to other parts of the system, including emergency care. Expanding support for longer consultations would reduce out-of-pocket costs for patients already facing significant barriers to care.

Current Medicare settings do not adequately reflect the true cost or complexity of delivering care in rural and regional communities. Fee-for-service models and insufficient rebates create strong incentives for shorter, high-volume consultations, which are incompatible with the longer appointments often required when working with interpreters, addressing complex health and social needs, or providing culturally responsive care. These pressures are further compounded by workforce shortages and thin market dynamics in rural areas, limiting provider availability and reducing system flexibility.

Access to specialist and diagnostic care in rural and remote areas also often requires patients to travel long distances to metropolitan or larger regional centres. While Patient Assisted Travel Schemes (PATS) exist to subsidise travel and accommodation costs, these schemes are not designed to fully cover the costs associated with accessing care and vary significantly across jurisdictions. This

[2] Khatri, R.B. & Assefa, Y. (2022). Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. BMC Public Health, 22(880), doi: 10.1186/s12889-022-13256-z

[3] Coumans, J.V.F & Wark, S. (2024). A scoping review on the barriers to and facilitators of health services utilisation related to refugee settlement in regional or rural areas of the host country. *BMC Public Health, 24*(1):199. doi: 10.1186/s12889-024-17694-9

inconsistency creates a postcode-based inequity in access to care, disproportionately affecting multicultural patients with fewer financial and social resources. Many patients still face significant out-of-pocket costs when accessing specialist care, and this is compounded for new migrants with added transportation barriers.

Multicultural women particularly face compounding barriers navigating Australia's health system, including stigma, unfamiliarity with service pathways caregiving responsibilities and added transportation hurdles especially if they do not have a driving license or are dependent on their partners. In situations of coercion or financial control, limited English proficiency can further isolate women from health services and prevent safe disclosure of violence. Without greater investment in reducing barriers to care, women may be unable to communicate their health needs or seek help independently of perpetrators.

Consultation Question 1: What should the Senate Inquiry know about the experiences of multicultural communities with Medicare in rural, regional or remote areas?

"Many people in multicultural regional communities still face real barriers to healthcare, such as long waiting times, limited bulk billing clinics, language barriers and travel distances"

"It is hard to find appropriate and continuity of care, let alone matching with a health provider who has some understanding of culture."

"Multicultural communities in rural, regional, and remote areas often face multiple barriers at the same time, including language difficulties, limited health literacy, transport challenges, and fewer available health services."

"[The Government] should provide more doctors. Sometimes you only get an appointment after long waiting times."

Recommendation 4: Expand and appropriately target block funding to support primary care delivery servicing multicultural communities

Improving the viability of health services in low volume or remote settings through block funding, including thin markets servicing multicultural rural and regional communities, is needed to adequately support comprehensive care for patients with complex needs, such as multicultural patients.

Bulk Billing Practice Incentive Program (BBPIP)

While the BBPIP incentive payment to practices has resulted in some additional uptake of bulk billing in rural and regional areas, reducing barriers to affordable primary health care, additional funding models are needed to ensure the ongoing viability of rural practices.

In many rural and regional communities, particularly those with smaller or more dispersed populations, fee-for-service models alone are insufficient to sustain primary care services. Low patient volumes, workforce shortages, and the increased time required to deliver culturally responsive care create conditions in which standard Medicare funding mechanisms do not adequately support service viability. This is a clear example of a broader structural issue: funding models have not kept pace with population need in rural and regional Australia.

Block funding provides a more stable and appropriate approach in these 'thin market' conditions. While fee-for-service models can incentivise service delivery, they do not adequately support comprehensive, continuous care for patients with complex needs, including multicultural communities who may require longer consultations, interpreter support, and more intensive care coordination.

Recommendation 5: Provide multilingual and culturally safe support for MyMedicare enrolment and telehealth access

Telehealth and Better Access reforms must include multilingual MyMedicare enrolment assistance and culturally appropriate digital navigation support. Without targeted initiatives, digital barriers may further limit access to care for multicultural communities, especially for older migrants with low digital confidence.

Telehealth Changes

Telehealth reforms aim to improve access and continuity of care, including for multicultural communities. For multicultural women, more effective access to telehealth may provide a more accessible pathway to care where gender norms, caregiving responsibilities or concerns about privacy limit their ability to attend in-person services.

However, effective telehealth access is dependent on digital literacy, privacy within the home, language support, confidence using digital platforms and trust in providers and systems. The introduction of MyMedicare registration as a prerequisite for telehealth eligibility may unintentionally disadvantage multicultural communities, who may experience lower levels of digital health literacy and face additional accessibility barriers. Without targeted safeguards, digital-first reforms risk widening the digital divide and excluding those already facing the greatest barriers to care.

This is consistent with FECCA's work with multicultural communities, which has highlighted a higher prevalence of digital exclusion due to language barriers and low trust in online systems when engaging with complex digital platforms.[4] These barriers may constrain equitable access to digital health and government services if reforms do not include targeted support.

Ultimately, while greater access to telehealth services is welcome and needed, particularly for those living in rural and remote areas, telehealth should complement rather than replace appropriate in-person care.

Recommendation 6: Reinstate telehealth exemptions for MHTP reviews and referrals

To ensure equitable access to mental health services for multicultural communities, we recommend reinstating telehealth exemptions for Mental Health Treatment Plan (MHTP) reviews and referrals. This would allow patients to access culturally competent providers, regardless of geographic location or administrative barriers, supporting timely, appropriate, and flexible care pathways.

Better Access Redesign

Multicultural communities experience a disproportionate burden of mental ill-health, and studies indicate this is especially acute for those living in rural and regional areas.[5]

Recent changes to Better Access mean MHTP reviews and referrals must be completed by a GP or medical practitioner with whom the patient has an established clinical relationship, either through the patient's MyMedicare account or a face-to-face visit within 12 months. While intending to strengthen continuity of care, these changes effectively restrict access to telehealth-delivered MHTPs for patients who do not have a stable GP relationship.

Multicultural patients in rural and regional areas may relocate frequently due to housing or employment instability, face barriers enrolling in MyMedicare, or need access to culturally responsive providers who may not be locally available and only accessible via telehealth. One consultation participant noted they have not had the same doctor for more than a year since arriving in Australia thirteen years ago. Limiting telehealth in these contexts reduces equitable access to culturally appropriate mental health services and may delay or prevent timely care. In some cases, these barriers can lead to crisis presentations that could otherwise have been prevented through early intervention.

Long-Acting Reversible Contraception (LARC) rebates

Increased rebates are welcome. However, multicultural women in rural and regional areas may continue to face barriers to sexual and reproductive health care, particularly where culturally safe services are unavailable. Without culturally safe practice, women may delay assessment, disengage from care, or avoid follow-up.

Recommendation 7: Interpreter access integrated into Medicare and increasing funding for interpreting services

Medicare reform should recognise the additional time required for interpreter-supported consultations. Greater funding is also needed to ensure the quality of interpreter services for multicultural patients. These measures would improve communication, enable earlier diagnosis and treatment, reduce avoidable emergency department presentations, and support the financial viability of local practices in rural and regional areas who service multicultural communities.

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[4] FECCA. (2024). Submission into the Communications Legislation Amendment (Combatting Misinformation and Disinformation) Bill 2024. https://fecca.org.au/wp-content/uploads/2025/02/FINAL_Misinformation-and-Disinformation-Submission-2024.pdf

[5] Hawkes, C., Norris, K., Joyce, J. & Paton, D. (2021). Individuals of refugee background resettled in regional and rural Australia: A systematic review of mental health research. Australian Journal of Rural Health, 29(6), 850-864. doi: 10.1111/ajr.12785

Recommendation 8: Support community-led health literacy and health system navigation initiatives

Funding and support for community-led health literacy and health system navigation initiatives in rural and regional areas, delivered through trusted community organisations, is integral to improving health outcomes for multicultural communities.

Financial Sustainability of Independently Owned Rural Practices

Multicultural patients often require longer, interpreter-supported, or more complex consultations, which are not adequately reimbursed under current fee-for-service structures. Evidence suggests that Medicare rebates frequently do not cover the operating costs of primary health care services in rural and regional areas. As a result, practices often absorb the cost of providing care for patients with complex needs.[6]

This issue reflects broader structural funding gaps within rural health systems, which disproportionately impact practices serving patients with more complex and time-intensive care requirements, such as multicultural communities.

In many rural and regional contexts, particularly in smaller or more dispersed communities, fee-for-service models alone are insufficient to sustain service delivery. In these thin market conditions, alternative funding approaches, such as block funding, are necessary to ensure continuity of care (see Recommendation 4).

Contribution of Medicare Settings to Avoidable Emergency Presentations

Barriers to primary care contribute to avoidable emergency department presentations among multicultural communities in rural and regional Australia. Consultation participants highlight language barriers, long wait times, difficulties navigating the health system, limited interpreter availability, and culturally inappropriate services as major barriers to primary healthcare (see Figure 2).

When multicultural communities are unable to access culturally safe and appropriate primary care, conditions may worsen and require more intensive and costly interventions. Improving early access to culturally responsive care is therefore critical not only for equity, but for system efficiency. Failure to address these barriers not only undermines equity but places avoidable pressure on already stretched emergency systems.

These challenges are not isolated but reflect broader structural limitations in rural health funding and workforce distribution, which disproportionately impact communities requiring more complex and culturally responsive care. For all patients, in regions where MBS utilisation declines due to remoteness and lack of access, emergency attendances increase correspondingly.[7] GPs serve as a gateway to allied health services. Therefore, when primary care is lacking, patients are more likely to turn to emergency departments for care.[8] These pressures are compounded for multicultural communities.

Culturally unsafe settings and institutional racism are major drivers of delayed care seeking. Addressing these challenges involves approaches that reflect local contexts and incorporate intersectional experiences, including those of multicultural women, multicultural people living with disability, older migrants, and people with insecure migration status (See Recommendation 9). AMWA's work has also highlighted that, where services are inaccessible or culturally unsafe, migrant and refugee women often absorb gaps through unpaid care, further compounding inequities and delaying engagement with formal health services.[9]

Interpreter-supported care should be recognised as a quality and safety issue rather than simply a communication preference. This is especially true for multicultural women who may be unable to communicate health needs or seek help independently of perpetrators in situations of coercion or financial control. Interpreter services are often available, but provision is insufficient, especially in regional areas.[10] This was highlighted by consultation participants, who described challenges accessing adequate

[6] National Rural Health Alliance. (2026). Pre-budget Submission 2026-27. – Defining Optimal Levels of Access to Primary Health Care in Rural and Remote Australia. https://www.ruralhealth.org.au/policy/submission/defining-optimal-levels-of-access-to-primary-health-care-in-rural-and-remote-australia/

[7] National Rural Health Alliance. (2025). Rural Australians still suffer most from preventable illness: AIHW latest data echoes NRHA call for urgent health reform. https://www.ruralhealth.org.au/media-release/rural-australians-still-suffer-most-from-preventable-illness-aihw-latest-data-echoes-nrha-call-for-urgent-health-reform/

[8] National Rural Health Alliance. (2025). The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia. https://www.ruralhealth.org.au/wp-content/uploads/2025/08/The_Forgotten_Health_Spend_Report_08_2025.pdf

[9] AMWA, NATSIWA, WWDA & WwWA. (2025). Delivering Quality Care More Efficiently. https://fecca.org.au/wp-content/uploads/2025/10/AMWA-NATSIWA-WWDA-WwWA-Delivering-Quality-Care-Submission.pdf

[10] Khatri, R.B. & Assefa, Y. (2022). Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. *BMC Public Health, 22*(880), doi: 10.1186/s12889-022-13256-z

interpreter support and communicating effectively during appointments, including one participant who noted long waiting times for interpreter-supported services. Another participant shared frustration with the quality of services:

> **"My wife utilised an interpreter service, as I couldn't interpret for her due to a conflict of interest. Unfortunately, I was quite disappointed with the experience. The interpreters made several mistakes, which forced me to step in and clarify things for my wife…It's concerning to think about how non-English speaking newcomers might struggle in similar situations. The inaccuracies in translation can pose serious risks, especially when it comes to medical terminology. It's really disturbing to see that the quality of translation services isn't up to par, and this could endanger the well-being of those who rely on them."**

Although the Government-funded Free Interpreting Service covers interpreter fees, interpreter-supported consultations require significantly more time than standard consultations, which is not recognised under the MBS. As a result, the use of interpreter services in consultations with patients who have limited English proficiency are low.[11] For small rural practices operating in thin markets, interpreted consultations generate less revenue under fee-for-service funding. This disincentivises interpreter use, contributing to poor communication, delayed diagnoses and avoidable emergency presentations. Importantly, this gap illustrated how current funding settings fail to account for the realities of an increasingly diverse rural population.

Culturally tailored and translated health campaigns, co-designed with communities, can also help ensure public health initiatives reach multicultural populations, leading to reductions in emergency presentations. This should include targeted campaigns supporting communities with Medicare navigation, MyMedicare enrolment, telehealth access, referral pathways and understanding Medicare rights and entitlements.

Delays in accessing primary care while awaiting Medicare eligibility due to visa status can also lead to worsening health conditions, meaning some patients require more intensive care once coverage becomes available (see Recommendation 1).[12]

[11] Tang, D., Dragoje, V., Wen, L.M. & Taki, S. (2024). The use of interpreter services and its barriers faced by hospital staff when accessing interpreters for patients with low English proficiency during the COVID-19 pandemic. *Health Promotion Journal of Australia,* 35(4), 1184-1193. Doi: 10.1002/hpja.850; Migrant and Refugee Health Partnership. (2020). Interpreter Engagement in General Practice in Australia. https://culturaldiversityhealth.org.au/wp-content/uploads/2020/06/Interpreter-Engagement-in-General-Practice-in-Australia.pdf

[12] Munro, D. & Joyce, N. (2019). An asylum seeker's access to Medicare and associated health services while awaiting determination of a Protection Visa application in Australia. https://www5.austlii.edu.au/au/journals/UNSWLawSocCConsc/2019/8.pdf

Consultation Question 2: How often do you, or people in your family or community, delay or avoid primary care because you cannot get help earlier from a GP, telehealth, or other primary care service?

"Sometimes it takes too long to get an appointment, or I wait until I can go to Melbourne and see someone."

"Many times. The people with language barriers or new arrivals that do not know the system delay or avoid the health system…That is very common."

"Very often. One significant reason for delaying or avoiding primary care is the language barriers that many in the community face when trying to explain their health concerns. When using telephone services, it's common to encounter difficulties due to varying accents…It can feel disheartening when it seems like only certain accents are recognised or understood…This lack of understanding can deter individuals from seeking help, as they may feel their concerns won't be properly conveyed or taken seriously."

Recommendation 9: Greater funding and incentives for culturally safe mixed-team models of care, including allied health, bicultural navigators, and community connector models

Medicare funding, including collaborative commissioning models, should better support multidisciplinary and culturally responsive care in rural and regional settings, including culturally safe allied health services, bicultural workers, multilingual health navigators, community connectors, trauma-informed community-facing staff and culturally responsive grassroots and community-led services that address the specific health needs of multicultural communities. These are critical access enablers in multicultural rural health policy and are often the difference between individuals accessing care early and disengaging from services entirely.

Adequacy of Medicare Support for Mixed-Team Models of Care

Multicultural populations often present with complex physical, psychological and social needs that require multidisciplinary care. However, current Medicare settings do not adequately support accessible and culturally safe mixed-team models of care.

Financial barriers play a significant role in limiting access to allied health services. Even with Medicare eligibility, many services attract high co-payments and have low bulk billing rates. This creates additional barriers to accessing important healthcare services.

A strong theme which emerged from consultation responses was the need for greater cultural safety in healthcare settings (see Consultation Question 3). Medicare funding should support this through greater investment in cultural safety training, bicultural workers, multilingual health navigators, community connectors, and trauma-informed community-facing staff.

Embedding trained multicultural navigators and bicultural community workers within health and community services can help address barriers by providing culturally trusted guidance, early intervention and warm referrals into primary health care. Health navigation roles are particularly valuable in rural and regional areas where services are fragmented and difficult to access. Navigators drawn from multicultural communities can act as cultural mediators between patients and providers, supporting community members to understand Medicare eligibility, access preventative care and engage with health services earlier.

Trusted multicultural grassroots and community-based organisations play a critical role in supporting access to care, particularly in regional areas. These organisations act as critical access infrastructure, particularly for health navigation, trust-building and early intervention. Collaborative commissioning could support these organisations through long-term, adaptable funding arrangements and genuine co-design with community.[13] Sustained investment in these models is not only a matter of equity, but a cost-effective strategy to improve early intervention, reduce system fragmentation and enhance long-term health outcomes.

[13] AMWA, NATSIWA, WWDA & WwWA. (2025). Delivering Quality Care More Efficiently. https://fecca.org.au/wp-content/uploads/2025/10/AMWA-NATSIWA-WWDA-WwWA-Delivering-Quality-Care-Submission.pdf

Consultation Question 3: What changes would make Medicare fairer and better suited to the needs of multicultural communities in regional, rural, or remote Australia?

"Medicare provides a good foundation, many still struggling with cost and cultural barriers that prevent them from getting the care they need early."

"Medicare could be improved for multicultural communities in regional and rural Australia by increasing access to interpreters, expanding funding for allied health services, and attracting more healthcare professionals to underserved areas. Supporting culturally appropriate services would also help ensure patients receive care that meets their language and cultural needs.

"Providing cultural competency training for healthcare providers can help them understand the unique needs and challenges faced by multicultural communities. This would improve communication and foster a more inclusive environment. Expanding access to interpreter services, both in-person and through telehealth, would help non-English speakers effectively communicate their health concerns…Developing health initiatives that are culturally relevant and tailored to the specific needs of diverse communities can promote better health outcomes."

"English should not be the benchmark for evaluating a person's capability or worth. Improvements in cultural sensitivity and understanding could make a substantial difference in patient care."

Recommendation 10: Stress testing for multicultural communities in rural and regional areas

Incorporating multicultural equity indicators into evaluation and reporting would help identify where reforms may be producing inequitable outcomes in practice and ensure accountability for equitable access.

Stress testing for rural, regional and remote communities

While rural stress-testing has been proposed as a mechanism to ensure reforms do not disadvantage rural communities, it is equally important that policy assessments recognise impacts on multicultural communities. The Collaborative's work and research consistently emphasises the need for disaggregated data and equity monitoring across cultural and linguistic diversity to ensure reforms do not inadvertently widen disparities. Reforms should be supported by transparent monitoring of outcomes across remoteness, language background, cultural background and visa status. Without clear accountability mechanisms, there is a risk that reforms may inadvertently entrench or exacerbate existing disparities.

Addressing the social determinants of health

Ultimately, improving health outcomes for multicultural communities in rural, regional and remote Australia requires a holistic policy approach that addresses the social determinants of health alongside Medicare reform. This requires coordinated action across portfolios, including health, migration, housing, employment and social services, rather than siloed policy responses. Factors such as secure employment, accessible transport, stable housing and freedom from systemic racism shape people's ability to access and benefit from health care. Without coordinated action across these areas, improvements to Medicare alone will not fully address the structural barriers affecting multicultural communities. Delivering equitable health outcomes therefore requires sustained, whole-of-government commitment and high-level political leadership.

Conclusion

Multicultural communities are an increasingly important part of the fabric of rural, regional and remote Australia However, the growth of these communities has not been matched by investment in culturally safe, anti-racist and linguistically accessible primary health care. This misalignment reflects a broader structural gap between migration policy and health system planning, resulting in persistent inequities in access, experience and outcomes.

Ensuring equitable Medicare access requires policy settings that recognise the diversity, complexity and intersectional needs of rural populations. This includes addressing the structural barriers faced by multicultural communities, such as language access, visa-related exclusion, workforce shortages, and the limitations of current funding models. Reforms must be deliberately designed with equity at their core, rather than assuming a one-size-fits-all approach to rural, regional and remote healthcare. Without targeted,

structural reform to funding models, workforce distribution, and culturally safe models of care, Medicare will continue to fall short of delivering equitable access for multicultural communities.

There is also a clear need for stronger integration across policy domains. Improving health outcomes for multicultural communities cannot be achieved through Medicare reform alone. It requires coordinated, whole-of-government action across health, migration, housing, employment and social services, alongside sustained investment in community-led approaches that build trust, improve navigation, and support early engagement with care.

Embedding cultural safety, interpreter access, and community-led models within the health system is not only a matter of equity, but a critical component of quality, safety and system sustainability. Failure to act risks exacerbating existing disparities, increasing avoidable emergency presentations, and placing further pressure on an already stretched health system.

FECCA, the Australian Multicultural Women's Alliance and the Australian Multicultural Health Collaborative bring complementary expertise in multicultural policy, lived experience leadership, health system engagement and community consultation. Together, we represent a broad national network of multicultural organisations and community leaders across Australia. We stand ready to work in partnership with the Australian Government to co-design and implement reforms that are equitable, culturally responsive and effective for multicultural communities living in rural, regional and remote Australia.

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