

Rural, regional and remote Medicare access and funding

A Dementia Australia submission

27 March 2026

Introduction

Dementia Australia welcomes the opportunity to provide a submission to the inquiry into rural, regional and remote Medicare access and funding.

As the national peak body for people impacted by dementia, our recommendations seek to improve the experiences and outcomes for the estimated 446,500 people living with dementia and their carers across Australia. This includes the 29,000 people living with young onset dementia (aged less than 65 years) and the 1 in every 2,900 babies born with a condition that causes childhood dementia (1).

As a provider of trusted information, education and support services, more than third of our clients live in regional or remote areas, a clear indicator of the demand for tailored dementia support within and for these communities (2).

Two in three people with dementia are living in the community (1). People living in regional areas are on average older than those in major cities, and experience complex co-morbidities (3). This is combined with ongoing health inequities, exacerbated further for people from First Nations communities. Research consistently indicates that rates of dementia are around three to five times higher in First Nations communities than those of the broader Australian population (1).

Medicare is consequently a critical care pathway for all Australians of all ages living with dementia and particularly in rural, regional and remote Australia.

November 2025 Medicare changes

We do not have sufficient data or feedback from people with living experience to comment on the impact of the November 1 2025 Medicare changes at this early stage. Instead, we have taken the opportunity to provide the Committee with an overview of the range of Medicare funding and access issues that impact people living with dementia, many of which are exacerbated for people living rural, regional and remote areas.

We continue to support ongoing efforts to increase access to bulk billing GP consultations. It is also important to note that although telehealth expansions are valuable, telehealth is not always appropriate for people living with dementia due to barriers using video and phone

technologies. Use is also hampered by poor phone and internet connectivity in some areas. For people living with dementia with more advanced cognitive impairment, telehealth may be inappropriate resulting in increased confusion and disorientation. Access to support people and/or advocates who can provide assistance in getting the most out of technology is essential.

MBS funding must also complement the aged care and disability systems, to avoid further hospital admissions. This includes offering incentives for GPs to provide timely care in residential aged care, to avoid unnecessary ambulance call outs and avoidable hospitalisations.

The issues outlined below address items c,d,f and g of the Committee's terms of reference.

Issues affecting rural, regional and remote Australians living with dementia

Several systemic issues contribute to avoidable emergency department presentations and preventable hospital admissions, as well as poor health and wellbeing for people living with dementia, including:

- Inconsistent assessment, diagnosis and management of dementia
- Limited access to mixed-team models of care, specialist support services and allied health
- Workforce dementia capability
- Workforce capacity remains stretched with low staff retention
- Poor education and low awareness of dementia in the community and amongst healthcare professionals
- Limited accessibility of transport to access specialist services and additional costs for travel time
- Limited availability of culturally appropriate services and supports
- Rapid declines in wellbeing and function and a loss of independence and confidence without appropriate support
- Premature entry into residential care for people who with appropriate Support at Home funding and effective mixed-team models of primary care, could continue to safely live independently.

A carer in regional NSW highlighted a common experience, noting the “shortage of doctors in town”, and that *“Mum would have seen upwards of 8 different doctors from when she was diagnosed until she died...The doctor had little if any understanding of dementia and I feel that in rural and regional Australia this is the norm.”*

Impacts on Medicare

In addition to unmet needs of people living with dementia, current Medicare settings contribute to several key pressures.

Inadequate support to address modifiable risk factors

The 2024 report of the Lancet Commission on dementia prevention, intervention, and care found that addressing 14 modifiable risk factors, starting in childhood and continuing throughout life, could prevent or delay up to 45% of dementia cases globally. These risk factors include: high low-density lipoprotein cholesterol, vision loss, lower levels of education, hearing impairment, high blood pressure, smoking, obesity, depression, physical inactivity, diabetes, excessive alcohol consumption; traumatic brain injury, air pollution and social isolation (4). In Australia, action to address modifiable risk factors could prevent or delay up to 43% of dementia cases (4). Evidence from overseas trials including the FINGER and POINTER trials demonstrates that structured programs combining physical activity, nutrition, cognitive training, and vascular risk management can significantly delay cognitive decline (5). Primary care professionals are critical partners in supporting brain health and dementia prevention, and need to be supported to engage patients in risk identification and reduction in modifiable risk factors. General Practitioners (GPs) want to provide more preventative care but note a lack of time and financial incentives as barriers to them doing so. These pressures are greater in rural and regional areas, where fewer GPs limit access to timely, continuous, and comprehensive care and referral pathways may be more complex (6).

Delayed diagnosis or misdiagnosis

Diagnosing dementia is not a straightforward process and people with dementia, their families and carers often report experiencing a lengthy and distressing diagnosis process. There are over 100 different types or causes of dementia (7). This variation can require several diagnostic tests to determine a correct diagnosis. People with dementia, especially people with young onset dementia, may experience several misdiagnoses before it is confirmed they have dementia.

GPs are most often the first port of call for people with memory concerns and their families. However, there are barriers to the diagnosis of dementia in general practice, including time constraints, diagnostic uncertainty, denial of symptoms and stigma. People living with dementia note that time constraints are a significant barrier as they need time to think and speak. The opportunity to speak with carers to truly understand symptoms and behaviours is also limited given that such consultations are not currently covered by the MBS. In rural, regional and remote communities there are few GPs who remain in a community over time and know their patients, leading to people with dementia reporting to us that they must retell their experiences to new doctors and lose continuity of care.

Limited availability of local specialists and specialist equipment (e.g. PET scans) mean people living in rural, regional and remote locations are less likely to receive a timely diagnosis, with people required to travel significant distances to see specialists. With more than one appointment often needed to confirm a diagnosis of dementia, this places considerable time and financial pressures on people with dementia, their families and carers living in these communities.

Delayed or misdiagnosis results in preventable distress and delayed access to support, education and limited choices for people living with dementia.

Avoidable hospitalisations

People living with dementia are hospitalised at twice the rate of people of similar age without dementia and at 2-3 times greater risk of adverse events once hospitalised (8). An estimated 79% of people aged 85 and over have two or more long-term health conditions (9). Effective earlier management of chronic health conditions, including dementia, can prevent unnecessary hospitalisation, improve quality of life for older people and reduce the burden on Medicare (10).

Preventing admissions also reduces risks of physical deconditioning and exposure to infection, preventing further readmissions or longer hospital stays.

Recommendations

The National Dementia Action Plan 2024-2034 identifies measures to improve equity for regional, remote and rural Australians living with dementia (11). However, no additional investment (including Medicare funding) has been allocated to support delivery. **We urge the Senate Committee to recommend urgent investment into delivering the actions outlined in this plan.** Action 7 (Build capability of the workforce to care and support people living with dementia) and Action 8 (Improve dementia data, maximise the impact of dementia research and promote innovation) are critical to ensuring Medicare is sustainable and stress tested for future changes, given workforce implications and the lack of quality data currently available to best facilitate effective, evidence-based Medicare access and funding decisions.

In addition, we recommend the below reforms to Medicare to expand access to dementia prevention, diagnostic and support services in regional and rural areas:

1. **Improve prevention activity in primary care by addressing appropriate system reform including MBS item number changes.** This could include changes to the definition of chronic disease in MBS item numbers 701,703, 705 and 707 to include dementia as well as the utilisation of MBS practice-based incentives or training for GPs and Practice Nurses.
2. **Improve timeliness and accuracy of diagnosis through primary care including by extending the criteria by which GPs can order Medicare funded MRIs of the brain and/or other emerging diagnostic tests** (e.g. blood biomarkers under evaluation) for suspected mild cognitive impairment and/or dementia.
3. **Increase access to integrated primary health models, including allied health support**, to manage co-morbid chronic conditions and reduce avoidable hospital admissions among people living with dementia.

Dementia Australia also supports the Royal College of General Practitioners call for a **40% increase to Medicare rebates for Level C and Level D consultations** to enable people with complex conditions, such as dementia to receive timely, comprehensive and more affordable access to primary care tailored to their needs.

Conclusion

We thank the committee for their consideration of these issues and welcome further opportunities to discuss these recommendations. The Dementia Australia Policy team can be contacted via policyteam@dementia.org.au

References

1. Dementia Australia. Facts and Figures 2026 [Available from: <https://www.dementia.org.au/about-dementia/dementia-facts-and-figures>].
2. Australian Institute of Health and Welfare. National Dementia Action Plan indicators dashboard 2025 [Available from: <https://www.aihw.gov.au/reports/dementia/ndap-indicators-dashboard/contents/action-1/measure-1-4-dementia-services-rural-areas>].
3. Australian Institute of Health and Welfare. Older Australians 2024 [16 March 2026]. Available from: <https://www.aihw.gov.au/reports/older-people/older-australians/contents/population-groups-of-interest/regional-remote-communities>].
4. Livingston G, Huntley J, Liu KY, Costafreda SG, Selbæk G, Alladi S, et al. Dementia prevention, intervention, and care: 2024 report of the Lancet Standing Commission. *The Lancet*. 2024;404(10452):572-628.
5. Baker LD SH, Espeland MA, Whitmer RA, Kivipelto M, Woolard N, Katula J, Papp KV, Ventrelle J, Graef S, Hill MA, Rushing S, Spell J, Lovato L, Felton D, Williams BJ, Ghadimi Nouran M, Raman R, Ngandu T, Solomon A, Wilmoth S, Cleveland ML, Williamson JD, Lambert KL, Tomaszewski Farias S, Day CE, Tangney CC, Gitelman DR, Matongo O, Reynolds T, Pavlik VN, Yu MM, Alexander AS, Elbein R, McDonald AM, Salloway S, Wing RR, Antkowiak S, Morris MC, Carrillo MC. Study design and methods: U.S. study to protect brain health through lifestyle intervention to reduce risk (U.S. POINTER). *Alzheimer's & Dementia*. 2023;30(2):769-82.
6. (RACGP) RACoGP. General Practice Health of the Nation 2025. East Melbourne; 2025.
7. Dementia Australia. Causes and types of dementia 2025 [16 March 2026]. Available from: <https://www.dementia.org.au/about-dementia/causes-and-types-dementia>].
8. Panayiotou A. Preventing Avoidable Hospital Admissions for People with Dementia – Final Report. Melbourne Ageing Research Collaboration (MARC); 2018.
9. Australian Institute of Health and Welfare. Multimorbidity in Australia. Canberra: AIHW; 2025.

10. North Western Melbourne Primary Health Network. Early interventions for healthy ageing. 2024.

11. Australian Government Department of Health and Aged Care. National Dementia Action Plan 2024–2034. Australian Government Department of Health and Aged Care; 2024/12/05.