



Rural, regional and remote Medicare access and funding

Senate Standing Committees on
Rural and Regional Affairs and
Transport Inquiry

**Submission from the
Aboriginal Medical Services Alliance of
the Northern Territory (AMSANT)**

March 2026



CONTENTS

About AMSANT	3
Executive Summary	4
Recommendations	5
Rural, regional and remote health and Aboriginal and Torres Strait Islander health	6
Aboriginal community controlled health services as essential platforms for improving rural, regional and remote health	7
The need for single-source, long-term grant funding for ACCHSs	9
The need for Medicare administrative systems that are appropriate to the remote context	9
Addressing clinical workforce shortages in rural, regional and remote Australia	11

About AMSANT

The Aboriginal Medical Services Alliance Northern Territory (AMSANT) is the peak body for Aboriginal Community Controlled Health Services (ACCHSs) in the Northern Territory (NT). AMSANT strives to deliver robust policy advice and advocacy to improve Aboriginal health and wellbeing across the NT.

The ACCHSs sector is the largest provider of primary health care to Aboriginal people in the Northern Territory. ACCHSs deliver comprehensive primary health care in an integrated, holistic, culturally secure framework. This holistic approach combines a population health approach with delivering primary care to individuals and action on the social determinants of health. Crucial to effective advocacy, research and policy reform are ACCHSs, being the critical link to current Aboriginal health impacts and outcomes—centring cultural safety and community connection.

Addressing the broader social determinants of health, including housing, poverty, environmental health and social and educational disadvantage, is critical to AMSANT’s core business. Through high level collaborations with the Northern Territory and Commonwealth Governments, AMSANT continues to ensure Aboriginal voices, our member perspectives and community-driven solutions are central to informing culturally safe policy and service delivery.

Throughout this submission, AMSANT chooses to use the term Aboriginal to best reflect the people and communities we directly represent and work with across the NT. We wish to acknowledge with equal respect Torres Strait Islander people as First People of Australia, affirming their enduring sovereignty, cultures and connection to land and sea.

If you require further information in relation to the content of this submission, please contact submissions@amsant.org.au.



This submission addresses the Inquiry's Terms of Reference with a particular focus on Term of Reference (f): reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians.

It also addresses Terms of Reference (a), (c), (d) and (e), with specific reference to the Northern Territory context and the role of ACCHSs in delivering primary health care to rural, regional and remote communities.

Executive Summary

There is a clear gradient in health between those living in rural, regional and remote areas and those in Australia's major cities. However, much of this gap in health outcomes is due to the higher proportion of Aboriginal and Torres Strait Islander people living in these areas compared to those living in urban Australia. Accordingly, effectively addressing the health gap between the cities and rural, regional and remote areas means addressing the health gap between Aboriginal and Torres Strait Islander communities and non-Indigenous Australia.

ACCHSs are the key platform for improving Aboriginal and Torres Strait Islander health, and hence the health of rural, regional and remote Australia. ACCHSs currently provide two-thirds of the total Aboriginal primary health client contacts in the Northern Territory and have played a key role in driving Aboriginal health gains in the jurisdiction. While set up 'by Aboriginal people and for Aboriginal people', many ACCHSs in the Northern Territory service non-Indigenous clients in the regions they operate, either because those clients are part of an Aboriginal family or because ACCHSs become the service of last resort for primary health care in remote areas where for-profit private general practice models fail.

Fundamental to the success of the ACCHS model has been our mixed-mode funding model, combining grant funding (predominantly from the Australian Government Department of Health and Aged Care) with Medicare claiming and access to the Pharmaceutical Benefits Scheme via Section 100. The grant funding provide a stable base for our multidisciplinary primary health care teams including General practitioners, nurses, Aboriginal Health Practitioners and allied health professionals. However, Medicare funding (which provides around 8% of ACCHS funding in the Northern Territory) is an essential supplement to fill gaps in service provision and provide flexibility.

However, while the mixed-mode funding model is essential to the success of ACCHSs, it has a number of weaknesses, especially regarding the fragmentation and complexity of grant funding, and Medicare system design that often does not fit with the lived realities of Aboriginal life and the remote context.

In addition, access to Medicare funding and the delivery of primary health care service require the presence of a clinical workforce. In the Northern Territory shortages of key primary health care professionals including doctors threaten to undermine the gains made in recent years and make access to vital Medicare funds increasingly difficult.

Recommendations

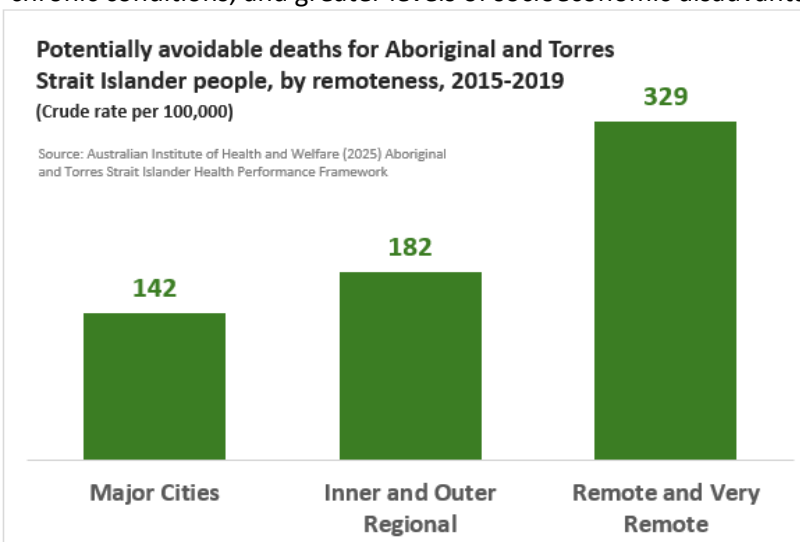
1. That the Inquiry recognizes that addressing the health of rural regional and remote areas requires a focus on Aboriginal and Torres Strait Islander health, given that a significant proportion of the health gap between rural regional and remote areas and the major cities is due to the higher proportion of Aboriginal and Torres Strait Islander people in those areas, and the fact that Aboriginal and Torres Strait Islander health significantly declines with remoteness.
2. That the Inquiry recognizes the key role of Aboriginal community controlled health services in improving health in rural regional and remote Australia, particularly as successful platforms the delivery of primary health care services and their role as stable and established platforms for accessing Medicare funds for those in these areas.
3. That the Australian Government commits to establishing a statutory 'Aboriginal Health Authority of the Northern Territory' to provide single-source long-term grant funding for all ACCHSs in the Northern Territory on the basis of need in order to reduce funding fragmentation.
4. That the Australian Government reclassify ACCHS clinics providing services to communities with no immediate access to a hospital as 'multi-purpose centres' that provide 24-hour emergency and other hospital-level care, to allow them to access hospital activity based funding from the Australian Government.
5. That the Australian Government addresses the systemic challenges of Medicare's Assignment of Benefits in Aboriginal primary health care by formally confirming the existing exemption for all Aboriginal community controlled health services from the requirements for individual patient signature for each claim, recognising the low risk of Medicare fraud in these settings and the high administrative burden this requirement puts upon service providers in an environment marked by high patient mobility, low literacy and high biographic variation.
6. That the Australian Government simplifies and integrates Medicare administrative systems (including supporting their integration with commonly used Client Information Systems) to ensure they are fit for purpose in remote and very remote contexts.
7. That the Australian Government allows Aboriginal and Torres Strait Islander people in MM6 and MM7 regions to be registered for MyMedicare with more than one Aboriginal community controlled health service to take account of high levels of client mobility and the need for integrated care.
8. That the Australian Government to address the supply of overseas trained and non-vocationally registered doctors to work in remote areas by reversing the July 2022 decision to allow these professionals to work in MM1 and MM2 areas, and to allow them to access unfilled GP training places in the Northern Territory. MM1 and MM2 areas where there is a specific identified need should still be eligible to recruit overseas trained and non-vocationally registered doctors. Aboriginal community controlled health service should be automatically considered 'in need' so this change does not disadvantage our sector in these regions.
9. That the Australian Government in collaboration with the State and Territories and meaningful input from our sector, to develop an international migration campaign with streamlined approval processes specifically for remote primary health care. This should focus on developed countries given the ethical challenges of recruiting from developing countries. Generous

relocation packages and sign on bonuses will be required given the intense competition for health professionals globally and within Australian state health systems.

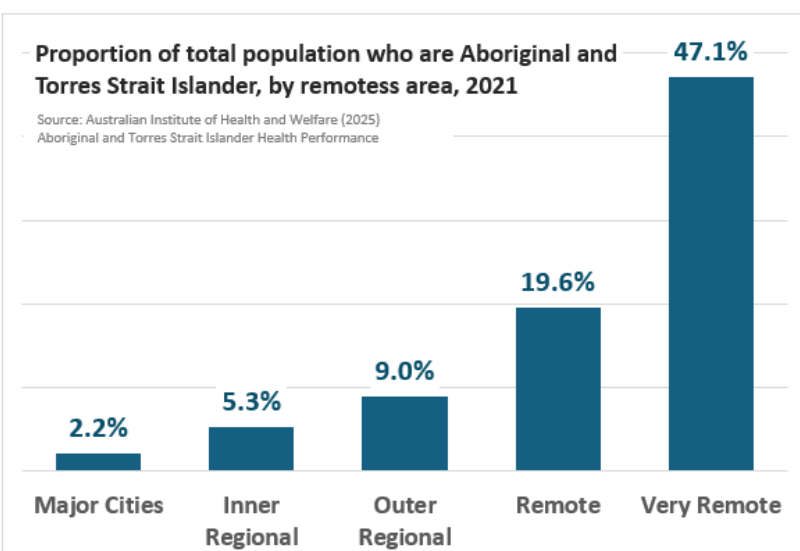
10. That the Australian Government introduce retention payments for remote area nurses after 12 months of service, mirroring the Commonwealth payments already in place for doctors, scaled for MM6 and MM7 locations.
11. That the Australian Government address maldistribution and over-specialisation of General Practitioners, including through geographic restriction of Medicare provider numbers such that new practitioners could not access Medicare from locations which were already well supplied with doctors.

Rural, regional and remote health and Aboriginal and Torres Strait Islander health

There is a clear gradient in health between those living in rural, regional and remote areas and those in Australia’s major cities. Rates of preventable disease and avoidable hospitalisations are higher as remoteness increases, with significantly higher mortality rates in very remote areas compared with major cities¹. These disparities are the result of reduced access to health services, higher rates of chronic conditions, and greater levels of socioeconomic disadvantage².



A large part of the health gap between the cities and rural, regional and remote Australia is due to the much greater proportion of Aboriginal and Torres Strait Islander people who bear an increasing burden of disease as remoteness increases.



As a result of the processes of colonisation, Aboriginal and Torres Strait Islander people bear a much greater burden of ill health and mortality than non-Indigenous Australians. This becomes greater with remoteness: for example, potentially avoidable deaths for Aboriginal and Torres Strait Islander people in remote areas are almost two-and-a-half times higher for those in remote and very remote areas compared to those in major cities³.

Aboriginal and Torres Strait Islander people also make up a much greater proportion of the population as remoteness increases. While Aboriginal and Torres Strait Islander people make up only 2.2% of the population in the major cities, they are almost one half (47.1%) of the population in very remote areas⁴.

These two facts together tell a clear story: **effectively addressing the health gap between the cities and rural, regional and remote areas means addressing the health gap between Aboriginal and Torres Strait Islander communities and non-Indigenous Australia.**

While this is true for all of Australia, it is particularly relevant for the Northern Territory which is entirely outer regional (60% of the population), remote (21%) or very remote (19%)⁵.

RECOMMENDATION 1. *That the Inquiry recognises that addressing the health of rural regional and remote areas requires a focus on Aboriginal and Torres Strait Islander health, given that a significant proportion of the health gap between rural regional and remote areas and the major cities is due to the higher proportion of Aboriginal and Torres Strait Islander people in those areas, and the fact that Aboriginal and Torres Strait Islander health significantly declines with remoteness*

Aboriginal community controlled health services as essential platforms for improving rural, regional and remote health

ACCHSs are the key platform for improving Aboriginal and Torres Strait Islander health, and hence the health of rural, regional and remote Australia.

ACCHSs provide a comprehensive model of primary health care that goes beyond the treatment of individual clients for discrete medical conditions to include population health programs including health promotion and prevention; public health advocacy and intersectoral collaboration; a focus on cultural security; participation in local, regional and system-wide health planning processes; structures for community empowerment, engagement and control; and significant employment of Aboriginal people.

ACCHSs currently provide two-thirds of the total Aboriginal primary health client contacts in the Northern Territory⁶, and have been central to achieving improvements in health outcomes over the last two decades. While the health gap remains unacceptably high, this includes a 9 year increase in life expectancy for men (from 56.6 years in 1999 to 65.6 years in 2018) and almost 5 years for women (from 64.8 to 69.7 years over the same period)⁷.

The evidence of the effectiveness of ACCHSs in addressing Aboriginal and Torres Strait Islander health has led to their recognition in government policy at the highest levels. The *National Agreement on Closing the Gap*⁸, signed by all Australian Governments, includes a commitment to ensuring:

... a strong and sustainable Aboriginal and Torres Strait Islander community-controlled sector delivering high quality services to meet the needs of Aboriginal and Torres Strait Islander people across the country [Priority Reform Two – Building the Community Controlled Sector].

While set up 'by Aboriginal people and for Aboriginal people', many ACCHSs in the Northern Territory service non-Indigenous clients in the regions they operate, either because those clients are part of an

Aboriginal family or because ACCHSs become the service of last resort for primary health care in remote areas (see below). Overall, ACCHSs in the Northern Territory have a non-Indigenous client population of over 7,300 people (12% of the total client population, and provide them with almost 50,000 episodes of care per year⁹.

ACCHSs therefore benefit not just Aboriginal people but the non-Indigenous community as well.

Fundamental to the success of the ACCHS model has been our mixed-mode funding model, combining grant funding (predominantly from the Australian Government Department of Health and Aged Care) with Medicare claiming and access to the Pharmaceutical Benefits Scheme via Section 100.

The grant funding provide a stable base for our multidisciplinary primary health care teams including General partitioners, nurses, Aboriginal Health Practitioners and allied health professionals. However, Medicare funding (which provides around 8% of ACCHS funding in the Northern Territory) is an essential supplement to fill gaps in service provision and provide flexibility. This model provides an essential balance between stability and flexibility, with a number of essential benefits especially in the rural, regional and remote context:

- primary care service delivery in remote and regional contexts where fee-for-service private general practice models fail
- provision of multidisciplinary care based on teams of salaried General Practitioners, nurses, Aboriginal Health Practitioners and allied health professionals
- care provided at no cost to the client in regions marked by economic disadvantage
- a focus on health promotion and public health that is often not possible in solely fee-for-service models (with ACCHSs playing a leading role in responding to the COVID-19 pandemic and keeping all people in remote, rural and regional Australia safe)
- provision of appropriate care in cross-cultural environments marked by high burdens of illness and especially chronic disease, where client consultations are significantly greater than those in urban, mainstream services.

However, while the mixed-mode funding model is essential to the success of ACCHSs, it has a number of weaknesses, especially regarding:

- the fragmentation of grant funding, and
- Medicare system design that often does not fit with the lived realities of Aboriginal life and the remote context.

RECOMMENDATION 2. That the Inquiry recognises the key role of Aboriginal community controlled health services in improving health in rural regional and remote Australia, particularly as successful platforms the delivery of primary health care services and their role as stable and established platforms for accessing Medicare funds for those in these areas

The need for single-source, long-term grant funding for ACCHSs

Despite the importance of the ACCHS sector in delivering primary health care in the Northern Territory, grant funding for the sector is highly fragmented, leading to high levels of administrative overburden.

A recent funding mapping study conducted on behalf of the Northern Territory Aboriginal Health Forum found that the way Aboriginal primary health care is funded wastes resources, hinders effectiveness, and fails to distribute funding fairly. In particular, the system places an extraordinary administrative burden on AMSANT members, each of whom has on average 35 grants, each of which requires an average of 4 reports and acquittals per year (totalling 140 reports per ACCHS per year)¹⁰.

Single-source, long-term grant funding for ACCHSs in the NT is needed to address the challenges of this funding fragmentation. This includes establishing an Aboriginal Health Authority of the Northern Territory. This would be a Commonwealth statutory body that would pool all Aboriginal primary health care grant funding from both Australian and Northern Territory Government sources, and distribute it equitably to all ACCHSs on the basis of need in single-source, long-term block funding agreements.

In addition many ACCHSs in very remote areas provide emergency care (including overnight stays in the clinic) to their communities 24 hours a day, 7 days a week. This is comparable to hospital care and outside the model of care provided by mainstream primary health care. This needs to be factored into funding levels. This is additional to the urgent care (immediate, non-emergency medical care for illnesses and injuries that don't require an emergency department presentation) provided by all ACCHS including ACCHSs in remote towns such as Alice Springs, Tennant Creek, Katherine and Nhulunbuy.

RECOMMENDATION 3. *That the Australian Government commits to establishing a statutory 'Aboriginal Health Authority of the Northern Territory' to provide single-source long-term grant funding for all ACCHSs in the Northern Territory on the basis of need in order to reduce funding fragmentation.*

RECOMMENDATION 4. *That the Australian Government reclassify ACCHS clinics providing services to communities with no immediate access to a hospital as 'multi-purpose centres' that provide 24-hour emergency and other hospital-level care, to allow them to access hospital activity based funding from the Australian Government.*

The need for Medicare administrative systems that are appropriate to the remote context

ACCHSs in the Northern Territory depend on Medicare revenue as an essential component of their mixed-mode funding model.

Unlike fee-for-service private general practice, this revenue is not directed to individual clinicians but flows to the organisation and is reinvested into service delivery for the community. The integrity and accessibility of Medicare administrative systems is therefore not a matter of individual practitioner compliance but of organisational sustainability and community health outcomes.

Assignment of Benefits

Since the 1990s, ACCHSs operating in MM6 and MM7 areas have operated under an Australian Government exemption from the requirement for individual patient signatures on Medicare bulk billing claims. A parallel exemption has applied to pathology ordering, allowing nurses in remote settings to order pathology using a doctor's provider number via a bulk assignment request form, without requiring the signature of either the treating doctor or the patient.

These exemptions were established in recognition of the realities of remote Aboriginal primary health care: high client mobility between communities, high rates of low literacy, significant biographic variation (including multiple names and inconsistent identifying information), and the clinical and logistical impracticality of obtaining individual signatures in high-volume, multidisciplinary care environments. They have underpinned the day-to-day operation of remote ACCHSs for over two decades and are embedded in the Communicare client information system used by the majority of NT ACCHSs. However, we understand that a new compliance system to commence on 1 July 2026 may put this long-established practice at risk.

The changes mentioned above were introduced primarily as an integrity measure to protect against Medicare fraud. AMSANT strongly supports the integrity of the Medicare system. However, individual patient signature requirements are a disproportionate and ineffective response to fraud risk in the ACCHS context.

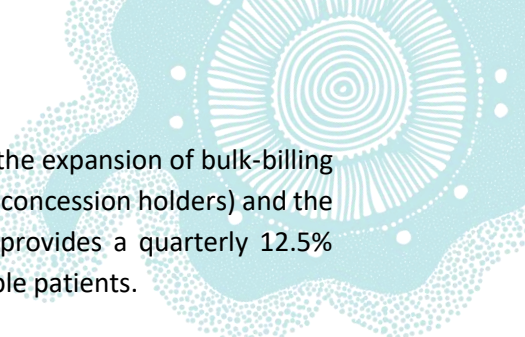
ACCHSs are systematic under-utilisers of Medicare relative to mainstream general practice, and existing longitudinal data held by Services Australia already provides a proportionate mechanism for identifying anomalous claiming patterns. ACCHSs are also incorporated bodies with established internal financial accountability and governance obligations that go well beyond private general practice — including annual external financial audits, anti-fraud policies, whistleblower protections, and internal Medicare auditing by dedicated MBS staff. Critically, Medicare revenue in ACCHSs flows to the organisation and community rather than to individual clinicians, with ACCHS doctors working as salaried employees with significantly reduced personal financial incentive to over-claim.

For these reasons, to remove any doubt, the Assignment of Benefit exemption should be formally confirmed for all ACCHSs, noting that many of these operating in non-remote areas (for example, Darwin which is classified as MM2 or regional centre) face similar issues with their client base, many of whom are themselves visiting from remote areas.

RECOMMENDATION 5. That the Australian Government addresses the systemic challenges of Medicare's Assignment of Benefits in Aboriginal primary health care by formally confirming the existing exemption for all Aboriginal community controlled health services from the requirements for individual patient signature for each claim, recognising the low risk of Medicare fraud in these settings and the high administrative burden this requirement puts upon service providers in an environment marked by high patient mobility, low literacy and high biographic variation.

Other Medicare administrative systems challenges

In January 2022, the Rural Bulk Billing Incentives (RBI) introduced higher Medicare payments for bulk-billed services in rural and remote areas for sites from MM2 (regional centres) through to MM7 (very remote communities).



From November 2025, two further significant changes were introduced: the expansion of bulk-billing incentive eligibility to *all* Medicare-eligible patients (not just children and concession holders) and the creation of the Bulk Billing Practice Incentive Program (BBPIP), which provides a quarterly 12.5% incentive if a service bulk bills every eligible service for all Medicare-eligible patients.

AMSANT welcomes recent Medicare reforms which have the potential significantly increase Medicare funds flowing to ACCHSs, which are then re-invested into service delivery. However ACCHSs operate in some of the most complex environments in the country – geographically, culturally, clinically and administratively – and the failure of Medicare’s administrative systems to take this into account means that the benefits of these reforms may not be fully realised, especially in very remote contexts.

In particular, our members note:

- complex compliance systems that are not integrated with the most commonly used Client Information System used by ACCHSs in the Northern Territory (Communicare)
- digital fragmentation across PRODA, PIP, WIP, AIR, HPOS and MyMedicare systems
- frequent Medicare claim rejections and the requirements for repeated MyMedicare patient re-registrations due to the social and cultural context where clients have multiple names, high mobility between communities and high biographic variation
- the difficulty of recruiting and retaining skilled administrative staff with relatively few Aboriginal people in remote and very remote areas having the literacy and numeracy to undertake complex administrative tasks. As a result, responsibility frequently falls upon clinicians, placing an unnecessary administrative burden on them and taking them away from the delivery of care.
- a high reliance on locum doctors in remote and very remote settings (see section on *Workforce* below), limited time and systems for correctly linking and registering each of these for the purpose of BBPIP.

RECOMMENDATION 6. That the Australian Government simplifies and integrates Medicare administrative systems (including supporting their integration with commonly used Client Information Systems) to ensure they are fit for purpose in remote and very remote contexts.

RECOMMENDATION 7. That the Australian Government allows Aboriginal and Torres Strait Islander people in MM6 and MM7 regions to be registered for MyMedicare with more than one Aboriginal community controlled health service to take account of high levels of client mobility and the need for integrated care.

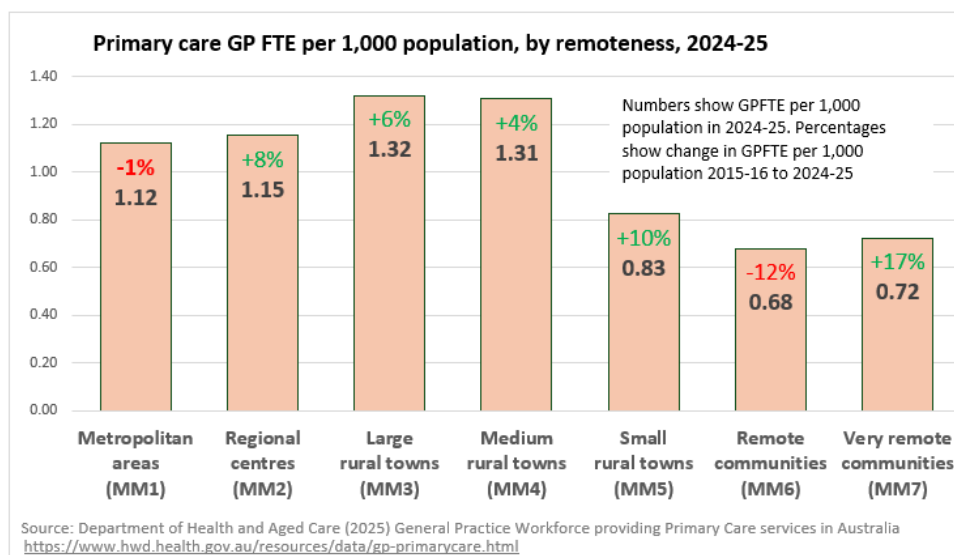
Addressing clinical workforce shortages in rural, regional and remote Australia

Access to Medicare funding, as well as the delivery of grant-funded primary health care services, requires the presence of a clinical workforce. However, in the Northern Territory the health gains

of the last twenty years are under threat due to shortages of key primary health care professionals, including doctors.

While the health needs of communities increase with remoteness, unfortunately the distribution of the medical workforce trends in the opposite direction: doctors tend to be concentrated in the cities, regional centres and medium to large rural towns¹¹. The rate of General Practice Full Time Equivalent (FTE) positions in remote (MM6) and very remote (MM7) areas are around half that of the best-supplied areas of Australia. While the rate of GPs per population is increasing in most areas, there is significant concern about the declining rate of these health professionals in remote (MM6) areas, which has fallen by 12% in the decade between 2015-16 and 2024-25 (see graph)¹².

AMSANT members continue to report severe difficulty in recruiting doctors, and a consequent high reliance on locums. The July 2022 decision to allow International Medical Graduates to work in MM1 and MM2 areas as part of their visa requirements had an




immediate negative effect on the capacity of the Northern Territory to recruit doctors.

The shortages are forcing primary health care services to Aboriginal communities to close clinics or reduce opening hours. The long-term effects may be worse as the shortages drive greater focus on immediate care (acute medicine) at the expense of chronic disease management and illness prevention, where the long-term health gains are to be made.

Unless these shortages in the primary health care workforce are addressed as a matter of urgency, the health gains led by Aboriginal primary health care services in the Northern Territory will stall or even reverse.

AMSANT has developed a suite of potential solutions focused on the needs of primary health care in the Northern Territory. These were presented to the *Northern Territory Primary Health Care Workforce Summit* on 23 August 2023 in Alice Springs, attended by Assistant Ministers Malarndirri McCarthy and Ged Kearney and [a copy accompanies this paper](#).

Many of the twenty recommendations proposed are still relevant, but of these we identify the following priorities for immediate action.



RECOMMENDATION 8. *That the Australian Government to address the supply of overseas trained and non-vocationally registered doctors to work in remote areas by reversing the July 2022 decision to allow these professionals to work in MM1 and MM2 areas, and to allow them to access unfilled GP training places in the Northern Territory. MM1 and MM2 areas where there is a specific identified need should still be eligible to recruit overseas trained and non-vocationally registered doctors. Aboriginal community controlled health service should be automatically considered 'in need' so this change does not disadvantage our sector in these regions.*

RECOMMENDATION 9. *That the Australian Government in collaboration with the State and Territories and meaningful input from our sector, to develop an international migration campaign with streamlined approval processes specifically for remote primary health care. This should focus on developed countries given the ethical challenges of recruiting from developing countries. Generous relocation packages and sign on bonuses will be required given the intense competition for health professionals globally and within Australian state health systems.*

RECOMMENDATION 10. *That the Australian Government introduce retention payments for remote area nurses after 12 months of service, mirroring the Commonwealth payments already in place for doctors, scaled for MM6 and MM7 locations.*

RECOMMENDATION 11. *That the Australian Government address maldistribution and over-specialisation of General Practitioners, including through geographic restriction of Medicare provider numbers such that new practitioners could not access Medicare from locations which were already well supplied with doctors.*

References

- ¹ Australian College of Nursing. *Improving health outcomes in rural and remote Australia: Optimising the contribution of nurses*. 2018; Available from: <https://www.acn.edu.au/wp-content/uploads/position-statement-discussion-paper-improving-health-outcomes-rural-remote-australia.pdf>
- ² National Rural Health Alliance. *Rural Health in Australia Snapshot 2025*. 2025; Available from: <https://www.ruralhealth.org.au/rural-health-in-australia-snapshot/>
- ³ Australian Institute of Health and Welfare. *Aboriginal and Torres Strait Islander Health Performance Framework*. 2025; Available from: <https://www.indigenoushpf.gov.au/>.
- ⁴ Australian Institute of Health and Welfare. *Aboriginal and Torres Strait Islander Health Performance Framework*. 2025; Available from: <https://www.indigenoushpf.gov.au/>.
- ⁵ Northern Territory Department of Treasury and Finance (2026) Northern Territory Economy: Population. Available: <https://nteconomy.nt.gov.au/fast-facts/population>
- ⁶ Trends in the Northern Territory Aboriginal Health Key Performance Indicators, 2010 to 2021. <https://digitallibrary.health.nt.gov.au/prodjsmui/bitstream/10137/12549/1/Northern%20Territory%20Aboriginal%20Health%20Key%20Performance%20Indicators%20Report%202010-2021.pdf>
- ⁷ Zhao, Y., et al., *Improved life expectancy for Indigenous and non-Indigenous people in the Northern Territory, 1999–2018: overall and by underlying cause of death*. Medical Journal of Australia, 2022. **217**(1): p. 30-35
- ⁸ Australian Government. *National Agreement on Closing the Gap (July 2020)*. <https://www.closingthegap.gov.au/national-agreement-closing-gap-glance>
- ⁹ Figures from 2025 Northern Territory Aboriginal Health KPI reports.
- ¹⁰ Burgess P and Haal K 2026 *Mapping of 2023/24 Northern Territory (Summary of Project Findings) Primary Health Care Funding*. Northern Territory Health Forum Available from: <https://digitallibrary.health.nt.gov.au/entities/publication/5299636a-f50b-4285-925d-355baa405069>
- ¹¹ Many national datasets do not fully capture the complexity of the health workforce in remote and very remote areas, where the reliance on locums, fly-in fly-out clinicians, high turnover, and the delivery of care through salaried positions under grant funded models, can distort estimates of the workforce available.
- ¹² Department of Health and Aged Care (2025) General Practice Workforce providing Primary Care services in Australia. Available: <https://www.hwd.health.gov.au/resources/data/gp-primarycare.html>