

# Submission To Senate Inquiry – Rural, Regional and Remote Medicare Access and Funding

## Submission to the Senate Community Affairs References Committee

### Inquiry into Rural, Regional and Remote Medicare Access and Funding

**Submitted by:** David Murtagh, Simbani Research Pty Ltd

**Location:** Rural Darwin, Northern Territory

**Professional background:** Medical informatics; remote and rural health systems

#### 1. Introduction and context

I make this submission as a resident of rural Darwin and as a health informatics professional who has worked extensively across very remote parts of the Northern Territory. My experience spans more than three decades supporting frontline clinicians, Aboriginal Community Controlled Health Organisations (ACCHOs), government health services, and visiting providers through the design, implementation and operation of digital health systems in some of Australia's most resource-constrained settings. For approximately 11 years, I was directly involved in the development and implementation of the Northern Territory Shared Electronic Health Record (the NT Shared Health Record), prior to and during the creation of My Health Record (MHR). This work provided sustained, ground-level exposure to how Medicare rules, funding incentives, workforce shortages, inter-organisational collaboration and digital infrastructure intersect in real-world remote care delivery.

My submission focuses on how current and proposed Medicare settings affect access, sustainability, and the quality of care in rural, regional, and remote Australia, with particular emphasis on telehealth, team-based models of care, and the unintended consequences of rules designed primarily for metropolitan practice environments.

The submission argues that current Medicare settings, and recent or proposed changes affecting rural, regional and remote Australia, continue to be shaped by metropolitan assumptions that do not reflect the operational realities of remote healthcare delivery. In remote contexts, Medicare policy stability, telehealth flexibility, and support for mixed-team models of care are critical.

Key concerns include:

- The impact of restrictive telehealth settings on continuity of care.
- The financial fragility of independently owned, rural practices using activity and throughput-focused funding models; and

- Medicare rules that limit Nurse Practitioners' ability to practise to full scope.

In the Northern Territory, these constraints directly contribute to delayed care, avoidable emergency department presentations, and preventable hospital admissions, often involving costly aeromedical retrievals.

My submission highlights the importance of mixed-team models of care in rural and remote communities, where Nurse Practitioners, Remote Area Nurses, Aboriginal Health Practitioners, allied health professionals and visiting specialists form the backbone of service delivery. Two reforms are identified as having immediate, high-impact benefits: removal of the 12-month face-to-face requirement for Nurse Practitioners and enabling Nurse Practitioners to directly refer patients to allied health services.

From a digital health perspective, the submission emphasises that continuity of care in high staff turnover, remote environments depend on automated information sharing, not GP's memory of a patient's conditions and personal circumstances. Experience with the NT Shared Health Record demonstrated that automatic upload of health summaries was critical to clinical uptake and safety, a lesson that should inform future Medicare-linked digital policy design.

Finally, the submission notes that uniform Medicare rules have unequal effects. Large corporate providers are better able to absorb compliance costs and adapt to frequent policy changes, while small rural clinics face increased financial risk. Without mandatory rural, regional and remote stress-testing of Medicare reforms, changes intended to improve efficiency may inadvertently reduce access and increase downstream hospital costs.

I recommend targeted reforms to ensure Medicare is fair, workable and sustainable for rural, regional and remote Australians, including permanent telehealth settings based on geography, full scope-of-practice recognition for Nurse Practitioners, explicit support for mixed-team care, and systematic rural impact assessment of all future Medicare changes.

## **2. Impact of the 1 November 2025 Medicare changes on access to primary care and telehealth**

From a remote and very remote perspective, Medicare policy stability is as important as Medicare funding levels. Sudden or poorly tested changes disproportionately affect communities with few alternative providers, limited transport options, and fragile service viability.

Telehealth is not a convenience in remote Australia; it should be a core clinical infrastructure. Any tightening of telehealth eligibility, frequency, or provider rules directly translates into delayed care, missed follow-up, reduced collaboration between healthcare providers and increased reliance on emergency departments. In communities where fly-in/fly-out clinicians rotate frequently, continuity of care often depends on remote review supported by complete, shared medical records and telehealth.

Policies that implicitly assume regular face-to-face access fail to account for:

- Seasonal road closures and weather isolation
- Workforce vacancies and high turnover
- Many communities have no resident healthcare professionals

Medicare changes that reduce telehealth flexibility risk undoing gains made since 2020, particularly for chronic disease management, mental health follow-up, and post-discharge care.

### **3. Financial sustainability of independently owned rural general practices and small community-controlled healthcare providers**

Small rural practices operate under fundamentally different conditions from metropolitan or corporate-owned clinics. They face:

- Higher per-patient operating costs
- Smaller and more complex patient populations
- Limited ability to cross-subsidise services
- Dependence on short-term workforce solutions

Current Medicare funding and incentive structures often reward throughput and standardised service models, which favour large corporate providers with scale, centralised administration and sophisticated billing systems.

In contrast, community-embedded rural practices provide:

- Informal care coordination, which is not billable under Medicare
- Cultural brokerage and long-term relationship building
- Crisis response because there are no other services available

Without Medicare settings that explicitly recognise these roles, independent rural practices remain financially fragile despite delivering high public value.

### **4. Avoidable emergency presentations and preventable hospital admissions**

In the Northern Territory, the link between primary care access and hospital demand is direct and observable. When Medicare rules restrict who can provide care, how care can be delivered, or how often patients can be reviewed, the system shifts pressure downstream to emergency departments.

Common drivers of avoidable hospital use include:

- Delayed follow-up due to Medicare restrictions
- Inability of Nurse Practitioners to practice to full scope
- Fragmented care caused by poor information sharing

These issues are magnified in remote settings where hospitalisation often involves aeromedical retrieval at extreme cost.

### **5. Adequacy of Medicare support for mixed-team models of care**

Effective remote healthcare depends on mixed-team models, not GP-only care. In many NT communities, Nurse Practitioners, Remote Area Nurses, Aboriginal Health Practitioners, allied health professionals and visiting specialists are the primary care workforce.

Two specific Medicare settings warrant urgent reform:

### **5.1 Removal of the 12-month face-to-face rule for Nurse Practitioners**

Reinstating or maintaining face-to-face requirements for Nurse Practitioners disproportionately harms remote patients who may not see a GP for months at a time. In practice, this rule constrains access rather than protecting quality.

Allowing Nurse Practitioners to provide ongoing care, including via telehealth, without arbitrary face-to-face reset requirements would immediately improve continuity and access.

### **5.2 Allowing Nurse Practitioners to directly refer to allied health**

Preventing Nurse Practitioners from directly referring to allied health services creates unnecessary duplication, delays and costs. In remote areas, it often means no referral occurs at all.

Allowing direct referral would better reflect actual team-based care models and reduce avoidable escalation to hospital services.

## **6. Digital health, shared records and continuity of care**

The NT Shared Health Record demonstrated that automatic upload of health summaries was critical to success. Clinicians did not have time to manually curate records, particularly in high-turnover environments.

This design choice enabled:

- Continuity across rotating clinicians
- Safer after-hours and emergency care
- Reduced reliance on patient recall

As Medicare increasingly relies on digital workflows, policy must recognise that automation is essential in remote contexts. Systems that depend on optional or manual clinician behaviour will fail in high-pressure, under-resourced environments.

## **7. Impacts of Medicare rules on corporate providers versus rural clinics**

Corporate providers are better positioned to adapt to frequent Medicare changes, absorb compliance costs, and optimise billing. Small rural clinics cannot.

Uniform Medicare rules therefore have non-uniform effects. Without rural-specific safeguards, changes intended to improve efficiency can accelerate market exit by small providers, reducing local access and increasing long-term system costs.

## **8. Recommended reforms**

I recommend that the Committee consider:

1. Mandatory rural, regional and remote pilot-testing of all Medicare changes prior to implementation
2. Permanent telehealth settings that recognise geographic isolation, not just pandemic conditions
3. Full scope-of-practice Medicare recognition for Nurse Practitioners, including referral rights
4. Funding models that explicitly support mixed-team and community-embedded care
5. Medicare recognition of care coordination and continuity activities by mandatory use of My Health Record in remote practice

6. Alignment of Medicare policy with digital health realities, including automated information sharing
7. Urban based healthcare providers should be incentivised to provide telehealth services to people from remote areas.

## **9. Closing remarks**

Medicare remains one of Australia's most important institutions. However, its settings continue to reflect metropolitan assumptions that do not hold in rural, regional and remote Australia. Policy makers need to listen to the people who use healthcare services in remote Australia. Without deliberate design for remote contexts, well-intentioned reforms risk widening inequity, increasing hospital demand, and undermining the sustainability of the services communities rely upon.

I appreciate the opportunity to contribute to this inquiry and would be happy to provide further evidence if required.