Submission to the Senate Inquiry on the Government's Changes to Rural, Regional and Remote Medicare Access and Funding

February 2026

Sonia Miller, MHSc, FACMHN
Nurse Practitioner – Psychiatry
Credentialed Mental Health Nurse (ACMHN)
ACA Member – Level 4, Senior Clinical Psychotherapist
NDIS Registered Provider – Therapy and Behaviour Supports

Sefronia Oakes, MNSc, MNP
Nurse Practitioner – Psychiatry
Credentialed Mental Health Nurse (ACMHN)

Further contributions made from wider network of National NP-MH Special Interest Group.

Primary contact:
Sonia Miller
Email: mhnpconsulting@gmail.com
Phone: [redacted]

Contents

Executive Summary

This submission is made on behalf of Nurse Practitioners – Mental Health (NP-MHs), an advanced practice workforce delivering specialist mental health care in primary care settings across rural, regional and remote Australia.

NP-MHs work with individuals and families experiencing severe and persistent mental illness, neurodevelopmental conditions, alcohol and other drug comorbidity, trauma, homelessness and psychosocial disability, including children of parents with mental illness.

The 1 November 2025 Medicare changes have reduced affordable access to primary mental health care in rural and remote communities by restricting telehealth, disrupting continuity of care for high-risk populations who face clinical, functional, socioeconomic and geographic barriers to attending in-person services.

Current Medicare rebates and incentive structures do not reflect the time, complexity and risk involved in NP-MH care, undermining the sustainability of independently owned rural practices.

Exclusion of NP-MHs from MyMedicare and associated incentive programs increases out-of-pocket costs, limits service availability, and contributes to referral bottlenecks and pressure on public mental health services.

Essential components of NP-MH practice, including care coordination, safety planning, interagency liaison and report writing, remain largely unfunded under Medicare.

Current Medicare settings contribute to avoidable emergency department presentations and preventable hospital admissions by limiting early intervention and continuity of community-based mental health care.

Medicare policy restricts effective mixed-team models by excluding NP-MHs from initiating care plans and participating fully in incentive programs, despite their advanced scope of practice.

Existing incentive structures disproportionately favour large corporate providers and disadvantage small, community-embedded rural clinics delivering complex, relational mental health care.

Collectively, these issues exacerbate inequity, increase downstream system costs, and reduce access to specialist mental health care for vulnerable rural, regional and remote populations.

Introduction and Background

Thank you for the opportunity to provide a submission to the Senate inquiry into the Government's changes to rural, regional and remote Medicare access and funding. This submission is presented on behalf of Nurse Practitioners – Mental Health (NP-MHs), an advanced practice workforce delivering specialist mental health care within primary care settings across Australia.

While nurse practitioners from a range of specialty areas contribute to mental health care, this submission specifically focuses on NP-MHs who work directly with individuals and families affected by mental illness, co-occurring alcohol and other drug use, homelessness or housing instability, trauma, and complex psychosocial needs. NP-MHs play a critical role in supporting people accessing primary health services who experience significant barriers to specialist care. NP-MHs are endorsed by the Nursing and Midwifery Board of Australia following completion of master's-level education and extensive supervised advanced practice. This often involves more than a decade of combined study, training, and supervised practice, supported by submission of an AHPRA portfolio of evidence to meet endorsement requirements.

Building on the foundation established by Graduate Diploma Qualified Mental Health Nurses (specialist scope of practice), NP-MHs deliver an extended scope of practice that includes diagnostic assessment and confirming diagnosis, prescribing and monitoring medications, conducting clinical investigations, providing therapeutic interventions, undertaking developmental and behavioural assessments, offering family-focused care, and managing mental health crises across the lifespan.

NP-MHs work extensively with individuals and families experiencing severe and persistent mental illness, neurodevelopmental conditions (including autism spectrum disorder, attention deficit hyperactivity disorder and intellectual disability), psychosocial disability, co-occurring substance use, trauma-related presentations, and complex multi-agency involvement. This includes significant work with children of parents experiencing mental illness, a group recognised as being at particularly high risk of trauma exposure, developmental delay and long-term mental health difficulties. Clinical experience consistently demonstrates the importance of timely, skilled intervention and accessible primary care pathways for these families.

Current Medicare settings do not adequately reflect the scope, role and contribution of NP-MHs in rural, regional and remote communities. As a result, access to care, continuity of treatment, workforce sustainability and system efficiency are being undermined, particularly for populations with complex and high-risk mental health needs.

The following submission addresses the Senate Terms of Reference, drawing on the collective experience of NP-MHs working across rural, regional and remote Australia.

1. Impact of the 1 November 2025 Medicare Changes on Access to Primary Care, Including Telehealth

NP-MHs practising across rural and remote regions report significant adverse impacts following the 1 November 2025 Medicare changes, particularly due to reduced access to telehealth-delivered primary mental health care. These impacts are disproportionately affecting people with severe mental illness, neurodevelopmental conditions, alcohol and other drug comorbidity, homelessness, and children within vulnerable family systems.

In routine clinical practice, reduced telehealth availability has disrupted continuity of care for individuals and families who are unable to attend in-person appointments. NP-MHs consistently report barriers including:

Clinical and functional barriers

- Severe or acute mental health symptoms (including anxiety, depression, psychosis, agoraphobia) that limit capacity to travel
- Neurodevelopmental or cognitive differences affecting planning, communication, or navigation of services
- Behavioural or sensory sensitivities that make clinic environments overwhelming, particularly for children
- Comorbid physical health conditions, disability, or mobility limitations
- Immunocompromise or acute illness restricting safe exposure to public settings

Practical and socioeconomic barriers

- Travel costs, fuel expenses, parking fees, and long-distance travel requirements associated with repeated in-person appointments, particularly in rural and remote regions
- Limited access to reliable transport or inability to afford travel
- Childcare costs or the need to coordinate care for siblings when attending appointments for one child
- Time off work required for parents or carers to attend appointments, resulting in lost income
- Disproportionate impact on women, who are more often primary carers for children with mental health and neurodevelopmental conditions
- Accommodation costs where services are located at significant distance from home
- Appointment times that are inflexible or poorly aligned with school hours, work commitments, or family routines
- Financial strain associated with repeated in-person visits, including out-of-pocket costs for private consultations, which are often prohibitive for families
- Competing family demands and carer responsibilities that limit capacity to engage with clinic-based care

Service-level and environmental barriers

- Clinic environments that are inaccessible, overstimulating, or unsuitable for individuals with sensory sensitivities or children with complex needs
- Limited appointment availability, particularly outside standard business hours
- Parking constraints, distance, and geographic isolation in rural settings
- Workforce shortages that reduce flexibility in service delivery and appointment scheduling

Trauma, stigma, and cultural safety considerations

- Trauma triggers associated with clinical environments and in-person service attendance
- Fear of stigma or discrimination when attending services in person
- Cultural safety concerns for Aboriginal and other marginalised communities
- Previous negative experiences with health services contributing to disengagement from care

The cumulative effect of these barriers is increased appointment non-attendance, deterioration in mental health stability, disengagement from care, and avoidable escalation to emergency or crisis services. Restrictions on telehealth access therefore risk cost-shifting rather than cost-containment, particularly in rural and remote contexts where workforce shortages already constrain access to care.

Elevated rates of appointment non-attendance have a measurable impact on the sustainability of NP-MH services. Telehealth delivery enables assertive follow-up, reduces avoidable disengagement, and supports continuity of care for high-risk populations.

2. The financial sustainability of independently owned rural general practices under current Medicare funding and incentive structures

NP-MHs report that independently owned rural practices are experiencing significant financial strain under current Medicare funding arrangements. Rebates for mental health and developmental care do not adequately reflect the time, complexity, and risk involved in managing patients with severe and persistent mental illness, neurodevelopmental conditions, and high psychosocial need.

Exclusion of NP-MHs from participation in MyMedicare and associated incentive programs further undermines practice viability and directly increases out-of-pocket costs for patients seeking NP-led care. This exclusion limits the ability of rural practices to offer affordable, accessible services and contributes to bottlenecks in referral pathways, with increased reliance on a small number of private psychiatrist providers and an already overburdened public mental health system.

In addition, a substantial proportion of essential clinical work undertaken by NP-MHs remains unfunded. This includes safety planning, liaison with schools, parents, carers and other services, NDIS reporting and documentation, and multidisciplinary case conferencing. These activities are critical to patient safety and continuity of care but are currently non-billable under Medicare, placing further financial pressure on small rural practices.

Current Medicare funding and incentive settings also undermine workforce attraction and retention in rural, regional and remote communities, as NP-MH-led practices become financially unsustainable and clinicians are discouraged from establishing or remaining in rural primary mental health roles.

Without reform to Medicare rebates and incentive eligibility, the current funding model risks undermining the sustainability of NP-led rural practices, reducing service availability, and exacerbating workforce shortages in areas already experiencing limited access to mental health care.

In rural and remote contexts, children and adolescents are often discharged from public mental health services without access to a child and adolescent psychiatrist consultation. Ready access to NP-MHs within primary care, without complex referral requirements or long waiting lists, supports timely intervention, reduces system bottlenecks, and contributes to the financial and operational sustainability of independently owned rural general practices.

3. The extent to which current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas.

Current Medicare settings contribute to avoidable emergency department presentations and preventable hospital admissions in rural, regional and remote areas by constraining access to timely, continuous, community-based mental health care. Restrictions on telehealth and limitations on Medicare-funded primary mental health services reduce opportunities for early intervention and proactive management, increasing the likelihood of crisis escalation.

In clinical practice, these gaps contribute to emergency presentations related to suicidal distress, behavioural escalation, alcohol and other drug relapse, and deterioration of severe and persistent mental illness. When continuity of care is disrupted, individuals are more likely to present in crisis rather than receiving preventative or stabilising support in the community. This represents a clear pattern of cost-shifting from primary care to more expensive acute and emergency services.

The impacts extend beyond individual patients to families and communities. Children of parents with mental illness, who already face elevated developmental and psychosocial risk, are particularly affected when preventative and relational care is unavailable. Lack of accessible, ongoing support increases the likelihood of family crisis presentations, involvement of emergency services, and avoidable hospital admissions.

Previous Medicare-funded initiatives demonstrate the effectiveness of alternative models. The former Mental Health Nurse Incentive Program (MHNIP) provided flexible, nurse-led mental health care in primary settings, enabling assertive follow-up, care coordination, early identification of relapse, and sustained therapeutic engagement. This model aligned with stepped-care principles and was associated with reductions in emergency department presentations and hospital admissions for people with complex mental illness.

NP-MHs possess the clinical expertise to deliver this level of preventative and stabilising care, including comprehensive assessment, crisis prevention, medication management, and long-term support for people with acute, chronic, and enduring mental illness. Currently NP-MH access to services does **not require a GP or specialist referral**, allowing children, adolescents, and families discharged from public mental health services to re-engage with primary mental health care in a timely and accessible manner. However, current Medicare settings do not adequately support NP-MH-led primary care models, limiting their capacity to prevent deterioration and reducing system efficiency.

As a result, shifting care from community-based primary mental health services to emergency and inpatient settings leads to significantly higher system costs without corresponding improvements in outcomes.

Failure to adequately fund early intervention and continuity of care in primary settings increases pressure on emergency departments, inpatient units, and public mental health services. This outcome is inconsistent with national mental health reform objectives, including those articulated by the Productivity Commission, which emphasise prevention, early intervention, integrated community care, and delivery of the right care in the right place at the right time.

4. The adequacy of Medicare support for mixed-team models of care in rural, regional and remote communities

Effective health care delivery in rural, regional and remote communities relies on well-integrated, multidisciplinary teams, including general practitioners, nurse practitioners, specialist nurses (ie. Maternal and child health nurses, diabetes nurse consultants, mental health nurses, practice nurses (distinct from Nurse Practitioners due to differing scopes), allied health professionals, and visiting specialists). NP-MHs are a critical component of these mixed-team models, providing advanced mental health assessment, diagnosis, prescribing, therapeutic interventions, developmental and behavioural support, and crisis management.

Despite this expertise, current Medicare settings significantly limit the integration of NP-MHs into team-based primary care. While NP-MHs may participate in Medicare-funded case conferencing, they are excluded from initiating case conferencing consultations, chronic disease management plans and mental health treatment plans (and the associated Developmental Care Plans under the new Thriving Kids program). This exclusion persists despite NP-MHs frequently managing clinical presentations that exceed the complexity typically addressed within standard primary care, particularly in rural settings where access to psychiatrists and paediatricians is limited or no access without traveling to metropolitan areas.

As a result, many NP-MHs are structurally prevented from full participation in multidisciplinary primary care clinics and are often forced to operate outside formal team-based models due to restricted Medicare billing pathways. This creates a clear disadvantage for the public, who receive lower Medicare rebates for NP-MH services despite these clinicians delivering specialist-level, evidence-based care that is urgently needed in rural and remote communities.

Nevertheless, NP-MHs play a central role in collaborative care by coordinating with general practitioners, referring appropriately to psychiatrists, paediatricians and other specialists, and providing advanced-practice treatment while families remain on extended waiting lists. NP-MHs can initiate and manage psychotropic medications in accordance with clinical guidelines, supporting timely, safe and effective intervention for high-needs populations and preventing unnecessary escalation to emergency and acute services.

The ongoing absence of Medicare mechanisms allowing NP-MHs to initiate essential care plans undermines the effectiveness of mixed-team models of care. This restriction limits the ability of rural, regional and remote communities to benefit from a fully functioning, multidisciplinary mental health workforce and represents a misalignment between Medicare policy and contemporary models of integrated, team-based care.

5. The impacts of current Medicare rules and incentive arrangements on large corporate providers compared with small, community-embedded rural clinics

Current Medicare rules and incentive arrangements disproportionately favour large corporate primary care providers, while undermining the viability of small, community-embedded rural clinics and sole independent practices where NP-MHs most commonly practice. Medicare funding structures are optimised for short, high-volume consultations that align with standard general practice item numbers, rather than the extended, relational, and multidisciplinary care required for complex mental health and neurodevelopmental presentations.

Corporate models are therefore structurally incentivised to prioritise throughput and episodic care. These models do not readily accommodate NP-MH roles or the delivery of longer consultations, ongoing therapeutic engagement, and intensive care coordination. As a result, specialist NP-MH expertise is frequently excluded from corporate primary care settings despite significant unmet need in rural and regional communities.

In contrast, NP-MHs working in small rural clinics and sole practitioners, provide comprehensive biopsychosocial assessment, behavioural and developmental interventions, family-based work, crisis support, alcohol and other drug management, and coordination with schools, disability services, child protection, and community agencies. This model of care is essential for addressing the complex and intergenerational needs commonly seen in rural populations.

These activities require longer appointments and substantial non-billable time, including care coordination, documentation, and interagency liaison. Current Medicare rebates do not adequately recognise or fund this work. Consequently, NP-MH-led and small community-based rural clinics carry a disproportionate financial burden while delivering the most intensive and essential care for high-needs populations.

Overall, Medicare incentives currently reward organisational efficiency and consultation volume rather than clinical complexity and continuity of care. This misalignment places small, community-embedded rural clinics and sole practitioners at ongoing financial risk, reduces the sustainability of NP-MH-led services, and limits access to specialised, relationship-based mental health care for vulnerable rural, regional and remote communities.

6. Reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians, including the requirement for rural stress-testing of future changes

To ensure Medicare is equitable, effective, and sustainable for rural, regional and remote Australians, reforms must better reflect workforce realities, population need, and the delivery of complex care outside metropolitan settings. Current arrangements insufficiently account for rural access constraints, high psychosocial complexity, and reliance on multidisciplinary primary care models.

NP-MHs identify the following reforms as necessary to improve access, efficiency, and long-term system sustainability:

Governance and system design

- Mandatory rural, regional, remote and high-risk population stress-testing of all proposed Medicare changes prior to implementation, to assess impacts on access, continuity of care, and downstream service demand.

Access and service delivery

- Expanded and protected telehealth access for vulnerable populations, including those with severe mental illness, neurodevelopmental conditions, disability, trauma histories, and significant functional impairment
- Inclusion of NP-MHs in Medicare items for developmental, behavioural, and neurodevelopmental health services, reflecting the growing demand in rural communities
- NP led and initiated chronic disease management plan, mental health plans and developmental care plans to refer to allied health professionals.

Workforce and funding parity

- Reform of NP Medicare arrangements, including new item numbers enabling independent (not group-restricted) care planning, case conferencing (separate from GP initiated case conferencing items), interagency liaison, family and carer consultations, and report writing
- Funding support for outreach, assertive follow-up, out of consulting rooms and integrated care models delivered by NP-MHs, equivalent to those available to general practitioners and allied health providers.
- Structural funding support for small, community-based primary care practices comparable to that available to GP-led services

Incentives and participation

- Inclusion of NP-led primary care practices in Medicare incentive programs, including the Practice Incentives Program (PIP), Workforce Incentive Program (WIP), and participation in MyMedicare
- Collectively, these reforms would enable Medicare to better support contemporary, multidisciplinary models of care and improve access, continuity, and outcomes for rural, regional and remote populations.

7. Other related matters

Children of parents with mental illness represent one of Australia's highest-risk populations for trauma exposure, developmental delay, and long-term mental health difficulties. Early, accessible, family-focused intervention is critical to mitigating these risks. Strengthening Medicare support for NP-MH-led care, including continuity of therapeutic engagement and family-based work, is essential to improving outcomes for these children and reducing intergenerational disadvantage.

People living with severe and persistent mental illness also represent one of the largest cohort receiving the Disability Support Pension. This reflects longstanding underinvestment in early intervention, sustained community-based care, and integrated primary mental health services. Medicare settings that limit access to preventative and stabilising care contribute to long-term functional decline, workforce exclusion, and increased reliance on income support and acute services.

Addressing these issues requires Medicare policy settings that prioritise early intervention, continuity of care, and multidisciplinary primary mental health services, particularly in rural, regional and remote communities where alternative service pathways are limited.

Conclusion

NP-MHs collectively observe that the 1 November 2025 Medicare changes have exacerbated existing inequities for rural, regional and remote Australians, particularly for individuals and families living with complex mental health conditions, neurodevelopmental disorders, psychosocial disability, alcohol and other drug comorbidity, trauma histories, housing instability, and other forms of disadvantage outlined in this submission.

High-quality mental health care in rural and remote communities depends on strong integration with local services, including primary care, schools, alcohol and other drug supports, child protection, disability services and community-led initiatives. Wherever possible, face-to-face care should remain the guiding intention and preferred mode of service delivery, as it supports therapeutic engagement, relational continuity, and comprehensive assessment of complex presentations.

However, as demonstrated throughout this submission, the realities of rural mental health care; including geographic isolation, transport barriers, housing instability, parental mental illness, acute crises, neurodevelopmental complexity and fluctuating symptom severity; mean that rigid face-to-face requirements can unintentionally exclude those at greatest risk. Effective models of care must therefore combine a commitment to in-person services with clearly defined, flexible provisions for telehealth and outreach, ensuring continuity of care for high-needs populations.

Sustainable Medicare reform must recognise the essential role of NP-MHs within rural primary care, support multidisciplinary and team-based models, enable appropriate use of telehealth, and strengthen funding mechanisms for small, community-embedded rural clinics, NP-MH led and sole practitioners delivering complex mental health care. Without these reforms, inequities in access will persist, workforce sustainability will be undermined, and preventable escalation to acute and emergency services will continue.

NP-MHs welcome the opportunity to provide further evidence, data or case examples to assist the Committee in its consideration of these matters.

References

Productivity Commission (2020). Mental Health Inquiry Report. Australian Government.

Australian Government Department of Health and Aged Care. Mental Health Nurse Incentive Programme (archived).

Australian Government Department of Health and Aged Care. Medicare Benefits Schedule – Telehealth Services.

Australian Government Department of Health and Aged Care. MyMedicare and Primary Care Incentives.

Australian Institute of Health and Welfare (AIHW). Mental health services in Australia.

Australian College of Nurse Practitioners (ACNP) (2025). The Hidden Cost of Policy Change: Patient Impact of the 12-Month Face-to-Face Telehealth Rule – Nurse Practitioner insights on the impact on patient care in primary and acute settings. Policy Impact Analysis, August 2025.