



Rural Allergy Group
Intrinsic Healthcare
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To: The Secretary

Senate Rural and Regional Affairs and Transport References Committee

Re: Inquiry into Medicare Access in Rural, Regional and Remote Australia

Dear Committee Members,

I write to provide a submission to the Senate Rural and Regional Affairs and Transport Committee Inquiry into Medicare access in rural, regional and remote Australia.

I am an endorsed Nurse Practitioner and owner of an independently operated allergy and immunology service based in Ballarat and Warrnambool, Victoria. Through these clinics, I provide care across western Victoria and into South Australia, including Mount Gambier. I have also provided telehealth services to patients in Mildura, a geographically isolated regional centre located more than five hours from metropolitan tertiary services.

My practice manages complex allergic and immunological conditions including severe asthma, food allergy, immunotherapy and chronic immune-mediated disease. In the majority of the communities I service, there is no resident allergist or immunologist. West of Ballarat, through to Adelaide, there are no allergist or immunologists. Telehealth has therefore been critical to equitable access.

The Medicare changes implemented on 1 November 2025 have materially reduced access, increased financial burden for rural patients, and undermined the sustainability of small, community-embedded specialist services.

I address the Terms of Reference below.

[The impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians](#)

The requirement that a patient must have attended an in-person consultation within the preceding 12 months to access Medicare-rebated telehealth has had a disproportionate impact on patients in MMM2 – MMM7 communities.



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In these communities, patients frequently travel between two and five hours for specialist-level care. For many families, attending in person involves:

1. Loss of income due to time off work
2. Significant travel costs
3. Childcare and logistical barriers
4. Accommodation where same-day return is not feasible

Where a first consultation is conducted via telehealth, no Medicare rebate is available. This removes the capacity to bulk bill and shifts the full cost of care to the patient. For financially vulnerable families, this creates a direct barrier to entry into specialist care.

Similarly, if more than 12 months have elapsed since an in-person consultation, patients must either travel long distances to re-qualify for telehealth, pay privately, or defer care. For chronic allergic and immunological conditions, review intervals are determined by clinical stability, not administrative deadlines. The 12-month rule does not align with evidence-based chronic disease management.

In effect, the policy creates a metropolitan-centric access model applied uniformly to geographically unequal contexts.

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

As an independently owned regional specialist service, my practice operates within narrow financial margins. Large metropolitan or corporate providers may absorb changes to rebate eligibility across scale. Small regional clinics cannot. Where a Medicare rebate does not apply, I cannot bulk bill. The result is a binary choice: absorb uncompensated clinical time or pass costs onto patients. Prior to 1 November 2025, many follow-up phone consultations were bulk billed, particularly for asthma reviews, medication titration, test results and immunotherapy monitoring. Under the current settings, where no rebate is payable, fees have had to be introduced to maintain business viability.

This is not an expansion of service; it is the continuation of necessary care without reimbursement.



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If Medicare funding structures fail to support telehealth in MMM2 – MMM7 communities, the long-term consequence will be contraction of small, community-embedded services and increased centralisation of care.

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

Allergy and immunology conditions such as severe asthma are high-risk and time-sensitive.

Timely telehealth review enables:

- Early intervention during deterioration
- Medication adjustment before crisis escalation
- Reinforcement of asthma action plans
- Monitoring of immunotherapy safety

When access is delayed due to cost or travel barriers, deterioration may go unmanaged. This increases the risk of emergency department presentation and hospital admission.

Preventative outpatient management is significantly more cost-effective than acute hospital care. Restricting affordable telehealth in MMM2 – MMM7 communities risks shifting costs from Medicare outpatient services to state-funded hospital systems.

This is neither economically efficient nor clinically optimal.

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

Rural healthcare relies on flexible, mixed-team models involving general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists. Nurse Practitioners are specifically positioned to extend specialist-level access in regional settings where medical subspecialists are not locally available. However, Medicare telehealth restrictions limit the ability of Nurse Practitioners to provide continuity across geographically dispersed catchments. If Medicare intends to support multidisciplinary and distributed models of care,



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funding structures must enable care to be delivered across distance. Current settings constrain, rather than enable, mixed-team functionality.

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

Corporate providers may leverage economies of scale, cross-subsidisation and metropolitan density. Community-embedded rural clinics operate on proximity, trust and narrow catchment sustainability. The removal of telehealth rebate eligibility disproportionately impacts small providers who serve wide geographic regions without local specialist competition. There is a structural inequity in applying uniform telehealth rules to non-uniform service environments. Without adjustment, Medicare policy may unintentionally accelerate consolidation of services away from rural ownership and toward larger corporate entities.

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

I recommend the following reforms:

- Removal of the mandatory 12-month face-to-face requirement for telehealth rebates for patients residing in MMM2–MMM7 locations.
- Eligibility for Medicare-rebated telehealth for initial consultations where no equivalent local service exists within a defined geographic radius.
- Formal rural stress-testing of all future Medicare changes to model impact across MMM classifications before implementation.
- Strengthened recognition and funding support for Nurse Practitioner-led specialist services in regional communities.
- Flexibility in telehealth arrangements for chronic and complex disease management.



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Policy reform must acknowledge that geographic classification materially alters access impact. Medicare settings that function adequately in MMM1 environments may not be workable in MMM2–MMM7 contexts.

Telehealth is not supplementary in rural Australia; it is foundational infrastructure.

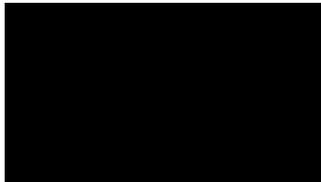
The 1 November 2025 changes have increased out-of-pocket costs for rural families, reduced capacity to bulk bill vulnerable patients, and undermined continuity of care for chronic disease management.

If Medicare reform is to achieve equity, funding settings must reflect geographic reality, workforce distribution and the structural differences between metropolitan and rural service delivery.

Uniform policy without rural stress-testing risks entrenching inequity rather than reducing it.

Thank you for the opportunity to contribute to this inquiry. I would be happy to discuss any of the above in more detail if needed.

Kind regards,



Sigrid Pitkin

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