Australian College of Nursing

Parliamentary Inquiry

Rural, regional and remote Medicare access and funding

An Australian College of Nursing (ACN) Submission

Australian Government
Senate Standing Committees on Rural and Regional Affairs and Transport
PO Box 6100
Parliament House
Canberra ACT 2600

Email: rrat.sen@aph.gov.au

Dear Committee Secretary,

Re: Rural, regional and remote Medicare access and funding [2026]

The Australian College of Nursing (ACN) would like to thank the Rural and Regional Affairs and Transport References Committee for the opportunity to comment on the *Rural, regional and remote Medicare access and funding* Parliamentary Inquiry.

ACN is a peak nursing body that supports equity for all. Representing the nursing profession, we advocate for social models of health care that address the needs of individuals and communities and take into account social, economic, and environmental factors. We advocate for access and health equity through evidence-informed, person-centred care across the lifespan.

ACN acknowledges that Medicare is a long-standing, highly complex system that requires continual review and refinement to achieve the best outcomes for all Australians. As the national voice of nursing, ACN has responded only to those Terms of Reference most relevant to the nursing profession and where our expertise enables us to provide meaningful, evidence-informed feedback. We remain committed to advocating for nurses as leaders in driving systemic reform and championing nurse-led models of care that are responsive to Australia's evolving health needs.

Our full submission is attached.

If you would like to discuss any aspect of ACN's response, please contact advisory@acn.edu.au

Yours sincerely,

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Chief Executive Officer
Australian College of Nursing

18 February 2026

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Background

Australia's primary health care system has undergone significant reform in recent years, driven by the dual pressures of a shifting disease burden and longstanding challenges in ensuring equitable access to care across rural, regional, and remote communities. Despite sustained investment in general practice and digital health infrastructure, profound disparities persist in health outcomes and service availability outside metropolitan centres. Rural and remote Australians experience higher rates of chronic disease, greater avoidable morbidity, and markedly reduced access to timely primary care services compared with their urban counterparts.[1] [2] These inequities are compounded by persistent workforce maldistribution, long travel distances, and the growing reliance on understaffed or single-provider clinics to meet complex community needs.

In this context, virtual care delivered through digital technologies has become an essential way to provide safe, timely and cost-effective health care in areas where recruiting and retaining clinicians remains a significant challenge. The rapid expansion of telehealth during and after the COVID-19 pandemic demonstrated its value in maintaining continuity of care, supporting chronic disease management, and reducing preventable hospital presentations, particularly in thin rural markets where face-to-face services may be unavailable for months at a time.[3] [4] [5] Nurses and nurse practitioners (NPs) have a critical role in sustaining health care access in these communities, frequently providing the only locally available primary care service.

However, Medicare settings have not kept pace with the changing structure of the health workforce or the evolving needs of rural populations. The Medicare Benefits Schedule continues to rely heavily on General Practitioner- (GP) centred fee-for-service arrangements, limiting the ability of other health professionals, including NPs, nurses, and allied health practitioners, to practise to their full scope without gap or full fee paying from consumers. These constraints are amplified in rural and remote areas where multidisciplinary and nurse-led models are often the only viable way to ensure access to continuity of regular and preventive care. Reforms intended to strengthen continuity of care or support in-person services, while well intentioned, have at times produced unintended consequences that further restrict access for communities already facing significant disadvantage.[6] [7]

The introduction of new Medicare telehealth requirements on 1 November 2025 must therefore be understood within this broader context of rural health inequity, structural funding limitations and unmet workforce needs. While policy changes may be effective in metropolitan regions with higher clinician density, their impact can be markedly different in rural and remote settings where service availability is constrained, reliance on telehealth is high, and NP-led models often function as the primary or sole point of care.

The following sections outline the Australian College of Nursing's analysis of these issues, drawing on member insights, contemporary evidence, and the lived reality of health care delivery in underserved communities. They highlight where Medicare settings continue to fall short, how current policies contribute to avoidable emergency presentations, and what reforms are required to ensure fair, workable, and sustainable access to primary care for all Australians, regardless of geographical location.

Approach

In preparing this response, ACN has addressed the following terms of reference:

a) the impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians.

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

d) the adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities, including the roles of general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists.

f) 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; and

g) any other related matters.

ACN is addressing the above Terms of Reference as our focus remains on areas where nursing expertise provides the strongest evidence and the greatest opportunity for reform. We emphasise that recent telehealth restrictions and GP-dependent rules are undermining access and equity, particularly in rural and remote communities. Current Medicare settings are also contributing to avoidable emergency presentations and preventable hospital admissions.[8] [9]

ACN further highlights that Medicare's GP-centric structure does not adequately support multidisciplinary models of care. Sustainable reform must expand funding for nurse practitioner scope, strengthen multidisciplinary team funding, and enhance digital infrastructure. We also draw attention to persistent issues in digital systems, workforce shortages, limited recognition of community mental health nurses, and the proven benefits of nurse-led clinics.

a. the impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians

The changes to Medicare-funded telehealth appointments introduced on 1 November 2025 were thoroughly examined by ACN to understand their rationale, potential benefits for practitioners and public health, and any unintended consequences. While the changes appear to be grounded in a logic aimed at improving health outcomes through continuity of care and increased in-person consultations, several significant unintended consequences have already emerged.

To begin, nurse practitioners (NPs) are now subject to the same legislative requirements as general practitioners for comparable MBS telehealth items.[10] [11] However, because NPs do not have equivalent access to the full range of Medicare Benefit Scheme (MBS) item numbers, this alignment has resulted in a disproportionate restriction on their scope of practice. For instance, exemptions from the 12-month face-to-face requirement apply to certain mental health and eating disorder items, but NPs, despite being qualified to provide these services cannot utilise these exemptions because they are not eligible to bill these MBS items, meaning people who

must or choose to use NP services are penalised and potentially paying more for these services.[12]

More concerning is the announcement that consumers enrolled in MyMedicare are exempt from the mandatory face-to-face requirement for telehealth appointments.[13] While ACN does not oppose this rule in principle, NPs remain ineligible to participate in MyMedicare unless affiliated with a RACGP accredited general practice.[14] This exclusion is viewed by many of our members as inherently discriminatory. After the recent removal of collaborative arrangement requirements,[15] a milestone achievement for equitable and accessible care, this policy shift represents a step backwards. Numerous ACN members report NP-led telehealth is critical in rural and remote communities, where GP wait times can exceed three months or where no GP services are available at all.

While practitioners are affected, the greatest impact of these issues is felt by health care consumers. Many Australians, especially those living in rural and remote regions, already face substantial barriers to accessing subsidised services, or any services at all.[16] [17] Long travel distances and extended wait times are well-known contributors to poor health outcomes and reduced engagement with care.[18] Digital health has provided Australia with the opportunity to deliver subsidised and specialised services to remote communities without the costly and often unsuccessful task of placing clinicians in these locations. Even with high incentive packages, many remote areas remain underserved by any health care professional.[19] [20]

While the recent Medicare changes may be appropriate in high-density metropolitan areas or Modified Monash Model (MMM) 1–3 regions, they disproportionately disadvantage people in more remote communities, individuals with limited transport options, and low-income populations. They also disproportionately impact NPs and, in particular, NP-led clinics. It is essential that access to care in rural and remote communities is not restricted to GP-dependent services, as GP shortages can lead to increased emergency department presentations and delayed treatment for otherwise manageable conditions.[21] [22] [23]

c. 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 are attributable to reductions in emergency department presentations, particularly in rural and remote settings.[24] Evidence strongly indicates that, in underserved areas with limited or absent GP presence, the placement of a clinician or team of clinicians leads to reductions in emergency department presentations.[25] [26] [27] However, what is shown to have the greatest impact on the reduction of emergency department (ED) presentation is multidisciplinary team- and nurse-led services.[28] [29] [30] These are primarily funded through blended models, government incentives, block funding, or as private enterprises. Since these models of care are not eligible for Medicare funding, we affirm that Medicare settings are ultimately contributing to avoidable emergency department presentations through lack of acknowledgement and sustained funding of proven effective methods.

A wide range of nurse-led services provide compelling evidence of this impact. Services such as Australian Primary Health Care Nurses Association models, OneBridge, and independent

NP-led practices routinely divert people who would otherwise present to ED for minor infections, wound care, chronic disease flare-ups, mental health distress, dehydration, pain, and early respiratory exacerbations. An ACN member's nurse-led clinic audit data supports these observations: 60–75% of walk-in nurse-led clinic patients report they would have gone to an ED if the clinic were not available; more than 80% of presentations are managed safely without ED referral; 70–85% of chronic disease flare-ups are resolved early by nurses; and over 65% of acute mental health presentations are handled without escalation.[31]

The success of nurse-led models is also demonstrated by services such as Earworx, which has delivered more than 300,000 safe procedures, treats over 1,200 people each week, and diverts thousands of unnecessary GP and ED visits.[32] Yet, due to limited public funding, these services operate largely through private billing and are ineligible for any incentive payments, including bulk-billing and Workforce Incentive Program, constraining access for those who would benefit most. NPs are also not eligible for Aged Care or After Hour Incentives available to GPs, further limiting their ability to provide care and services in residential aged care settings, contributing to avoidable emergency department presentation and preventable hospital admissions.

Together, this evidence demonstrates current Medicare structures, by limiting funding for nurse-led care, telehealth, and allied health referrals, actively contribute to avoidable emergency department use and preventable hospitalisation.

ACN strongly supports the implementation of recommendations outlined in the *Unleashing the Potential of our Health Workforce – Scope of Practice Review*[33] (Scope of Practice Review), particularly those aimed at strengthening multidisciplinary care for underserved populations. The review proposes shifting the fee-for-service to blended payment ratio from 90:10 to 60:40 over time, improving service accessibility and outcomes in rural and remote communities. ACN believes this ratio should be flexible, adapting to local need, such as maintaining a 90:10 balance in MM1–MM3 regions, while MM7 communities may benefit from ratios as low as 20:80. This flexibility would ensure communities receive the care that is actually available to them, whether delivered by GPs, NPs, nurses, or mixed models, ultimately improving equity and health outcomes across Australia. Importantly, access to blended funded models must be afforded to a variety of primary care practices, especially nurse-led models as described in this response. The Australian Commission on Safety and Quality in Health Care's *National Safety and Quality Primary and Community Healthcare Standards* provide an avenue for accreditation for primary care practices as an alternative to the exclusionary RACGP accreditation standards.

d. the adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities, including the roles of general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists

ACNs survey found unanimous agreement: not one member believes Medicare adequately supports the mixed-team models vital to delivering health care in rural, regional and remote communities. As outlined previously, Medicare's funding model remains heavily GP-centric, creating structural barriers in areas where GP access is limited or absent. The Scope of Practice Review[34] highlights that primary care funding continues to operate under a blanket 90:10 fee-for-service to blended-funding ratio, a structure that disadvantages regions where multidisciplinary models already exist, but consumers cannot access them due to funding

settings. The same review also identified significant concerns regarding NP and multidisciplinary referral rights.[35] Without subsidised referral pathways and access to allied and mental health services, consumers in underserved areas are at increased risk of deterioration and avoidable emergency department presentations.

This lack of structural support is exacerbated by Australia's chronic underinvestment in preventive health. Only 1.34% of total health expenditure is allocated to public and preventive health, far below comparable OECD nations such as the United Kingdom (8.2%) and Canada (5%).[36] [37] [38] This gap underscores the urgent need to shift towards preventive models of care. Evidence shows every dollar invested in preventive health delivers a return of two to four dollars, reinforcing both the economic and social value of investing in proactive care rather than continuing to rely on reactive, crisis-driven services.[39] [40]

Urgent care centres provide a clear example of how alternative models can improve access and reduce strain on the health care system. Strong evidence shows walk-in and nurse-led models substantially reduce health care costs and emergency department presentations.[41] Yet, at a national scale, the Australian Government's early data indicate that Medicare Urgent Care Clinics (MUCCs) have not yet produced significant reductions in ED presentations, a view shared by the RACGP and AMA.[42] Furthermore, feedback from ACN members and rural health organisations suggests that several MUCCs have been unable to open, or have been forced to reduce operating hours, due to the lack of available medical workforce (GPs).[43] [44]

ACN acknowledges these are early results and notes that MUCCs are still in their infancy. Nevertheless, ACN contends that a key operational barrier exists within the Urgent Care Operational Guidelines, which require a GP to lead the clinic.[45] This requirement prevents NPs from exercising independent practice and leading care within these clinics, constraining their utilisation, and creating unnecessary shortfall in MUCC service delivery capacity. This restriction directly conflicts with the *Nurse Practitioner Workforce Plan's*[46] intent to increase NP-led services and improve access for people, particularly in underserved areas.

ACN calls for the amendment of these guidelines to explicitly permit NPs to lead care within MUCCs. Enabling NPs to lead MUCCs, particularly in areas with limited GP presence, would expand access, reduce system bottlenecks, and provide a more accurate evaluation of MUCC performance. Importantly, ACN also recommends assessing MUCC outcomes at a community level, as national level data can obscure the significant benefits these clinics may offer to rural and remote populations.

The limitations within Medicare also have profound implications for mental health care, an area of rapidly growing need. Mental health services across Australia are increasingly unable to meet demand, and these challenges are amplified in rural and remote communities.[47] Despite their extensive education and skills, NPs cannot access MBS mental health items, nor do they receive the telehealth exemptions available to GPs for mental health services. Further widening this gap in access to mental health care is the absence of any MBS item numbers for Credentialed Mental Health Nurses (CMHNs), despite their recognised expertise in delivering quality mental health care.[48] Without the ability to provide subsidised assessments, plans or referrals, CMHNs and NPs are effectively prevented from supporting consumers who already face major access barriers due to their socioeconomic status or location. For rural and remote communities,

enabling clinicians to practice to their full scope is not only appropriate, but also essential to ensure people receive the mental health care they need without being forced into costly private care pathways.

f. 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

ACN member survey respondents identified five core priorities for strengthening access and equity in rural, regional and remote primary care. Foremost, members emphasised the need to expand NP access to telehealth services, noting that restrictions on NP-delivered telehealth disproportionately disadvantage communities where face-to-face care is limited or impractical. This concern reflects the broader trend of constrained service availability in thin markets, where telehealth frequently functions as the only viable mechanism for continuity of care.

Members also strongly supported enhanced rural workforce incentives, including the expansion of block and blended funding models. Persistent workforce maldistribution continues to undermine health outcomes in rural and remote areas, with national data demonstrating higher rates of potentially preventable hospitalisations and reduced access to primary care in regions with limited clinician supply.[49] [50] Addressing these entrenched disparities requires funding arrangements that enable service viability, support multidisciplinary practice, and recognise the higher cost of delivering care in geographically dispersed communities.

Members further identified the need for MBS reform to properly support multidisciplinary team models. This position aligns with the Scope of Practice Review,[51] which highlights that current funding and payment structures inhibit team-based care and limit the ability of all health professions to work to their full scope of practice.[52] Commonwealth initiatives *Innovative Models of Care Program*[53] (IMOC) and *Primary Care Rural Innovative Multidisciplinary Models*[54] (PRIMM) are already trialling community-designed multidisciplinary team approaches aimed at building sustainable rural primary care systems, and these reforms should be complemented by broader MBS policy change.

Improving digital infrastructure and interoperability also emerged as a critical priority. Members noted that fragmented digital systems impede care coordination, increase duplication, and hinder the efficient transfer of clinical information across providers. The *National Digital Health Strategy 2023–2028*[55] and the *National Healthcare Interoperability Plan 2023-2028*[56] provide a nationally endorsed foundation for progressing towards seamless, standards-based data sharing and improved digital connectivity across the health sector, including in rural and remote regions where clinicians rely heavily on interoperable systems. ACN both supports and welcomes the progression of this critical piece of work.

Finally, respondents stressed the importance of stronger collaboration with Aboriginal and Torres Strait Islander Health Services. Aboriginal Community Controlled Health Organisations (ACCHOs) deliver more than one million episodes of care each year in rural and remote locations and provide culturally informed, comprehensive primary care with well-documented benefits for the social determinants of health.[57] Strengthening partnerships with ACCHOs is essential to improving equity, supporting culturally safe care pathways, and ensuring that

reforms genuinely meet the needs of First Nations communities. Importantly, the ACCHO models of care are multidisciplinary and flexible to meet the needs of the community[58] and should be looked at as examples of successful provision of collaborative, multidisciplinary, continuity of care in primary care settings.

g. any other related matters

Achieving fair and sustainable Medicare reform for rural, regional and remote Australians requires addressing several systemic pressures that extend beyond funding mechanisms alone. Digital health fragmentation remains a significant barrier to coordinated care.[59] [60] Clinical information systems commonly used across primary care, hospitals and aged care do not integrate, resulting in siloed records, duplication of information, and inconsistent and delayed access to essential clinical data.[61] [62] National analyses show that fragmented digital systems lead to repeated registrations and incomplete histories, particularly affecting tourists, itinerant workers and transient rural populations who move frequently between services.[63] [64] This undermines continuity of care and places additional administrative burden on already stretched rural workforces.

Workforce challenges compound these digital barriers. Rural and remote areas continue to face entrenched shortages of health professionals partly due to long-standing deficits in local infrastructure such as housing, schooling, and basic services, factors consistently identified as key deterrents to recruitment and retention.[65] [66] National rural health data confirm that communities with limited social infrastructure experience poorer health outcomes and reduced access to primary care, with these structural limitations exacerbating clinical workforce maldistribution.[67] [68] Without addressing these foundational issues, reforms to Medicare funding, telehealth, and scope-of-practice cannot achieve their intended impact.

Overall, ACN believes that current Medicare settings remain poorly aligned with the realities of service delivery in rural and remote Australia. Restrictions on NP-led telehealth, GP-dependent program rules, inadequate support for multidisciplinary models, and fragmented digital systems collectively constrain access, efficiency, and equity. Rural stress-testing of future Medicare changes is therefore essential to ensure that reforms support, rather than inadvertently disadvantage, the communities most in need of a robust and flexible primary care system.

About ACN

The Australian College of Nursing is the peak professional body and leader of the nursing profession. We are a for-purpose organisation committed to our mission of Advancing Nursing and Shaping Health.

We support nurses to uphold the highest possible standards of integrity, clinical expertise, ethical conduct, and professionalism through our six pillars of Education, Leadership, Community, Social Impact, Advocacy and Policy.

We are the Australian member of the International Council of Nurses headquartered in Geneva in collaboration with the Australian Nursing and Midwifery Federation (ANMF).

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