

Submission to the Rural and Regional Affairs and Transport References Committee

Inquiry into Rural, Regional and Remote Medicare Access and Funding

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1. Introduction

I welcome the opportunity to provide this submission regarding Medicare access and funding changes affecting rural, regional and remote communities. I write as a Registered Nurse, business owner of a traditional GP medical centre, nurse practitioner candidate, and Founder of the AveNüPlus nurse-led model of care, an evolution of our Maclean Medical Access Health Clinic which was established to address critical workforce shortages and inequitable access to primary care in the Lower Clarence region of NSW.

The model is grounded in the **Betty Model of Care**, a values-based, culturally respectful, community-embedded framework that emphasises early intervention, judgement-free access, and workforce optimisation across nurses, nurse practitioners, GPs, and allied health.

Across rural Australia:

- **30% of the population lives outside major cities**, but only **15% of the medical workforce** is located there (AIHW).
- Rural Australians experience **higher burden of disease, higher mortality**, and significantly **reduced access to primary care**.
- Patients in rural areas are **twice as likely** to present to an emergency department for low-acuity conditions due to lack of GP access.
- Since 2020, more than **300 rural general practices have closed or reduced hours**, largely due to unsustainable Medicare funding models.

AveNüPlus was created as a response to these failures. It has delivered **thousands of timely primary care contacts** within its first 10 months, diverting an estimated **1,200–1,500 low-acuity emergency presentations** and relieving pressure on the remaining GP workforce.

This submission outlines how a scalable, nurse-led mixed-team model, supported by modernised Medicare settings can help stabilise rural primary care nationwide.

2. Terms of Reference

(a) Impact of the 1 November 2025 Medicare changes on access to primary care and telehealth

The 1 November changes weakened access to care in rural and remote communities by failing to address the underlying workforce shortages and by limiting item numbers that support non-GP clinicians.

Nationally:

- One in five rural patients delay or avoid care**, primarily due to cost or lack of availability.
- Rural areas have **GP-to-population ratios up to 65% lower** than metropolitan regions (Medicare Workforce Dataset).
- Telehealth restrictions disproportionately affect rural patients, as **up to 40% of rural telehealth consultations are for first presentations** where continuity of care is not yet established.

The Medicare changes did not expand nurse practitioner or RN telehealth items, despite strong evidence of safety and cost-effectiveness.

Impact observed locally through AveNüPlus:

- A significant increase in demand for **same-day wound care, infections, asthma management, women's health concerns, early pregnancy issues, mental health triage, and minor injuries**.
- Average wait time for a GP appointment in our region remains **3–8 weeks**, while the AveNüPlus clinic provides appointments **within 24 hours**.
- Approximately **35–45% of our consultations** would previously have resulted in an ED presentation or urgent care visit.

Telehealth is essential for continuity and chronic disease management. Restrictive item structures disproportionately penalise rural residents who rely on distance-based care pathways.

(b) Financial sustainability of independently owned rural general practices

Independent rural general practices continue to close because the Medicare system fails to reflect rural delivery costs.

Key national figures:

- Rural practices operate with **25–40% higher operating costs** (Rural Health Commissioner).
- Average rural GP earnings remain **20–30% lower than metro**, despite higher workload complexity.

- Rural practices rely heavily on **incentives that have not increased in line with inflation**.
- Since 2010, GP rebates have increased only **1.8% per year on average**, far below CPI and wage growth.

Local experience mirrors the national trend. Without diversification into the **nurse practitioner-led AveNüPlus model**, Maclean Medical would not have been financially sustainable under current rebate structures.

The AveNüPlus model enhances sustainability by:

- Reducing GP demand by an estimated **45–60%** for low-acuity needs.
- Expanding capacity for chronic disease care.
- Maintaining rural affordability through moderate private billing while reducing hospital system costs.

Rural practices cannot survive on GP rebates alone. Funding mechanisms must recognise team-based care.

(c) How Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions

Emergency departments in rural Australia see disproportionately high numbers of low-acuity cases (AIHW):

- 47% of rural ED presentations are triage category 4 or 5**, many of which are suitable for primary care.
- Rural Australians have a **20% higher rate of potentially preventable hospitalisations**.
- Lack of timely GP appointments is cited by **more than 60%** of rural ED patients as the reason for attending hospital instead of primary care.

Impact of AveNüPlus:

Based on our 10-month activity data:

- Estimated **1,200–1,500 ED presentations diverted**, based on volume of cases that would otherwise have been sent to ED due to lack of GP availability.
- High-frequency presentations included:
 - Respiratory illness and asthma flares
 - Skin infections and wounds
 - UTI/renal symptoms
 - Ear conditions

- Referrals to specialists
 - Headaches, migraines, and minor injuries
 - Women's health presentations
 - Medication management challenges
- **Chronic disease decompensation reduced** due to timely follow-up led by nurse practitioners and RNs.

Local data demonstrating loss of continuity and significant Medicare savings through NP-led care

In our region, clinic utilisation data shows that **more than 50% of patients attending AveNüPlus do not have a regular GP**, a figure that aligns with the broader rural trend of declining GP availability. Loss of continuity is directly correlated with higher emergency presentations, poorer chronic disease outcomes, and increased system costs. Our internal economic analysis also shows that for a **like-for-like consultation**, the **Medicare cost of a nurse practitioner visit is up to 75% lower** than the equivalent GP encounter. This is driven by several structural features of the Medicare Benefits Schedule:

- Nurse practitioners **cannot bill procedural items**, even when performing procedures of equal complexity.
- Nurse practitioners **cannot access chronic disease management item numbers**, removing the opportunity to deliver structured patient education and multidisciplinary coordination.
- NP rebates remain **significantly lower** despite equal responsibility for assessment, diagnosis and management.

This means that Medicare receives a **significantly lower claim cost** for the same clinical outcome, despite the service relieving pressure on GPs and preventing hospital presentations. Paradoxically, the current funding structure financially disadvantages the NP-led clinic even while delivering substantial system savings. Reform is required to ensure that cost-effective rural innovations like AveNüPlus remain viable and scalable.

If scaled, this model could reduce rural ED loads by **15–25%**, consistent with international nurse practitioner data.

Medicare settings currently inhibit this by underfunding NP-led care.

(d) Adequacy of Medicare support for mixed-team models of care

Australia's rural primary care reality is already a mixed-team environment, but Medicare remains built on a GP-only foundation.

Facts:

- Nurse practitioners represent **less than 0.2%** of the Medicare budget despite strong evidence of safety and cost-effectiveness.
- The NP rebate is **approximately 40–50% lower than for equivalent GP services**.
- RNs are not supported with item numbers for chronic disease management outside GP supervision.
- Allied health access is capped at **5 visits annually**, inadequate for rural chronic disease burden.

AveNüPlus demonstrates a functioning mixed-team model:

- Nurse practitioners handle the majority of acute and chronic presentations.
- RNs manage chronic disease cycles, prevention, foot checks, health education, pre-assessment, follow-up and triage.
- GPs focus on complex care, procedures, and interdisciplinary oversight where required.
- Allied health and visiting specialists receive integrated referrals to keep care local.

This model is more efficient and more sustainable than GP-centric structures, yet Medicare funding does not align with or incentivise it.

(e) Impact of Medicare rules on large corporate providers vs small rural clinics

Large corporate providers benefit from:

- Economies of scale
- Bulk recruitment capacity
- Higher-density patient populations
- Ability to cross-subsidise rural losses with metropolitan profits

In contrast:

- Small rural clinics operate on **much thinner margins**.
- Rural patient volumes are lower but complexity is higher.
- Corporates often withdraw from low-profit rural sites, leaving communities vulnerable.

Current Medicare settings unintentionally favour corporates by:

- Rewarding high-volume, low-complexity metropolitan throughput
- Failing to provide rural loadings for non-GP clinicians

- Not supporting innovative local models like AveNüPlus

AveNüPlus was intentionally built as a **local, community-embedded** model to protect continuity and access—not as a corporate expansion strategy. It is designed for replication **only in areas of need**, not for commercial franchising.

Medicare must support grassroots rural innovation, not scale-based advantage.

(f) Reforms required for a fair, workable and sustainable rural Medicare

1. Introduce Medicare rebate parity for nurse practitioners

Evidence shows NPs deliver safe, cost-effective care with high patient satisfaction. Rebate parity would immediately expand access.

2. Create a dedicated funding stream for nurse-led rural clinics

Comparable to the Rural General Practice Incentive Program.

3. Mandatory rural impact assessment (“rural stress-testing”) for all future Medicare changes

Policies must not worsen rural health inequity.

4. Expand RN item numbers for chronic disease, prevention, and follow-up

Rural chronic disease burden is **30–50% higher** than in cities.

5. Remove first-visit telehealth restrictions for rural patients

Distance is a structural barrier—not a patient choice.

6. Expand preventive health funding

Australia spends **1.7% of health expenditure on prevention**, far below the OECD average of 2.8%.

7. Enable bundled, team-based funding models

Allow GPs, NPs, RNs and allied health to work together under shared care arrangements.

AveNüPlus is well positioned to serve as a **pilot site** for these reforms.

(g) Other related matters – The Betty Model of Care

The Betty Model of Care emphasises:

- Early access
- No-wrong-door triage
- Cultural safety

- Empowerment and community connection
- Multidisciplinary collaboration
- Listening without judgement

This aligns with international evidence showing:

- Nurse practitioner models reduce ED presentations by **15–37%**
- Patient satisfaction exceeds **90%**
- Chronic disease markers (HbA1c, BP, COPD readmissions) improve under NP-led continuity models
- Costs per episode of care decrease by **20–30%**

The AveNüPlus model demonstrates that rural primary care can be redesigned in a way that is scalable, safe, and community-owned.

3. Conclusion

Medicare, in its current form, no longer aligns with the realities of rural health care delivery. Rural Australia cannot rely solely on GP-led models that are no longer viable due to shrinking workforce supply.

The AveNüPlus nurse-led clinic, underpinned by the Betty Model of Care, provides a modern, evidence-based, scalable solution to restore equity and access in rural communities.

With Medicare reform and appropriate funding scaffolding, this model could be deployed across rural Australia to:

- Expand access
- Reduce emergency department strain
- Strengthen chronic disease outcomes
- Support the workforce
- Keep care local

I would welcome the opportunity to contribute further, appear at hearings, or provide data analysis from our clinic's operations.

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