27 March 2026

Committee Secretary
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,

We write in solidarity on behalf of the undersigned organisations representing nurses, nurse practitioners, endorsed midwives and midwifery services delivering primary, specialist and maternity care across rural, regional and remote Australia.

Current Medicare and pharmaceutical policy settings are materially compromising timely access to essential health services in rural, regional and remote communities. These consequences are no longer theoretical. Since recent policy changes, services have reported disrupted care pathways, delayed reviews and increasing strain on already fragile rural models of care. These settings are no longer administrative inefficiencies; they are contributing to delayed diagnosis, fragmented care, avoidable hospital escalation and inequitable outcomes for high-risk populations.

We collectively support Medicare reform that improves equitable access to subsidised care, reduces duplication, removes unnecessary legislative restrictions and strengthens the sustainability of rural and remote services. However, without urgent policy correction, current arrangements will continue to undermine continuity of care and the viability of nurse- and midwife-led models that rural communities depend upon.

Impact of telehealth restrictions on continuity and safety

For many rural and remote Australians, telehealth is not a convenience; it is the only clinically viable pathway to continuity of care. The introduction of the 12-month face-to-face requirement for Nurse Practitioner MBS telehealth services has disrupted established care pathways in communities where no local alternative clinician exists. Patients are experiencing delayed reviews, postponed investigations and fragmented follow-up solely due to funding restrictions.

Where timely primary care review, prescribing and diagnostics are restricted, clinical deterioration is more likely to occur before intervention. These impacts are particularly concerning in high-risk clinical contexts, including oncology surveillance and survivorship care, complex mental health follow-up, chronic disease management and palliative care.

In oncology surveillance alone, Nurse Practitioners frequently provide longitudinal follow-up for patients with breast, prostate, bowel and lung cancers. They monitor for recurrence, manage treatment toxicities and coordinate care with tertiary services. Disruption to these established pathways represents a material risk to early detection of recurrence and timely intervention in high-risk populations.

While endorsed midwives are not subject to the 12-month telehealth requirement, broader Medicare funding limitations and insufficient structural support for midwife-led continuity models continue to constrain access to antenatal, postnatal and perinatal mental health care in rural and remote communities. Sustainable maternity continuity models require funding architecture that reflects contemporary scope of practice and rural workforce realities.

Financial sustainability and structural inequity

Independently owned nurse practitioner and midwife-led practices, as well as multidisciplinary rural clinics, are experiencing increasing financial pressure under current Medicare arrangements.

Nurse practitioner-led primary care services remain:

- Ineligible for MyMedicare registration
- Excluded from Bulk Billing Incentive Programs
- Ineligible for key advanced diagnostic and procedural MBS items
- Without appropriate rebates for after-hours and on-call services

Similarly, endorsed midwife-led models are constrained by limited MBS support for continuity of care, prescribing and integrated maternity pathways. These settings widen the remuneration gap between GP-delivered and nurse practitioner-delivered services and create perverse incentives that undermine multidisciplinary workforce models. It is inconsistent to promote workforce expansion through the Commonwealth's *Nurse Practitioner Workforce Plan* while structurally limiting the funding mechanisms that enable that workforce to practise sustainably.

Higher service delivery costs in rural and remote areas, combined with longer consultation times for complex physical and mental health presentations, are not adequately recognised. The result is increasing workforce attrition, reduced service availability and clinic closures in communities that can least afford further loss of care.

Repatriation Pharmaceutical Benefits Scheme (RPBS) exclusion

The exclusion of Nurse Practitioners from prescribing under the Repatriation Pharmaceutical Benefits Scheme (RPBS) represents a clear and correctable gap in continuity of care.
This exclusion forces Department of Veterans' Affairs patients to transfer to alternative prescribers solely to access subsidised medications. In rural and remote communities, where alternative providers may be limited or unavailable, this creates unnecessary delays, duplication and fragmentation of care.

Patients are required to disrupt established therapeutic relationships for administrative reasons alone. This undermines patient trust, increases inefficiency and places additional strain on already stretched services.

Avoidable emergency presentations and hospital admissions

Current Medicare restrictions on Nurse Practitioners contribute directly to avoidable emergency department presentations and preventable hospital admissions in rural and remote communities, where timely primary care intervention is essential.

Barriers to telehealth review, limited access to diagnostics, restricted referral pathways and lack of support for after-hours services collectively delay early intervention. These delays disproportionately affect Aboriginal and Torres Strait Islander peoples, older Australians, veterans and those living in communities identified as socio-economically disadvantaged under the SEIFA IRSD index.

In maternity care, insufficient structural support for endorsed midwife-led continuity models reduces flexibility in rural settings and places additional strain on hospital-based services. In rural and remote Australia, when primary care access fails, escalation to hospital care is often the only remaining option- but at significantly greater cost to both patients and the health system.

Inadequate support for multidisciplinary rural models

Rural and remote healthcare is delivered through collaborative models involving general practitioners, nurse practitioners, endorsed midwives, registered nurses, remote area nurses, Aboriginal and/or Torres Strait Islander Health Practitioners, allied health professionals and visiting specialists.

However, Medicare settings do not adequately support these models. Key barriers include:

- Ineligibility of nurse practitioner-led clinics for MyMedicare
- Exclusion from bulk-billing incentive programs
- Urgent Care Clinic operating requirements mandating onsite GP presence, preventing appropriate workforce flexibility
- Absence of MBS items enabling nurse practitioners to initiate chronic disease and mental health management pathways or refer directly to allied health providers
- Lack of structured support for maternity continuity models led by endorsed midwives

These constraints force duplication of care for administrative purposes, increase out-of-pocket costs and weaken sustainable workforce planning. The current policy architecture does not reflect contemporary regulation, scope of practice or the realities of rural service delivery.

Call for urgent reform

We collectively call for:

- Immediate review of the 12-month telehealth requirement in rural, regional and remote contexts
- Inclusion of nurse practitioner- and midwife-led services in MyMedicare
- Eligibility for the Bulk Billing Incentive Program
- Removal of outdated collaborative model requirements in Urgent Care Centres that no longer reflect contemporary regulation
- Access to advanced diagnostic, procedural and referral MBS items consistent with scope of practice
- Inclusion of Nurse Practitioners in the Repatriation Pharmaceutical Benefits Scheme
- Structured MBS support for chronic disease, mental health, maternity and after-hours care delivered by nurses and midwives
- Mandatory rural and remote impact stress-testing of all future Medicare reforms

Reform is not optional. Without urgent correction, current policy settings will continue to compromise safety, sustainability and equitable access for rural, regional and remote Australians.

We thank the Committee for considering these matters and welcome the opportunity to contribute further to the development of a Medicare system that is fair, workable and sustainable for the communities we collectively serve.

Yours sincerely,

On behalf of the undersigned organisations

[redacted]

Adjunct Professor Chris Helms
CEO, Australian College of Nurse Practitioners

[redacted]

Emma Barritt
Chief Executive Officer
CRANAPlus

[redacted]

Daniel Lightowler
President
Gastroenterological Nurses College of Australia

[redacted]

Claire Johnson
Acting Executive Director
College of Emergency Nursing Australia

[redacted]

Dr Stephen Duns
Chief Executive Officer
Australian Primary Health Care Nurses Association

[redacted]

Dr Margaret Faux
Chief Executive Officer
Synapse Medical Services

[redacted]

Dr Brendan Clifford
Vice-President
Drug and Alcohol Nurses Australasia

[redacted]

Melissa Caruso
President
Australia and New Zealand Urological Nurses Society

[redacted]

Jemma Still
Chief Executive Officer
Cancer Nurses Society Australia

[redacted]

Dr Ali Drummond
Chief Executive Officer
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

[redacted]

Professor Wendy Cross
Acting Chief Executive Officer
Australian College of Mental Health Nurses

[redacted]

Dr Kathryn Zeitz
Chief Executive Officer
Australian College of Nursing

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

Rural and Regional Affairs and Transport References Committee

27 February 2026

policy@acnp.org.au | 1300 433 660 | acnp.org.au

Acknowledgement of Country

Photo by René Riegal on Unsplash

The Australian College of Nurse Practitioners acknowledges the Traditional Custodians and Owners of the lands upon which we live, work and provide person-centred care. We recognise Aboriginal and Torres Strait Islander Peoples as Australia's first health practitioners and knowledge holders, and acknowledge their continuing contributions to health, wellbeing, and community connectedness, as well as their deep and enduring connection to Country. We pay respects to their Elders – past, present and emerging. We recognise and celebrate that Australia is home to many distinct Aboriginal and Torres Strait Islander nations, each with unique cultures, languages and traditions.

Table of Contents

Executive Summary

The Australian College of Nurse Practitioners (ACNP) welcomes the opportunity to contribute to the Senate Inquiry into Rural, Regional and Remote Medicare Access and Funding. This submission addresses the Inquiry's Terms of Reference relating to access to care, financial sustainability, avoidable hospitalisation, and the adequacy of current workforce models in rural and remote Australia.

This submission presents evidence that current Medicare settings are structurally misaligned with contemporary models of care and are contributing to reduced access, increased out-of-pocket costs, and avoidable hospital utilisation in rural and remote communities.

Rural and remote Australians experience disproportionately higher rates of chronic disease, preventable hospitalisation, and mortality, alongside persistent workforce shortages and limited access to general practitioners (GPs). In many of these communities, Nurse Practitioners (NPs) are already functioning as primary care providers, delivering comprehensive, continuous, and high-quality care across the lifespan. However, Medicare policy and funding mechanisms remain predominantly GP-centric and do not adequately recognise or enable NP-led models of care.

Over the past decade, NP service delivery has expanded substantially, with Medicare-subsidised NP services increasing by more than 400%. However, bulk billing rates have declined from over 94% in 2015-16 to approximately 81% in 2024-25, indicating a growing shift of healthcare costs to consumers despite increasing workforce capacity. At the same time, approximately one-third of the NP workforce is either underutilised or not working in designated NP roles due to current funding and policy constraints.

Recent Medicare changes introduced on 1 November 2025 have further restricted access to care. In particular:

- The exclusion of NPs from the Bulk-Billing Incentive Program (BBIP) has created inequitable pricing structures and increased out-of-pocket costs depending on provider type
- Telehealth restrictions, including face-to-face requirements and narrow eligibility criteria, have reduced access to care for patients who rely on NP-led services, particularly in MM3–MM7 regions where in-person care is often not feasible
- The MyMedicare framework does not accommodate NP-led primary care where a GP is not engaged, limiting continuity of care and restricting access to subsidised telehealth

Findings from a recent national survey of 140 NPs indicate that current telehealth eligibility settings do not reflect real-world clinical practice, with approximately half of respondents reporting that none of the existing exemption criteria are applicable to their patient populations. These settings disproportionately affect older people, people with disability, and those requiring ongoing, longitudinal care.

These policy settings are producing system-level effects across MMM classifications, including reduced continuity of care, increased patient out-of-pocket costs, service withdrawal risk in underserved areas, and a growing reliance on emergency departments for conditions that could be managed in primary care.

There is strong and consistent evidence that NP-led models of care are clinically effective, improve access, and deliver significant economic value. Independent KPMG analysis demonstrates benefit–cost ratios ranging from 1.1:1 to 12.4:1, with savings driven by reductions in emergency department presentations, hospital admissions, and ambulance transfers. In high-need settings, NP models deliver substantial return on investment while improving equity and access.

The core issue is not workforce capability, but policy design. Medicare continues to fund provider type rather than the value and function of care delivered. This creates structural inequity, constrains workforce utilisation, and limits the scalability of models that are already addressing critical service gaps.

The ACNP recommends three priority reforms:

1. **Amend Medicare funding arrangements to enable equitable access to NP services,** including extending eligibility for the Bulk-Billing Incentive Program, access to chronic condition management plans to enable subsidised allied health care, applying after hours and rural loadings (MM3–MM7), and broadening the scope of MBS-subsidised diagnostic imaging and procedural services to NP-delivered care
2. **Reform telehealth policy settings** to remove the 12-month face-to-face requirement for NP-provided services in rural and remote areas and align eligibility with continuity-of-care models
3. **Revise the MyMedicare framework** to recognise NP-led practices as eligible primary care providers, enabling equitable access to registration and telehealth benefits

Targeted reform in these areas would support more efficient use of the existing workforce, improve access to timely care, reduce avoidable hospital utilisation, and deliver measurable economic benefits to both Commonwealth and state health systems.

Photo by Dominik Lange on Unsplash

Access to Care

Access to timely, safe, and responsive healthcare is fundamental to the health and wellbeing of all Australians. Medicare funding and access settings are central to enabling communities to receive care close to home, supporting sustainable services, and allowing all health professionals to work to their full clinical scope of practice. Current arrangements do not adequately reflect the recognised challenges of distance, workforce shortages, and service delivery in rural, regional, and remote areas.

This review presents a vital opportunity to examine how Medicare funding and access settings can better support innovative, team-based, and flexible models of care, including those delivered by NPs and other advanced practice clinicians. Strengthening these models is essential to improving access, reducing avoidable hospital presentations, addressing chronic disease, and improving health outcomes for communities facing the greatest barriers to care.

Meaningful reform arising from this inquiry has the potential to deliver lasting benefits for patients, communities, and the broader Australian health system by ensuring Medicare supports access to safe, high-quality, and sustainable healthcare, regardless of postcode.

Photo by Rémi Walle on Unsplash

Recommendations

The ACNP recommends a package of reforms designed to improve equitable access to primary care, enable NPs to work to full scope, strengthen rural and remote service viability, and reduce avoidable hospital utilisation.

Together, these recommendations respond directly to the evidence presented in this submission and aim to ensure Medicare supports care based on patient need and clinical function rather than provider type.

Recommendation 1: **Establish Medicare funding parity for NP-led primary care**	**Amend** the *Health Insurance Act 1973* and associated Medicare Benefits Schedule (MBS) Determinations to ensure that NPs can deliver Medicare-funded primary care on an equitable basis where they are the primary treating clinician. This should include: • Extending eligibility for the Bulk-Billing Incentives Program (BBIP) to NPs providing Medicare-rebateable services; • Appling rural loading and after hours adjustments (MM3-MM7) to NP-delivered services on the same basis as equivalent GP services; • Enabling Medicare rebates for common procedural items performed by NPs in primary care and urgent care settings that are available to GPs; and • Reviewing NP attendance item structures to ensure rebates are sufficient to support financially sustainable bulk-billing and mixed-billing models in rural, regional and remote communities.
Recommendation 2: **Reform telehealth settings to support continuity of care in NP-led models**	**Amend** the *Health Insurance (Section 3C General Medical Services – Telehealth Services)* Determination to ensure telehealth policy supports continuity of care in rural, regional, and remote Australia. This should include: • Removing the 12-month face-to-face requirement for NP-provided telehealth services for patients in MM3-MM7 regions; • Creating additional exemptions for patient groups identified in the submission as disproportionately affected by current exemption rules, including older people, people with disability or mobility limitations, palliative care patients, veterans and children requiring ongoing specialist follow-up; and • Ensuring future telehealth reforms distinguish between low-value transactional models and clinically appropriate, relationship-based continuity-of-care telehealth.
Recommendation 3: **Recognise NP-led practices within MyMedicare and continuity-of-care frameworks**	**Amend** the *MyMedicare Program Guidelines* and associated registration rules to recognise NP-led practices as eligible primary care providers. This should include: • Recognising NP-led practices that are unable to engage a GP as eligible for patient registration; • Enabling patients to nominate a NP as their usual primary care provider; • Extending MyMedicare-linked telehealth access and continuity-of-care exemptions to patients registered with NP-led practices; and • Ensuring MyMedicare design reflects distributed and outreach-based models of care, including hub-and-spoke and multi-site service delivery in rural and remote areas.

Recommendation 4: **Expand NP authority for diagnostics, procedural items, care planning and referral pathways**	**Amend** relevant legislation, MBS tables, and subordinate instruments to align NP authority with scope of practice and reduce unnecessary general practitioner bottlenecks. This should include: • Authorising NPs to request MBS-rebateable diagnostic imaging aligned with their scope of practice, including plain film imaging, ultrasound, CT, MRI, DEXA and echocardiography where clinically appropriate; • Creating equivalent MBS items enabling NPs to initiate, coordinate, and claim chronic condition management plans, mental health treatment plans, and case conferencing as lead clinician. This will enable NPs to refer directly to subsidised allied health treatment services under these items; • Reviewing NP access to other referral and prescribing pathways (such as the RPBS) that currently disadvantage patients by provider type; and • Creating equivalent MBS items enabling NPs to perform commonly-requested diagnostic and therapeutic procedural items (e.g. ECGs, spirometry, wound suturing, etc.).
Recommendation 5: **Embed NPs as core clinicians in urgent care, aged care, and hospital avoidance models**	**Revise** relevant Commonwealth program guidelines and funding settings to enable NPs to function as lead clinicians in settings where they are already delivering high-value care. This should include: • Revising Medicare Urgent Care Clinic Operational Guidelines to permit NPs to act as lead clinicians where an appropriately credentialed NP is available; • Removing mandatory onsite GP requirements in urgent care settings when these are not clinically necessary; • Amending the General Practice in Aged Care Incentive (GPACI) or successor arrangements to include NPs as eligible providers and recipients of payments; • Supporting hybrid service models in aged care and rural outreach where local nurses work with NPs via telehealth to prevent unnecessary hospital transfer; and • Explicitly recognising NP-led care as part of Commonwealth strategies to reduce avoidable emergency department presentations and preventable hospital admissions.
Recommendation 6: **Make NP-led practices eligible for primary care incentive programs**	Amend the Practice Incentive Program (PIP), Workforce Incentive Program (WIP), and related program guidelines to recognise NP-led practices as eligible primary care providers. This should include: • Extending eligibility for NP-led practices to participate in PIP and WIP funding streams where they meet equivalent service delivery and quality requirements; • Enabling access to relevant incentives including: ▸ quality improvement payments ▸ rural support payments ▸ after-hours incentives ▸ Indigenous health incentives ▸ teaching and training payments ▸ digital health incentives • Enabling payments to be made directly to NP-led practices or employing organisations; and • Applying rural loading adjustments consistently across provider types.

Recommendation 7: **Establish dedicated public-sector and community-controlled funding streams for NP roles**	**Create** recurrent Commonwealth funding mechanisms to support NP roles in public health services, Aboriginal Community Controlled Health Services (ACCHS), aged care, and rural outreach models, particularly in areas of workforce shortage and high preventable hospital use. This should include: • dedicated funding for NP positions in high-need rural, remote, and community-controlled settings; • support for stable workforce models rather than short-term or fragmented funding arrangements; and • recognition of NP roles as part of Closing the Gap, hospital avoidance, and rural workforce strategies.
Recommendation 8: **Invest in NP work-force development, recruitment and retention**	**Develop** a targeted national strategy to expand and activate the NP workforce in rural, regional, and remote Australia. This should include: • funded clinical placements for NP candidates; • incentives for recruitment and retention in MM3–MM7 communities; and • specific measures to address the current underutilisation of the NP workforce.
Recommendation 9: **Require rural stress-testing of all Future Medicare Reforms**	Introduce a formal requirement that all future Medicare and primary care funding reforms be subject to rural, regional, and remote impact assessment before implementation. This should include assessment of likely impacts on: • affordability • continuity of care • telehealth access • workforce utilisation • service viability in MM2–MM7 settings • downstream hospital and emergency department demand

Introduction

The ACNP is the leading national body representing NPs and Advanced Practice Nurses (APN). We drive the advancement of nursing practice, provide expert patient-centered care, and strengthen consumer access to health services. Nurse Practitioners can independently perform advanced assessments, diagnose medical conditions, and manage complete episodes of care. They autonomously prescribe medicines, request and interpret advanced diagnostic tests, and can independently refer to medical specialists, similarly to GPs. They can work in a generalist or specialist capacity and are uniquely equipped to address unmet healthcare needs within rural, regional and remote communities and expand access to high-quality care, especially for underserved or marginalised populations.

Nurse Practitioners are regulated by the Nursing and Midwifery Board of Australia (NMBA) and work across diverse healthcare settings and specialty areas, ranging from metropolitan hospitals to remote primary healthcare clinics. Their practice spans a wide spectrum of adult and pediatric specialties, including accident and emergency, primary healthcare, mental health, aged care, palliative care, and condition-specific areas such as diabetes, cardiology and respiratory care.[1-5] Research consistently demonstrates high levels of patient satisfaction with care delivered by NPs, which contributes to improved treatment adherence and better health outcomes.[1,3,5-8] This success highlights the invaluable role of NPs within the Australian healthcare landscape and represents a significant step towards more accessible, efficient and cost-effective healthcare delivery.

Despite the depth, availability and proven capability of the workforce, NPs remain unevenly embedded within Australia's broader healthcare architecture. Many public, policy and program frameworks continue to default to a doctor centric model, even in settings where NPs are already delivering comprehensive, high quality care. This under representation is not reflective of NP expertise or workforce readiness, but rather the legacy of historical system design that positioned medical practitioners as the default providers of advanced clinical services. As a result, health system structures often fail to fully recognise or utilise the NP workforce, limiting opportunities for efficient workforce deployment and reducing timely access to care, particularly in communities where NPs are already well placed to respond to unmet health needs.

The Nurse Practitioner Workforce Plan[9], released by the Department of Health in May 2023, outlines strategies to remove systemic barriers to the NP clinical scope of practice. Eliminating legislative and operational barriers that lack a clinical basis, and which corrects misalignment with federal and state legislation across the Commonwealth, is essential for consistency across jurisdictions and enabling NP scope of practice. National uniformity in legislation, which harmonises and enables NP practice across state and Commonwealth instruments, is imperative for the safe, effective and timely diagnosis and treatment of diverse health conditions in our communities.

The ACNP strongly advocates for the recognition of the independent role of NPs, and their capacity to lead healthcare teams across various contexts. This recognition is essential to advance the nursing workforce, support the modern nursing role, and dispel outdated perceptions.

Terms of Reference

In this submission, the ACNP will address the following from the Rural and Regional Affairs and Transport References Committees Terms of Reference (ToRs):

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

b. the financial sustainability of independently owned rural general practices under current Medicare funding and incentive structures;

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;

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

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.

Photo by ZigicDrazen on Deposit Photos

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

The 1 November 2025 Medicare changes have introduced structural constraints that operate through three primary mechanisms:

a. financial disincentives for NP-led care,

b. restrictions on telehealth continuity, and

c. exclusion from continuity-of-care funding frameworks.

These mechanisms result in reduced service availability, increased out-of-pocket costs, and downstream increases in avoidable hospital utilisation.

Photo by Tarryn Grignet on Unsplash

Bulk-Billing Incentives Program (BBIP)

In many rural and remote communities, NPs often serve as primary healthcare providers, working independently to their full scope of practice, particularly in areas where GPs are scarce or only intermittently available. Despite NPs providing access to timely quality care in their communities, the Bulk-Billing Incentive Program (BBIP) was expanded on 1 November 2025 for GPs only, which provides a 12.5% bonus on eligible MBS benefits for practices that bulk-bill all patients. This incentive does not extend to NPs working in general practices, Aboriginal Community Controlled Health Organisations (ACCHOs) or NP-led clinics.

The effects of this exclusion are significant for NP-led clinics, general practices and ACCHOs in rural and remote areas who employ NPs. This is because NP employment costs are shifted to the employer in bulk-billing models or NPs are required to privately bill in those practices to create a sustainable employment. This causes confusion and cost-shifting to health consumers, particularly when they know they can see an NP for their health requirements but only be bulk-billed when they see a GP. This funding policy decision creates an unintended and unnecessary consumer driver towards GP services, which creates additional workforce and employer pressures. The unintended result is additional out of pocket costs for patients seeking care from NPs and employers reconsidering the role of NPs in general practice and ACCHOs in regional and remote areas. It affects health consumers directly, many of whom already experience multiple socioeconomic disadvantages compared with metropolitan populations, including poorer health outcomes, reduced access to primary healthcare, lower educational attainment and health literacy, and higher rates of unemployment.[10]

The effect of the BBIP program on stand-alone NP clinics is significant. Approximately, 32% of the total NP workforce is either unemployed or not working in named NP positions because of Commonwealth policy and funding frameworks that undermine the full clinical capabilities and responsibilities of NP-directed care. Prior to 1 November 2025, high rates of unemployment resulted in many NPs electing to work for telehealth-only models, which substantially reduce employment, operational and overhead costs. **With the 1 November 2025 changes many NPs were required to change their operational and employment models; therefore, the ACNP expects the percentage of bulk-billed NP services nationally will reduce substantially in 2025-26, which will result in more health services that require health consumer gap payment with NP-directed care during a cost-of-living crisis.** This means access to essential care will be more expensive for health consumers, as NPs are ineligible for bulk-billed health incentive payments and must rely on gap billing, high volume services or large corporate models to sustain their practices with current funding mechanisms.

An analysis of bulk-billed NP services using Commonwealth data was undertaken to substantiate this assertion. The most recent complete financial year with nationally comparable Medicare statistics for NP non-referred attendances is 2024–25. Using the Australian Government Department of Health, Disability and Ageing's Medicare quarterly "Primary Care Service Type Summary" dataset (which reports services and bulk billed services by primary care service type and state/territory), Australia recorded 1,648,651 Medicare subsidised NP services captured in the "Nurse Practitioner Services" primary care category in 2024–25, of which 1,344,842 were bulk billed, **giving a national NP bulk billing rate of 81.6%** (See Table 1).

Table 1: Nurse Practitioner Bulk Billing Rates 2015-16 to 2024-25

Fiscal Year	Total NP Services	Total NP Services	Bulk Billing Rate
2015-16	309,611	288,818	93.3%
2016-17	418,737	395,215	94.4%
2017-18	467,701	433,273	92.6%
2018-19	570,826	522,102	91.5%
2019-20	669,742	614,434	91.7%
2020-21	766,540	697,324	91.0%
2021-22	865,997	763,454	88.2%
2022-23	1,030,609	865,594	84.0%
2023-24	1,200,446	974,976	81.2%
2024-25	1,648,651	1,344,842	81.6%

Over the past decade, NP Medicare service volumes in this category increased substantially, while the bulk billing rate fell. In 2015–16, there were 309,611 NP services with a bulk billing rate of 93.3%; by 2024–25, services rose to 1,648,651 (an increase of ~432%) while the bulk billing rate fell to 81.6% (a drop of ~11.7%). This contributes to cost-shifting to consumers, occurring alongside a decline in NP bulk billing rates from over 93% to 81.6% despite a more than fourfold increase in service volume. This means there is growing NP capacity within the primary healthcare sector, particularly in regional and remote areas, but current Commonwealth funding and policy restrictions for NPs are contributing to increased shifting of healthcare costs to health consumers.

In addition, there is meaningful state/territory variation in the 2024–25 bulk-billing dataset. For example, ACT (86.4%), NSW (85.3%) and Queensland (83.1%) were above the national NP bulk billing rate, while Tasmania (70.6%) and South Australia (71.8%) were materially lower (See Table 2).

Table 2: Nurse Practitioner Bulk Billed Services by Jurisdiction 2024-25

State	Total NP Services	Bulk Billed Services	Bulk Billing Rate
NSW	451,594	385,029	85.3%
QLD	422,094	350,620	83.1%
VIC	367,971	293,447	79.7%
WA	258,485	205,103	79.3%
SA	76,541	54,927	71.8%
TAS	29,538	20,854	70.6%
ACT	24,086	20,813	86.4%
NT	16,068	11,783	73.3%

Importantly, the Commonwealth summary dataset demonstrates that bulk billing of NP professional attendances decreased in both major cities (MM1) and regional/rural/remote Australia (MM2–7) between 2015–16 and 2024–25. For NP attendances according to location, the bulk billing rate fell from 93.7% to 82.0% in MM1 (−11.7% change) and from 92.7% to 80.7% in MM2–7 (−12.05% change). The decline was therefore slightly larger in MM2–7 by 0.35 percentage points over the period from 2015-16 to 2024-25. As previously identified, with the 1 November 2025 changes for NP-directed care, it is expected the bulk billing rate will substantially decrease in 2025-26 onwards.

Australians in rural and remote communities have significantly higher rates of hospitalisation, deaths and injury, and often experience limited access to health services due to geographic isolation, workforce shortages and fewer specialists.[10] In addition, rural and remote populations tend to have lower levels of education, which influences employment opportunities and income, further reinforcing socioeconomic disadvantage.[10] These factors contribute to poorer overall health and wellbeing in rural and remote areas compared with major cities. As a result, the continued availability of bulk billing services provided by NPs may be at risk. Without access to BBPIP support, NP led services face greater financial pressure, which may force some providers to introduce or increase gap fees. This can lead patients to delay or forgo care, undermining continuity and access to essential primary health services. For NPs, the lack of BBPIP incentives limits the sustainability and growth of services in communities where they are often the sole healthcare provider, further exacerbating workforce shortages and deepening existing inequities in care delivery.

Photo by Sandie Peters on Unsplash

Telehealth Access and NP-led Models of Care

Historically, NP-led telehealth-only models have provided safe, effective, and well-governed access to primary care, mental health, and specialist services for communities where local face-to-face access is limited due to workforce shortages, geographic isolation, or other restrictive factors. These models have been particularly critical in settings with no or limited access to a medical practitioner, where patients rely on established therapeutic telehealth relationships with NPs to maintain continuity of care.

The introduction of Medicare telehealth changes on 1 November 2025, which subject NP telehealth items to "eligible telehealth practitioner" criteria and new face-to-face requirements for NPs, has significantly reduced access to these previously effective specialised models of care. Where patients are unable to meet the new face-to-face eligibility requirements, access to bulk-billed and subsidised NP-led telehealth has been effectively withdrawn, despite the absence of any feasible local rural or remote alternative. For many patients in regional, rural, and remote communities, attending a face-to-face consultation is impractical or impossible due to distance, travel cost, mobility limitations, caregiver responsibilities or ongoing GP workforce shortages.

The 1 November 2025 changes have directly undermined continuity of care for patients whose primary and ongoing therapeutic relationship is with an NP, and where patients do not meet the exemption criteria. Maintaining rapport, trust, and clinical oversight is particularly important for vulnerable populations who depend on long-term, consistent care. Pre-November 2025 telehealth settings enabled this continuity and ensured timely access where in-person care was not an option or the preferred model of care.

Reduced access to MBS-funded, NP-led telehealth has disrupted affordability and continuity of care for both adult and paediatric patients experiencing a range of medical and mental health conditions including, but not limited to: neurodivergence, ADHD, anxiety, depression, trauma-related conditions, and severe mental illness, cancer and palliative care, chronic disease management including diabetes and cardiovascular disease. Reduced access to care is increasing the risk of worsening morbidity and mortality, as well as crisis presentations in regional and remote areas.

Table 3: Current Exemptions to the Once in 12 Months Face-to-Face Rule for Subsidised Telehealth Services

If a patient is:
• experiencing homelessness
• under 12 months of age
• treated at an AMS or an Aboriginal Community Controlled Health Service (ACCHS)
• in a natural disaster area
• needing mental health planning and treatment services **(not available to Nurse Practitioners)**
• requiring urgent after-hours services in unsociable hours **(not available to Nurse Practitioners)**
• receiving blood borne viruses, sexual or reproductive health consultations
• registered in MyMedicare at the practice providing the telehealth service **(not available to NP led practices)**
• registered with a practice under MyMedicare and has phone attendance items 91900 or 91910 provided by that practice **(not available to Nurse Practitioners)**
• in isolation or quarantine for COVID-19 due to a state or territory public health order

MyMedicare and Telehealth Access

The introduction of the MyMedicare registration model, which was introduced by the Australian Government to strengthen the relationship between patients and their regular primary care team, provides an alternative pathway for patients to access Medicare rebated telehealth services. Under this system, patients formally register with a primary care practice, typically led by a GP, to strengthen continuity of care and facilitate access to longer telehealth items. For registered patients, certain face to face requirements can be waived, allowing telehealth consultations to be bulk billed without the usual prior in person encounter.

While this pathway may assist some patients, it has significant limitations for NP practice, particularly in rural, regional, and remote communities:

1. GP-Centric Registration:

- MyMedicare registration is primarily designed around GP-led practices. In many rural and remote communities, the NP is often the primary or sole healthcare provider. Under the current model, patients whose ongoing therapeutic relationship is with an NP may not be able to register the NP as their nominated provider.
- Consequently, NPs cannot fully leverage the less restrictive MyMedicare face-to-face pathway requirements, further limiting telehealth access for patients who rely on NPs for continuity of care. Minister Butler made a pre-election promise to include NP-led practices as eligible MyMedicare providers, but this has resulted in only those practices that are able to engage a GP.

2. Eligibility Barriers Remain for Remote Patients:

- For populations living hundreds of kilometres from the nearest practice, or with mobility or financial constraints, the 12-month face-to-face requirement to claim a MBS rebate for ongoing telehealth, is often impractical. Patients who cannot meet these criteria are excluded from accessing Medicare rebated telehealth, effectively removing previously available NP-led telehealth services.

3. Administrative and Workforce Implications:

- Practices must actively manage MyMedicare registrations and maintain evidence of eligibility. For NPs operating in small practices, administrative burdens increase, potentially diverting time from clinical care. In addition, NP-led services that were previously rebated under the Medicare telehealth framework are now constrained, impacting service viability and patient access.

4. Continuity of Care Risks:

- By limiting the ability of patients to access telehealth with their NP unless they satisfy MyMedicare registration or face-to-face requirements, these changes undermine continuity of care. This is particularly concerning for patients with chronic, complex, or psychosocial needs who rely on long-term therapeutic relationships with NPs, including those in remote communities where alternative providers are not available.

While MyMedicare has the potential to streamline telehealth access for some populations, the model fails to account for NP-led primary and specialist care in rural and remote areas. Restricting NP telehealth items based on MyMedicare eligibility or prior face-to-face consultations disproportionately impacts patients whose ongoing care is provided by NPs. Without amendments or exemptions recognising NP-led services, the 1 November 2025 Medicare changes, in combination with the current MyMedicare structure, risk reducing access, continuity, and equity in primary care for Australia's most isolated and vulnerable communities.

Veteran Community

The impact of the 1 November 2025 changes is particularly pronounced for populations with complex psychosocial needs. The Royal Commission into Defence and Veteran Suicide (Volume 4 - Health Care for Serving and Ex-Serving Members) highlighted the critical importance of early intervention and timely, accessible, and appropriate psychosocial care tailored to individual needs.[11]

In rural and remote settings, where specialist mental health services are often scarce or entirely unavailable, telehealth is not an adjunct to in-person care but the primary, and in many cases the only, means of accessing support.

For veterans experiencing post-traumatic stress disorder (PTSD), anxiety disorders, or agoraphobia, face-to-face care may be confronting or effectively inaccessible due to geographic isolation, workforce shortages, and travel constraints. Restricting telehealth access through eligibility-based requirements compounds existing barriers to care, increases the risk of disengagement, and undermines national reform efforts aimed at improving mental health outcomes for veterans and other vulnerable rural and remote populations.

Photo by Bumble-Dee on Deposit Photos

Findings from the ACNP National Survey

To assess real-world impacts, the ACNP undertook a national survey of 140 Nurse Practitioners, representing approximately 4% of the national workforce. While not a full census, the findings provide consistent and credible insight into how recent policy changes are affecting clinical practice across multiple jurisdictions and service settings. Descriptive statistics were used to analyse quantitative data from the survey, whereas thematic analysis of free-text boxes was undertaken to analyse qualitative data.

Quantitative Findings

Current telehealth policy settings are designed around episodic, exception-based use. In contrast, NP-led telehealth is predominantly used for longitudinal, continuity-of-care service delivery. Applying restrictive eligibility criteria designed for episodic care to continuity-based models has resulted in a structural mismatch that reduces access to clinically appropriate care, as demonstrated by the quantitative data below. For many patients, these changes result in delayed follow-up, interruption of chronic disease management, and increased reliance on emergency departments for conditions that would otherwise be managed in primary care.

Overall, NP survey respondents demonstrate they work in various contexts, with the largest cohort (67%) working in primary healthcare settings (See Figure 1).

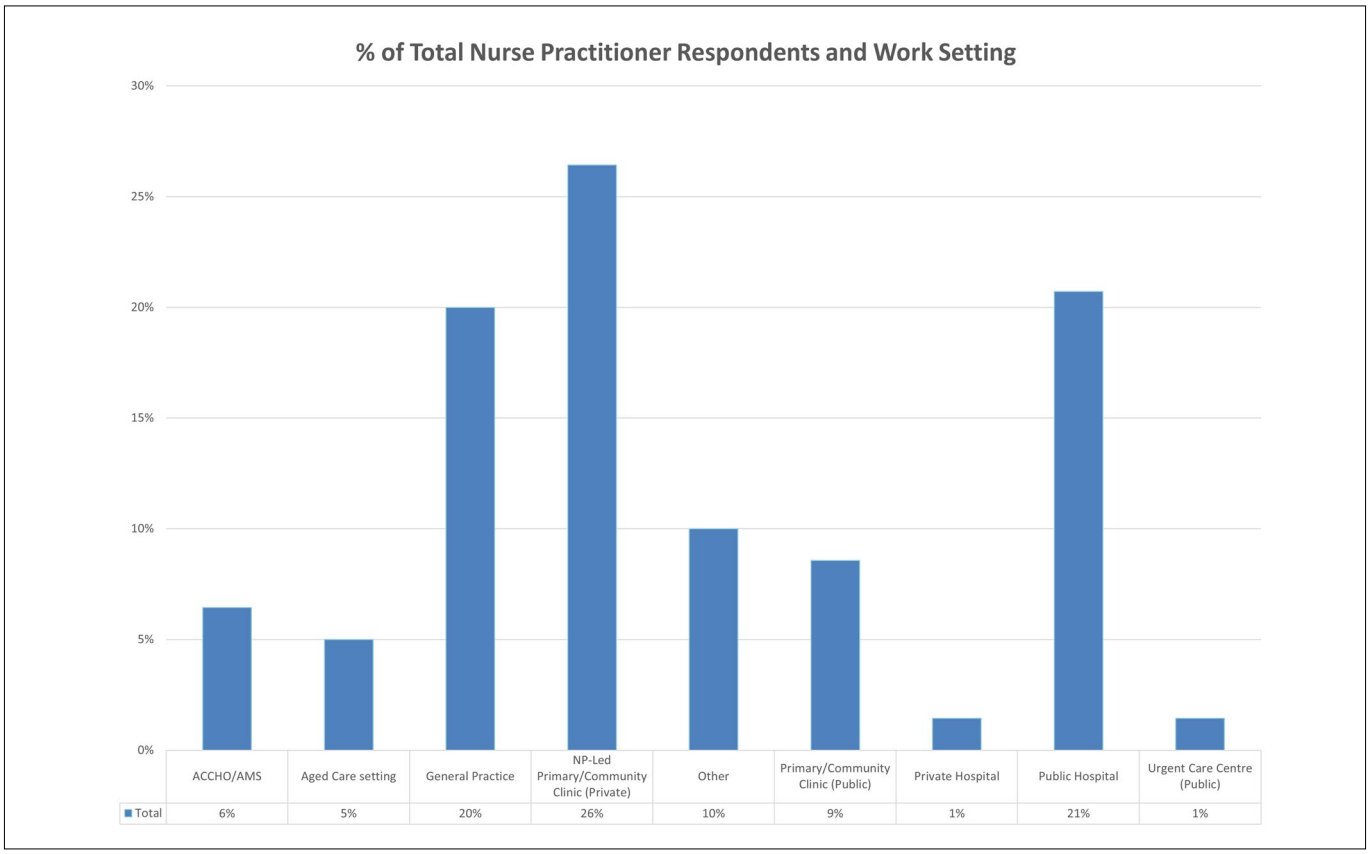

Figure 1: Primary Practice Settings of Nurse Practitioner Respondents

Respondents were asked what proportion of their clinical services were delivered via telehealth. Results indicate that telehealth provision is widely adopted by 90% of the NP workforce who responded, but is not the dominant format of care they provide (See Figure 2).

Only a small proportion (9%) are working in models that provide a high volume (81-100% of total clinical services) of telehealth services. This implies that telehealth is functioning as a complementary modality, not a replacement for face-to-face care, which is consistent with hybrid care models.

When respondents were asked the question *"How important is telehealth for patient access to clinical care?"* survey results demonstrate that respondents **identify telehealth as essential for patient access across all jurisdictions. Approximately 78% of all NP clinicians working in the private sector reported it was either very important or essential to delivering care.** Depending on the setting in which they practiced, of the NPs who rated telehealth as being very important or essential, the highest proportion were those practices that were NP-led clinics working in primary care (See Figure 3).

This means the 1 November 2025 telehealth restrictions have disproportionately impacted NP-led clinics in the primary healthcare sector, including those providing services in regional and remote areas.

Of the survey respondents, 39% indicated their principal place of practice was in Modified Monash Model (MMM) Region 1 (Metropolitan), with the remaining 61% working in MMM Regions 2-7 (Regional to Very Remote). Reliance on telehealth for clinical practice is consistent across all Modified Monash Model (MMM) categories and work settings, with 75% of respondents in every location rating it as a primary or highly important mode of access. This pattern appears not only in rural and remote areas, where distance and service scarcity drive dependence, but also in metropolitan settings, where telehealth helps address availability constraints and long wait times. Only a small minority (5%) of total NP respondents indicated that telehealth plays a minimal role in their practice (See Figure 4).

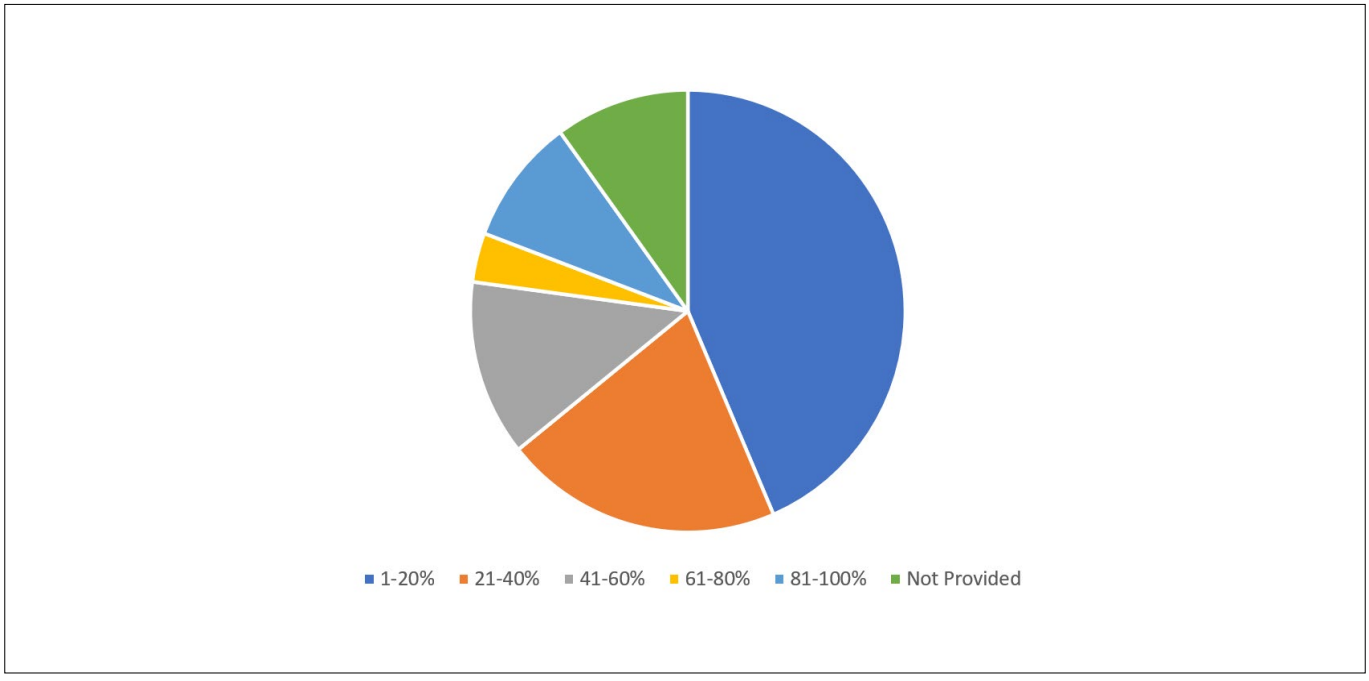

Figure 2: Telehealth Utilisation as a Percentage of Care by All Nurse Practitioner Respondents

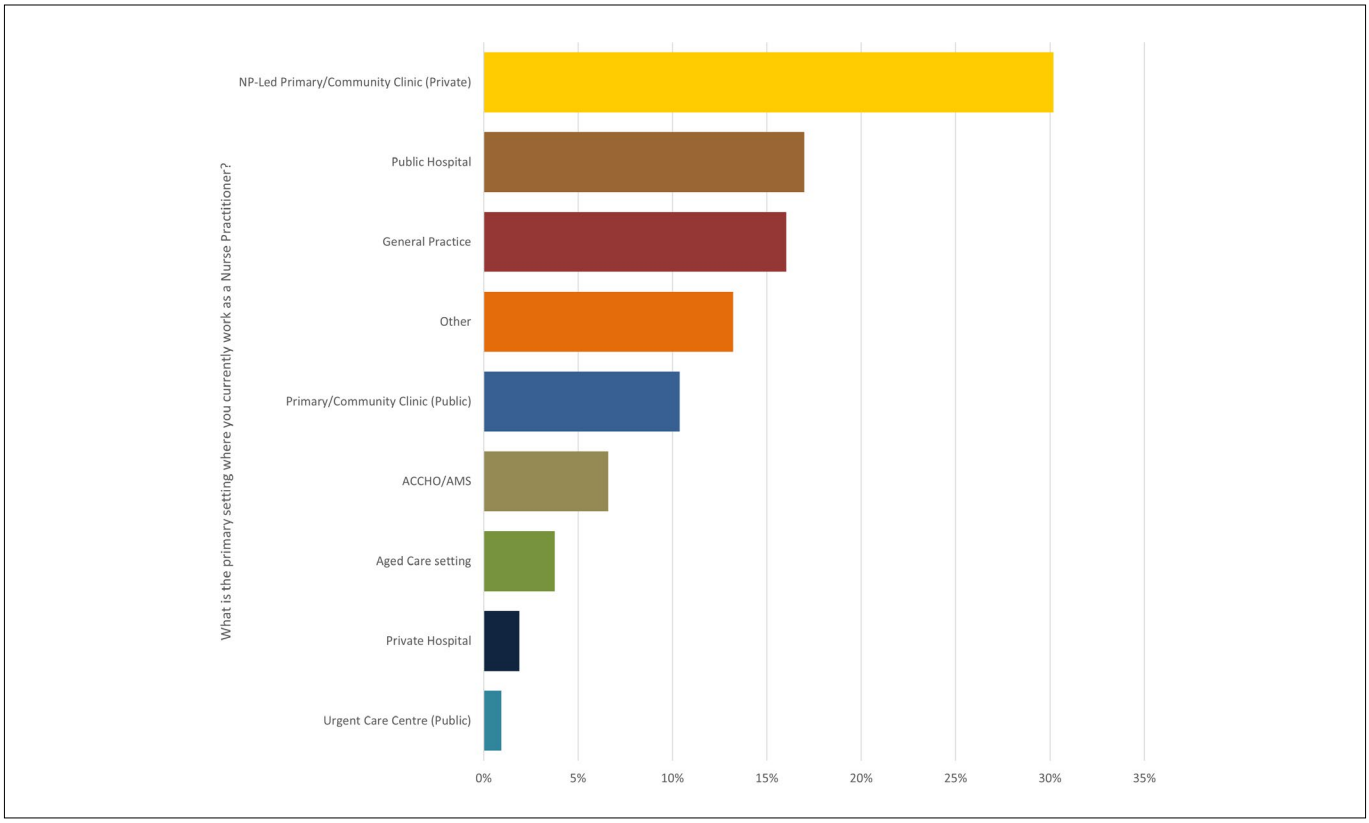

Figure 3: Proportion of Nurse Practitioners Rating Telehealth as Important or Essential for Service Delivery According to Work Setting

Of the survey respondents, 39% indicated their principal place of practice was in Modified Monash Model (MMM) Region 1 (Metropolitan), with the remaining 61% working in MMM Regions 2-7 (Regional to Very Remote). Reliance on telehealth for clinical practice is consistent across all Modified Monash Model (MMM) categories and work settings, with 75% of respondents in every location rating it as a primary or highly important mode of access. This pattern appears not only in rural and remote areas, where distance and service scarcity drive dependence, but also in metropolitan settings, where telehealth helps address availability constraints and long wait times. Only a small minority (5%) of total NP respondents indicated that telehealth plays a minimal role in their practice (See Figure 4). Of the total survey respondents, 74% report providing care to MMM2-7 (non-metropolitan populations), with 18% providing care to MMM6-7 (remote/very remote) locations via telehealth. Approximately 9% of NPs have a work setting that is primarily based in MMM6-7. This is important, as it means that remote service delivery exceeds the number of remote-based NPs, implying inbound outreach from less remote areas. Among those NPs who stated their principal work location was based in a metropolitan area (MMM1), 35% indicated they provide care to non-metropolitan aeras (MMM2-7) and 13% of those NP working in metropolitan areas provided care to remote/very remote areas (MMM6-7). Importantly, NP outreach clinics based in MMM2-5 locations are also servicing other non-metropolitan areas, with the strongest service concentrations in MMM 3 (30%) and MMM 4-5 (35%) areas.

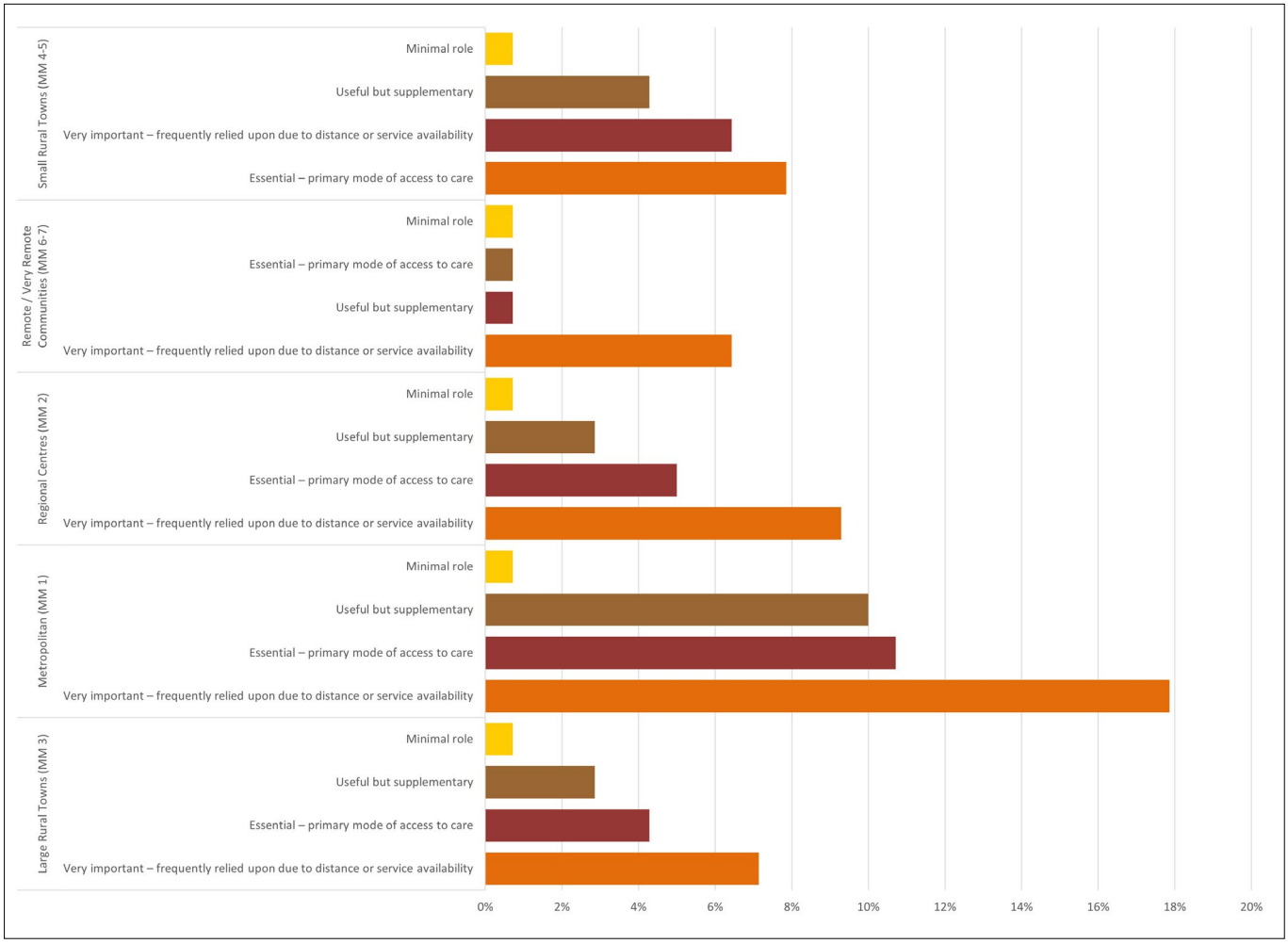

Figure 4: Total Nurse Practitioner Respondents' Rating of Telehealth Importance to Clinical Practice According to Modified Monash Model Work Setting

These data suggest that NPs are functioning as a transboundary workforce, who contribute to outreach clinics, visiting services, and hub-and-spoke models supported by telehealth. This implies that NP practice is inherently multi-site and networked through telehealth service provision, and should be viewed as a distributed service layer, as their practice is not fixed to a single MMM classification. Nurse Practitioners represent an already-functioning, scalable workforce model for improving access to care in regional and remote Australia, but current funding and classification systems likely undervalue and constrain their full potential impact because of the 1 November 2025 telehealth changes.

When respondents were asked which of the current MBS telehealth exemption criteria applied to their clinical practice, 51% stated none of the existing criteria were relevant to their patient populations. Figure 5 provides the most used current exemptions used by NPs in clinical practice.

The most striking finding is that for around half of respondents, none of the listed exemption pathways are commonly applicable. In practical terms, this indicates that most NP telehealth activity occurs outside the main telehealth exemption architecture.

This suggests a policy mismatch: the current telehealth eligibility framework appears to be structured around narrow exception categories,

while NP telehealth practice is being used for broader, more routine, and clinically necessary care. For example, non-exempt populations identified by NP respondents include older persons (66%), people with disability or mobility limitations (51%), palliative care patients (26%), veterans and/or veteran families (21%), and paediatric patients over 12 months of age (21%). These are not fringe groups. They are populations for whom telehealth is often clinically sensible, logistically necessary, or both. The two largest groups (older people and people with disability or mobility limitations) are especially important from a public policy perspective, because they are exactly the populations most likely to experience:

- transport barriers
- reduced mobility
- difficulty attending in person
- fragmented local workforce access
- repeated follow-up needs

The fact that these groups feature so prominently indicates that telehealth is being used to address access barriers in ordinary care delivery, not only in formally exempt circumstances.

Respondents were asked which clinical issues they commonly manage by telehealth for patients who are not exempt from the current eligibility rules. The most common responses are identified in Figure 6.

Telehealth is not confined to a narrow band of low-complexity care. It is being used across a broad clinical scope, including chronic disease management, preventive care, follow-up, symptom review, behavioural health, and selected acute presentations.

A subset of NPs (n=17/140, 12%) reported delivering 61–100% of their services via telehealth, indicating the emergence of telehealth-dominant models of care pre-November 2025. These practitioners provided services across a broad clinical spectrum, including acute minor illnesses and injuries (61%), mental health care (44%), musculoskeletal care (44%), renal care (40%) and cardiovascular and pulmonary disease (33%), dermatologic (33%), endocrine (28%) and preventive health (44%) interventions. The inclusion of chronic disease management and higher-complexity clinical areas demonstrates that telehealth can support comprehensive, ongoing care rather than being limited to low-acuity presentations.

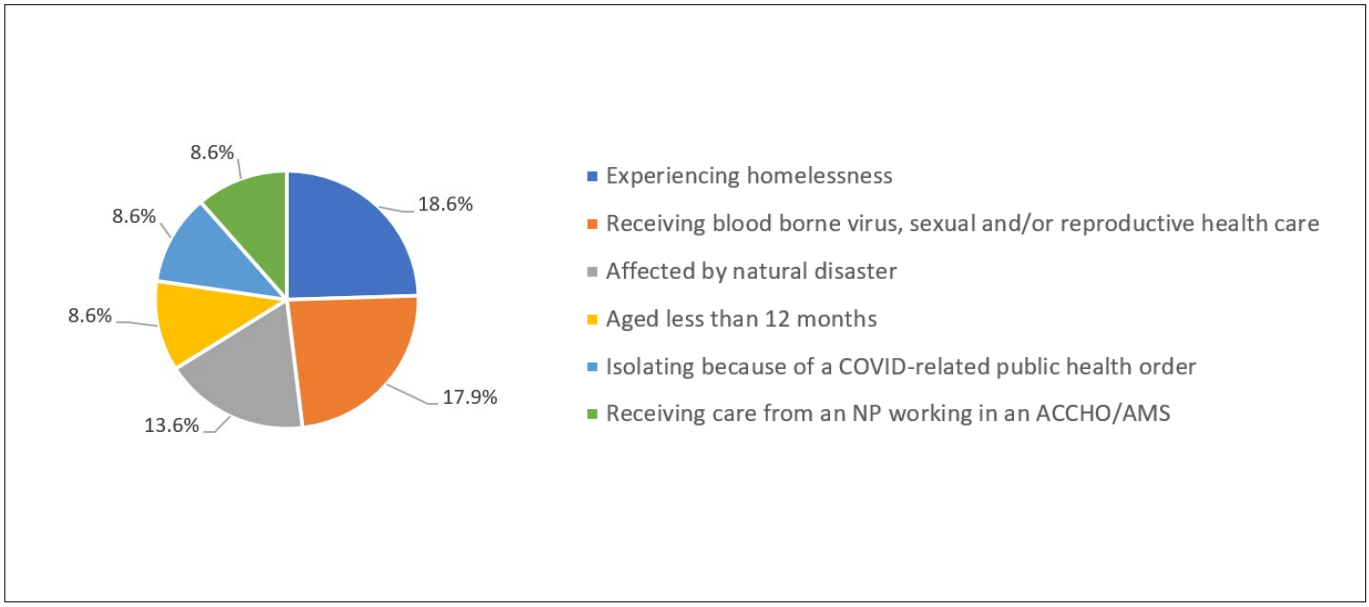

Figure 5: Telehealth Exemption Criteria Used by Nurse Practitioner Respondents

The relatively small proportion of practitioners operating at this level suggests that current policy and funding settings may be constraining the broader adoption of telehealth-enabled NP models, rather than reflecting limitations in clinical capability.

Importantly, there were no appreciable differences in clinical domains of practice when comparing the sub-sample of NPs who provide a high volume of telehealth services (61-100% of total service provision; n=17) with those with lower telehealth utilisation in their clinical practice (n=122). **Therefore, high telehealth utilisation is associated with care models built around continuity, monitoring, and accessibility, rather than episodic, one-off encounters.** They provide care across the same broad range of clinical domains as other practitioners, including acute care, chronic disease management, mental health, and preventive care. The key distinction lies in the model of care: high telehealth users demonstrate a shift toward longitudinal, review-based, and access-oriented service delivery. Clinical areas such as mental health, musculoskeletal conditions, renal disease, and lifestyle management are more prominent, reflecting their suitability for remote monitoring and follow-up. **These findings indicate that high telehealth utilisation represents a reconfiguration of care delivery rather than a limitation of clinical scope or supporting "low-value transactional models" of the MBS-subsidised telehealth system.**

These results demonstrate that telehealth is no longer a supplementary tool; it is a core component of equitable healthcare delivery for NP-directed services, enabling timely access, continuity of care and reduced travel burden for patients across the full MMM spectrum. These findings strongly support the need for changes needed to current telehealth exemptions, which target investment in rural and remote telehealth models, and the avoidance of restrictive policies based solely on geography, as such measures would risk undermining access for patients nationwide.

This is important evidence against the assumption that telehealth should be reserved only for a limited set of conditions or exceptional cases. In NP practice, telehealth is being used where it is clinically functional and operationally useful. **Therefore, aligning telehealth restrictions for NP services with those required for GPs was an inappropriate decision made by the Commonwealth. Instead, NPs should retain the broad exemptions for telehealth services that are seen with eligible midwives and allied health practitioners.**

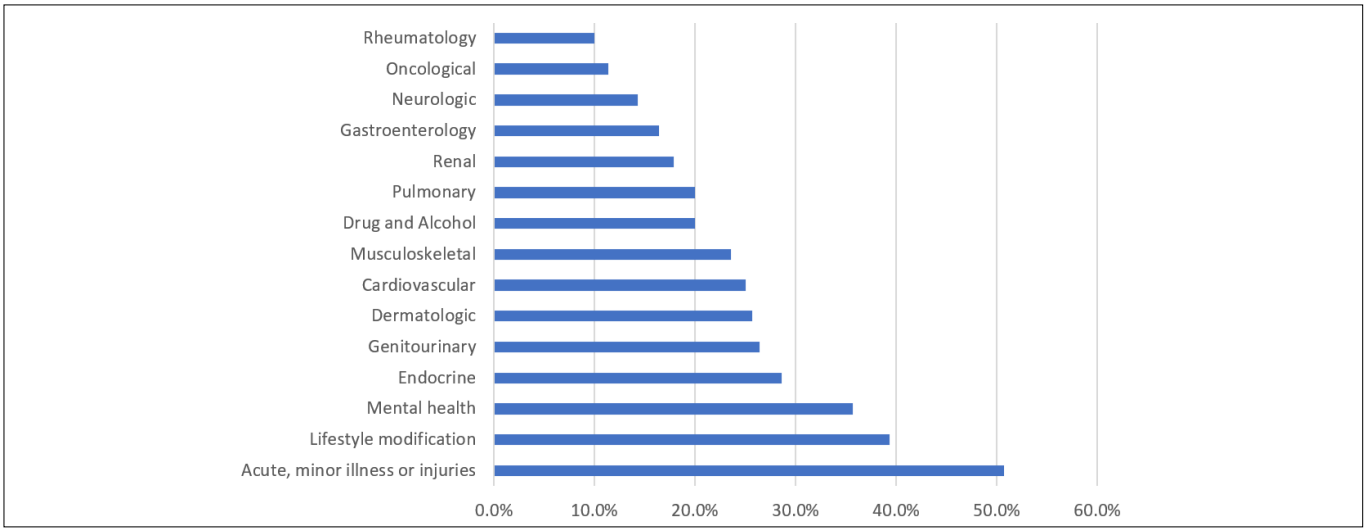

Figure 6: Clinical Issues Managed by Nurse Practitioner Respondents through Telehealth

Qualitative Findings and Case Studies

Qualitative findings from the ACNP member survey show significant impacts on key population groups who are currently ineligible under existing criteria and for whom affordable access to care is at risk, including consumers requiring:

Mental health care

Reduced access MBS funded NP-led telehealth has disrupted affordability continuity of care for patients with anxiety, depression, trauma-related conditions, and severe mental illness, increasing the risk of deterioration and crisis presentations.

Member feedback

As a Nurse Practitioner working in child and adolescent mental health, my service is based in an outer metropolitan area; however, many of my clients must travel from rural and regional areas for initial appointments. Ongoing follow-up consultations are provided via MBS-funded telehealth, ensuring both affordability and continuity of care without repeated long-distance travel.

Many of these families would be at risk of losing access to care if current telehealth eligibility criteria, particularly the requirement for annual face-to-face consultations, cannot be met due to distance or limited local service availability. Public child mental health services have very long waitlists, and accessing care often incurs hidden costs, including travel, parking, accommodation, time off work, and arranging care for other children. Most families do not see a child psychiatrist during their public mental health contact, and private child psychiatry is financially prohibitive.

To address these barriers, Medicare funded telehealth should include additional exemptions for mental health services for people residing in MMM 3–MMM 7 regions. Telehealth is a vital resource for ensuring direct access to specialty NPs, particularly for families living in rural, regional, and remote communities. Sustaining and strengthening telehealth availability promotes equitable care, removes geographic barriers, and helps prevent children from disengaging from essential mental health services.

Paediatrics

Families in remote areas face barriers maintaining ongoing paediatric care, including developmental monitoring and management of behavioural and chronic conditions, when telehealth eligibility is restricted.

Member feedback

Children in rural and remote communities face significant barriers to paediatric care, with families often travelling long distances and paying high costs to access specialists and allied health services. Current Medicare settings restrict NPs from initiating Mental Health Treatment Plans or Chronic Disease Management Plans, meaning many children miss out on subsidised speech therapy, occupational therapy, psychology, and other essential supports. GP only referral requirements further delay assessment for developmental disability, ASD/ADHD, behavioural concerns, and chronic conditions, creating bottlenecks in communities with limited or no GP availability. Additional policy barriers, such as the 12 month face to face telehealth rule, NP exclusion from bulk billing incentives, and restricted referral rights for diagnostics, compound inequities and make timely paediatric care financially and geographically inaccessible. Improving access requires enabling NPs to initiate care plans, removing telehealth restrictions for rural families, expanding NP diagnostic referral rights, providing access to bulk billing incentives, and supporting coordinated joint appointments to streamline care for families who already travel long distances.

Chronic disease management

Patients with long-term conditions such as diabetes, cardiovascular disease, respiratory illness, and pain conditions have experienced interruptions to routine monitoring, medication review, and early intervention, increasing the risk of preventable complications.

Member feedback

Chronic disease continues to disproportionately affect people living in rural and remote communities, who experience significantly higher rates of cardiovascular disease, diabetes, COPD, chronic kidney disease, cancer and multimorbidity. These patients face major barriers to timely, coordinated care, including limited access to essential allied health providers such as dietitians, exercise physiologists, diabetes educators and pharmacists, services that are critical for preventing disease progression and avoidable hospitalisations. Access is further compromised by restrictions preventing NPs from ordering a full range of diagnostic investigations, including ECGs, broader ultrasound, and selected CT imaging, resulting in delayed diagnosis and treatment.

Structural issues within the Medicare Benefits Schedule (MBS) further worsen chronic disease outcomes. NPs are unable to complete GP Management Plans (GPMPs) or Team Care Arrangements (TCAs), meaning patients miss out on the allied health rebates that are fundamental to chronic disease management. The 12 month face to face requirement for telehealth disrupts continuity of care for patients with unstable or complex chronic conditions, particularly those who are geographically isolated or have limited mobility.

NP consultation rebates remain too low to support the longer appointments required for comprehensive chronic disease care, and the exclusion of NPs from bulk billing incentives makes services unaffordable for many rural patients. Additionally, NP led clinics lack access to Medicare rebates for point of care testing such as HbA1c or ACR, despite these being essential for managing diabetes and kidney disease in remote settings where pathology access is limited.

Improving chronic disease care in rural and remote Australia requires urgent reform. Allowing NPs to complete Chronic Disease Management Plans and Team Care Arrangements would immediately expand patient access to subsidised allied health. Granting NPs full diagnostic access—including ECG, spirometry and a broader imaging list, would reduce delays and improve safety. Funding point of care testing in NP led clinics would strengthen onsite chronic disease monitoring, particularly in remote areas.

Restoring full telehealth access and bulk billing incentives are essential to ensure continuity and affordability of care. Introducing after hours and travel rebates for NPs working across dispersed communities would support viable service delivery. Finally, enabling NPs to lead case conferences, including within aged care, Department of Veteran affairs (DVA) and First Nations health, would ensure coordinated, multidisciplinary care for people with complex chronic illness.

Aged Care

Aged care residents in rural and remote Australia face significant barriers to timely, high quality care due to Medicare restrictions that limit the ability of NPs to provide essential, on site and telehealth services.

Member feedback

Aged care residents living in rural and remote areas are significantly disadvantaged under current Medicare settings. Residential Aged Care Facilities (RACFs) increasingly reliant on the expertise of NP-led care, yet current MBS rules limit the care NPs can provide. The 12 month face to face telehealth requirement is particularly harmful in this setting. Most aged care residents are frail, immobile, or living with advanced dementia, meaning they cannot travel for in person appointments. Because of this rule, NPs cannot claim telehealth consultations even when they are the only available clinician, leading to delayed care, unnecessary emergency department presentations, more ambulance transfers, and significant distress for residents, especially those with cognitive or sensory impairments.

Quality of care in aged care is further compromised by scope and funding gaps that do not reflect the reality of NP-led clinical work in RACFs. NPs are excluded from aged care specific MBS incentives, making it difficult to sustain consistent service delivery despite

NPs often providing most of the on site clinical assessment and management. They are also unable to complete death certificates even when they have been the primary treating clinician, cannot conduct MBS 715 (equivalent) Aboriginal and Torres Strait Islander Health Assessments, and are prevented from leading case conferences, despite being the clinician most familiar with the resident's care plan. These limitations, combined with restricted telehealth flexibility, also impede specialist NP services such as palliative care, dementia care, wound care and complex medication management.

Improving aged care access requires restoring telehealth as a viable mode of care and recognising the clinical responsibilities NPs already carry. Removing the face to face telehealth requirement for RACF residents would immediately enable safer, timelier care. Providing NPs with access to aged care bulk billing incentives, case conference items, and chronic disease and health assessment MBS items would support a more sustainable and coordinated model. Allowing NPs to issue death certificates where they are the treating clinician would reduce delays and distress for families. Hybrid models, where local aged care nurses collect vital signs and observations while the NP consults via video, should be explicitly supported. Expanding NP diagnostic referral rights for urgent clinical deterioration would further prevent unnecessary hospital transfers and improve resident outcomes.

First Nations

First Nations peoples in Australia continue to experience significantly disproportionate health outcomes, with life expectancy remaining lower, and rates of preventable illness, hospitalisation, and chronic disease notably higher than for non Indigenous Australians. These inequities stem from longstanding systemic, social, and cultural determinants that continue to impact access to care and overall wellbeing.

The survey findings indicate a clear need for broader and more flexible exemptions that recognise NP led continuity of care models and the realities faced by patients who have no viable in person alternatives. This is especially critical in First Nations communities, where NPs are frequently the most consistent, and often the only, primary healthcare providers. First Nations peoples continue to experience significantly higher rates of preventable illness, hospitalisation, and chronic disease, as well as disproportionate mortality from cardiovascular, respiratory, endocrine and injury related conditions. These inequities are compounded by longstanding systemic barriers and limited access to culturally safe, timely primary care, further reinforcing the essential role of NP led services in these settings.

Despite this, current Medicare Benefits Schedule (MBS) restrictions continue to limit the ability of NPs to request key diagnostic investigations, including echocardiograms. This is a critical gap in First Nations communities, where the burden of rheumatic heart disease, driven by acute rheumatic fever, remains disproportionately high and early cardiac assessment is essential for preventing progression, morbidity, and premature mortality. Restricting NP access to Medicare rebateable echocardiography forces patients to wait for or travel to a medical practitioner solely to obtain a referral, delaying diagnosis, increasing out of pocket costs, and risking further deterioration. In remote communities, where rates of chronic and potentially preventable hospitalisations are up to 2.7 times higher than for other Australians, such barriers have profound clinical and system wide consequences.

Without further exemptions to the face to face requirement, the post November 2025 Medicare settings risk reversing the gains achieved through NP led telehealth, disproportionately affecting isolated communities and vulnerable populations. Extending telehealth exemptions across regional, rural, and remote settings—alongside removing MBS restrictions that limit NP requested diagnostics, is essential to preserve access, maintain therapeutic relationships, and ensure equitable, culturally safe care delivery in communities where NPs are the primary, and sometimes sole, healthcare providers.

Member Feedback

Enable Nurse Practitioners to complete a comparable MBS rebateable item to MBS 715 – Aboriginal and Torres Strait Islander Health Assessment, ensuring full access to associated follow up items and incentive payments. Establishing an NP equivalent item would support culturally safe, continuous, and locally delivered models of care, particularly in communities where NPs are the primary healthcare provider. While limited telehealth exemptions currently apply to specific groups, these do not adequately reflect the realities of regional, rural, and remote Aboriginal and Torres Strait Islander populations, who continue to face structural, geographic, and socioeconomic barriers to face to face care. Expanding eligibility by creating an NP specific 715 equivalent item would improve access, reduce delays, and strengthen culturally appropriate health pathways embedded within local community controlled and NP led services.

The 1 November 2025 Medicare changes do not simply restrict individual services, but introduce structural inefficiencies into the primary care system. These settings reduce access, increase costs, and divert care into higher-cost hospital settings, despite the presence of an available and capable workforce.

Photo by Louise Beaumont on iStock

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

The current Medicare funding and incentive structures/arrangements fail to explicitly recognise primary care as a setting distinct from GP-led care and general practices. In practice, this results in primary care being narrowly defined through a GP-centric lens, effectively sidelining and overlooking NP practice and NP-led primary care. This omission has material consequences for service delivery, funding access, and patient care, despite NPs providing longitudinal, comprehensive primary care across metropolitan, regional, rural, and remote settings. By not explicitly describing NP-led clinics and general practices as "primary care", and instead defaulting to GP-led models through general practices, the policy implicitly excludes:

- NP-led primary care clinics unable to attract a GP
- multidisciplinary primary care services where NPs are the principal clinician
- community-embedded models that rely on NPs for continuity of care

This framing reinforces outdated assumptions about who delivers primary care and fails to reflect contemporary workforce models endorsed through national reform agendas, including the Nurse Practitioner Workforce Plan[9] and Scope of Practice Review.[12]

The policy changes have disproportionately affected NP led services, despite these services having stable, well documented care relationships that are equivalent in substance and quality to those recognised under GP led models.

- removing or restricting access to telehealth funding despite established therapeutic relationships
- undermining the financial viability of NP-led primary care clinics
- limiting patient access to ongoing care where NPs are the primary clinician

These impacts are most pronounced in rural and underserved communities, where NPs often provide most of the ongoing primary care and where alternative providers are limited or unavailable.

Patients who had built sustained, clinically appropriate telehealth relationships with their NP experienced:

- abrupt withdrawal of funding for services they had been receiving safely and effectively
- disruption to continuity of care
- increased barriers to access, including travel, cost, and delays
- forced the redirection of patients to unfamiliar providers, purely to meet eligibility criteria

The current MyMedicare architecture is built on the assumption that primary care is delivered exclusively through GP-led general practices. This assumption no longer reflects the reality of service delivery in many rural, regional, and remote communities, where NP-led practices provide essential, high-value primary care, often in areas with limited or no consistent GP availability. Despite this, NP-led primary care remains effectively excluded from the MyMedicare structure.

The current Medicare structure restricts access to essential diagnostics and referrals

Currently, NPs cannot provide MBS rebatable referrals for many plain-film imaging examinations and ultrasounds (e.g. spinal X-rays, orthopantomograms, vascular ultrasounds, thyroid ultrasounds) magnetic resonance imaging (MRI), CT scans (except the low dose CT available under the National Lung Cancer Screening Program), dual

energy X ray absorptiometry (DXA) scans, or echocardiography, despite higher rural and remote prevalence of conditions such as osteoporosis, rheumatic fever and post streptococcal disease where these investigations are the diagnostic gold standard.

These restrictions fragment care by forcing patients to book additional appointments solely to obtain a medical practitioner referral, causing delays in testing and diagnosis, duplication of effort, increased out of pocket costs, and significant inconvenience, particularly for those who must travel long distances.

Equity and Closing the Gap

In the context of Closing the Gap—Target 1 (Everyone enjoys long and healthy lives), timely access to essential healthcare is foundational. Limiting NP access to relevant MBS items directly constrains affordable care, undermining progress toward this target.[13]

System effects and workforce sustainability

The current Medicare architecture contributes to NP workforce attrition. Combined restrictions on MBS access and exclusion from key incentives and education funding make many NP led models financially unsustainable. By rewarding provider type rather than the value of care delivered, Medicare settings risk entrenching inequity, particularly in regional, rural and remote communities, driving avoidable ED presentations and worsening access unless reforms recognise and fund NP led primary care on an equitable basis.

Nurse Practitioners and Medicare Item Numbers

Nurse Practitioners are authorised to diagnose, treat, prescribe and refer, hold Medicare provider numbers, and bill a range of attendance items. However, material limitations remain:

- Chronic disease coordination: NPs cannot initiate and claim the same chronic disease management coordination items as GPs.
- Multidisciplinary planning: NPs cannot independently prepare and bill Medicare funded multidisciplinary care plans equivalent to GP led items.
- Mental health planning: NPs lack equivalent item numbers to prepare Mental Health Treatment Plans that enable subsidised psychological services.
- Care coordination leadership: While NPs can participate in case conferences, Medicare does not recognise them as primary coordinators on the same footing as GPs.

The practical impact is that even when an NP is the principal primary care provider, Medicare does not support them to lead and claim structured multidisciplinary coordination in the same way it supports GPs. In addition, NP attendance rebates are generally lower than equivalent GP rebates, increasing the risk of higher out of pocket costs for patients unless services are fully bulk billed.

Why This Matters in Rural, Regional and Remote Communities

Rural and remote Australia faces persistent GP shortages, higher rates of chronic disease, increased mental health burden, and reduced access to specialist and allied health services. Mixed-team models of care, incorporating GPs, NPs, nurses, Aboriginal Health Practitioners, allied health professionals and visiting specialists, are essential to delivering sustainable primary care in these settings.

However, the current Medicare funding architecture remains GP-centric. In communities where there may be limited or no permanent GP presence, this creates structural barriers. Even where highly qualified NPs are delivering comprehensive primary care, the funding model restricts their ability to claim coordination items that unlock allied health access and structured chronic disease management under Medicare.

This creates inefficiencies, underutilises the available workforce, and limits the financial viability of team-based care models in the areas that need them most.

Critical Access Implications for ACCHOs and NP-Led Practices

In rural and remote Australia, these funding limitations have particularly serious implications

for Aboriginal Community Controlled Health Organisations (ACCHOs) and NP-led practices. Many ACCHOs and standalone NP-led clinics operate in communities where they are the primary — and sometimes only — accessible healthcare provider. Some services are NP-led due to longstanding GP workforce shortages.

Where an NP is the lead clinician, the absence of Medicare item numbers for multidisciplinary team care coordination, chronic disease management planning, and mental health treatment planning means patients cannot access Medicare-subsidised allied health services in the same way they would under a GP-led model. This does not reflect a lack of clinical expertise; it reflects a funding gap.

As a result:

- Organisations must absorb unreimbursed coordination costs,
- Patients face out-of-pocket expenses,
- Or services are simply not delivered at the level of coordination required.

In communities already experiencing socioeconomic disadvantage, even small out-of-pocket costs can act as a barrier to care. Consequently, coordinated, team-based chronic disease and mental health care becomes financially inaccessible, not because providers lack capability, but because Medicare does not financially support NP-led multidisciplinary models.

In rural and remote settings, where workforce flexibility is essential and service availability is already constrained, this misalignment between scope of practice and Medicare funding directly affects equity of access, continuity of care, and health outcomes.

Photo by Dusan Petkovic on Deposit Photos

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

For patients able to register with a MyMedicare practice, the MyMedicare pathway can support ongoing telehealth access (and longer telehealth consults with a GP), which may benefit some regional communities. However, where a community's most accessible or consistent provider is an NP-led service, the policy design can still create inequity because MyMedicare is framed around general practice registration and GP telehealth settings, rather than recognising NP-led primary care relationships in a comparable way.

For rural and remote patients, "face-to-face" prerequisites can function as a de facto barrier where:

- there is no local clinic,
- clinician turnover is high,
- transport/accommodation costs are prohibitive,
- weather/road conditions limit travel,
- or patients have disability, caring responsibilities, or significant mental health barriers.

In these contexts, telehealth is often not a convenience; it is the only feasible pathway to timely primary care. Eligibility rules can unintentionally widen the rural–metro gap if they restrict telehealth for patients whose primary clinician is an NP. Funding that privileges provider type over an established therapeutic relationship can fragment care and increase avoidable escalation to ED/urgent care. Without explicit rural safeguards and NP-inclusive design, reforms intended to improve continuity may produce the opposite outcome in underserviced locations.

1. Apply rural/remote telehealth exemptions more broadly where workforce scarcity exists.
2. Ensure MyMedicare-related telehealth reforms do not inadvertently exclude NP-led primary care models that are filling primary care gaps.
3. Apply a rural/remote access test to telehealth rule changes prior to rollout, with consumer and clinician consultation from affected communities.

Photo by lucidwaters on Unsplash

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

Mixed team models of care are essential in rural, regional and remote communities, where persistent GP shortages and limited specialist availability necessitate flexible, multidisciplinary approaches. Despite this, current Medicare settings do not adequately support these models, particularly in relation to the role of NPs who frequently serve as the primary clinicians in communities facing the most severe workforce gaps.

The MBS does not align with the funding structures needed to sustain effective multidisciplinary team (MDT) care. Rural and remote communities rely heavily on MDT models involving NPs, registered nurses, allied health professionals, GPs and visiting medical specialists working collaboratively to deliver accessible, continuous and patient centred care. However, Medicare continues to reinforce a GP centric architecture that fragments service delivery, limits team flexibility and fails to recognise the leadership role NPs often play in complex care environments.

Structural restrictions within the MBS further limit the ability of non medical clinicians to work to their full scope. For example, NPs do not have authority to generate Medicare subsidised allied health referrals under the Chronic Condition Management framework. This means that even when an NP is the primary treating clinician, patients must book a separate appointment with a medical practitioner solely to obtain a referral, despite the NP having already completed a comprehensive assessment, diagnosis and management plan. These limitations undermine the effectiveness of MDT care and place unnecessary burdens on both patients and the broader health system.

Adequacy of Medicare Support for Mixed Team Models

The MBS remains structured around traditional GP led models of chronic disease management. GPs alone can initiate and claim rebates for chronic disease care planning, including GP Management Plans and Team Care Arrangements, which unlock access to Medicare subsidised allied health services. While allied health professionals can deliver services once a care plan is in place, funding is directed toward discrete episodes of care rather than the broader coordination roles required for effective MDT functioning. Although NPs may participate in some case conferencing items, existing arrangements do not offer equivalent recognition or remuneration for leading coordination activities, nor do they support MDT models where NPs are the primary provider.

This applies to the Chronic Condition Individual Allied Health and Other Primary Health Care items, which require that:

- a medical practitioner refers the patient; and
- the allied health professional bills using the relevant MBS item number and provides reports to the referring medical practitioner.

These requirements result in duplication of care and the redirection of clinical reports to the referring medical practitioner rather than the initiating NP. This can undermine continuity of care and, in some circumstances, breach patient confidentiality and consumer trust in nurse practitioner-led models of care.

The relevant GP equivalent allied health items required by NPs include, but are not limited to: Physiotherapy (10960), Occupational Therapy (10958), Dietetics (10954), Exercise Physiology

(10953), Podiatry (10962), Psychology (10968), Speech Pathology (10970), Audiology (10952), Diabetes Education (10951), Aboriginal and Torres Strait Islander Health Workers and Practitioners (10950), Chiropractic (10964), Osteopathy (10966) and Mental Health Workers (10956).

Furthermore, patients are currently only eligible for up to five MBS funded allied health services per calendar year where a medical practitioner has billed a GP Chronic Condition Management Plan, including GP items 965 or 92029, or prescribed medical practitioner items 392 or 92060, which is insufficient to meet the increasing chronic healthcare needs, particularly in rural and remote Australia.

Consequences for patients and rural services

In rural and remote settings, these restrictions:

- force patients to duplicate care for administrative purposes
- delay access to necessary allied health interventions
- Increase out-of-pocket costs in areas identified by the Socio-Economic Indexes for Areas (SEIFA) 2021 Index of Relative Socio-Economic Disadvantage (IRSD), which shows that rural regions often experience significant socio-economic disadvantage. These areas typically have a higher proportion of low-income households, more people in unskilled occupations, and fewer households with high incomes or skilled occupations. This pattern of disadvantage is commonly associated with factors such as remoteness, limited access to education and healthcare, and restricted economic opportunities[14]
- discourage continuity of care within established multidisciplinary teams

Patients who cannot afford additional appointments frequently forgo allied health care altogether, leading to preventable deterioration, increased disability and higher downstream hospital utilisation. The current structure also fails to recognise the professional scope of allied health practitioners. For example, physiotherapists are unable to refer directly to medical specialists under Medicare, despite referral and escalation being embedded within their professional standards and routine clinical practice. This further entrenches inefficiency, duplication and delay within mixed team care models.

The current Medicare architecture does not adequately support the mixed team models of care required in rural, regional and remote Australia. By limiting referral authority and Medicare access to medical practitioners alone, Medicare constrains workforce capability, fragments care delivery and reduces access to affordable services.

Inclusion of Nurse Practitioners as Eligible Providers for the General Practice in Aged Care Incentive (GPACI)

The General Practice in Aged Care Incentive (GPACI) is designed to support continuity of care and reduce avoidable hospitalisations among residential aged care residents. However, current program settings restrict eligibility to general practitioners, excluding NPs who are already delivering, and in many cases leading, primary clinical care within these settings.

This exclusion creates a structural inefficiency. In aged care environments characterised by high clinical complexity, limited on-site medical availability, and frequent acute deterioration, NPs play a critical role in providing timely assessment, prescribing, and care coordination. Where NPs are unable to access GPACI incentives, the financial viability and scalability of these models is reduced, limiting access to care and increasing reliance on hospital services.

In aged care settings, where avoidable hospital transfers are a major driver of system cost and patient harm, this exclusion directly undermines efforts to reduce emergency department presentations and hospital admissions. Independent analysis demonstrates that NP-led models reduce downstream hospital utilisation and deliver strong economic value, with benefit–cost ratios of up to 12.4:1.

This reflects a broader structural issue within Medicare, where funding is tied to provider

type rather than the clinical function being performed. Nurse Practitioners in regional and remote Australia deliver comprehensive, timely, and continuity-based primary care in residential aged care homes, often in locations where GP services are limited or unavailable. Excluding NPs from GPACI therefore limits effective workforce utilisation and reduces access to care for some of the most vulnerable populations.

To improve the effectiveness of mixed-team care, Medicare should recognise the contribution of NPs by enabling their participation in incentive structures such as the GPACI.

Payment structure under this model:

- $300 per patient, per year should be paid to the responsible NP; and
- $130 per patient, per year to the employing or contracting practice or primary care organisation.

This structure aligns with existing GPACI payment settings and reflects the equivalent clinical responsibility of NPs as primary treating providers. Payments would be made quarterly, in addition to existing Medicare and DVA rebates.

Rural Loadings

To ensure equitable support across the workforce, rural loadings and after-hours incentives applied to GPs should equally apply to NPs delivering care in **MMM 3–7** regions.

Benefits for Rural Mixed Team Models

Recognising NPs in GPACI would strengthen mixed team care models by:

- improving continuity and timeliness of care in aged care homes
- reducing avoidable hospital transfers
- supporting integrated multidisciplinary practice across GPs, NPs, nurses, allied health and visiting specialists
- bolstering workforce capacity in communities with chronic provider shortages
- ensuring equitable recognition of NP contributions to high quality primary care

Photo by Elaine Alex on Unsplash

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

Despite providing Medicare funded services, although with significantly lower rebates, NPs and NP led practices remain structurally excluded from key funding mechanisms administered by Services Australia. This includes all three Practice Incentive Program (PIP) payment streams (quality, capacity and rural support), as well as other critical incentives such as teaching, after hours, Indigenous health, aged care, quality improvement and digital health payments. These exclusions make NP led models financially unsustainable, particularly in rural and remote communities where NPs are often the sole primary care providers, and they undermine equitable access to essential healthcare services. These include:

- PIP Quality Improvement (PIP QI) payments - Quality improvement in general practice
- Rural loadings and incentive supplements
- Education and training allowances linked to General Practice Medicare-funded service delivery - Payment to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing to enter the Australian medical profession.
- GP Procedural Payment – Rural Support Stream
- After hours Incentive - to support general practices to provide their patients with appropriate access to after-hours care.
- The Workforce Incentive Program (WIP)

These funding streams are embedded as general practice–specific mechanisms, rather than being linked to the delivery of primary care under the MBS. Consequently, NP-led practices, despite providing ongoing, comprehensive primary care, are excluded from funding intended to support practice sustainability, workforce education, quality improvement, and rural service viability.

Photo by Robyn Mackenzie on Deposit Photos

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

Reforms are needed to ensure Medicare remains fair, workable, and sustainably funded for rural, regional, and remote Australians. Rural communities face unique challenges, including workforce shortages, geographic isolation, and limited access to both primary care and specialist services. NP-led telehealth models have historically provided safe, effective, and well-governed access to essential care in these areas, supporting continuity of treatment and reducing the need for costly and burdensome travel. Any future Medicare changes should include rural stress-testing to assess the impact on access, affordability, and health outcomes, particularly for vulnerable populations such as children, older adults, and those with complex or chronic conditions. Ensuring Medicare reforms are tested and adapted for rural contexts is critical to maintaining equitable health outcomes across Australia.

The policy response to online-only, transactional telehealth business models should be targeted to those models and should not unintentionally restrict continuity-of-care telehealth for patients who rely on established clinical relationships, particularly in MMM 2-7 settings. As highlighted throughout our submission, such a broad, system-wide policy change has caused far-reaching detrimental effects on access to affordable, high-quality NP-led care.

Maintaining stability in primary care provision is essential to ensure continuity of care, equitable access, and positive health outcomes for patients, particularly those in regional, rural, and remote Australia, where access is already very limited and health outcomes are among the poorest in the country.

Photo by Wedge on Deposit Photos

Other related matters

Economic Cost Benefit of Nurse Practitioner Service Delivery

Independent cost–benefit analysis undertaken by KPMG provides compelling evidence that NP models of care deliver substantial economic, clinical, and equity benefits, particularly in public-sector, Aboriginal Community Controlled Health Services (ACCHS), aged care in rural, and remote settings. The KPMG analysis examined multiple NP models across primary health care and aged care and found consistently positive returns on investment, with benefit–cost ratios ranging from 1.1 to 12.4, and several mature models delivering between $5 and $12 in system savings for every dollar invested.[15]

In high-need settings, including remote Aboriginal and Torres Strait Islander communities, NP-led primary health care models demonstrated especially strong value. One ACCHS-based NP model operating at an annual cost of approximately $160,000 generated estimated annual benefits exceeding $1.5 million, resulting in a benefit–cost ratio of 9.7. These savings were primarily driven by improved access to timely primary care, enhanced chronic disease management, continuity of care, and consequent reductions in avoidable emergency department presentations, hospital admissions, and ambulance transfers. Similar results were observed in aged care settings, where NP models costing approximately $62,400 per annum delivered estimated benefits of more than $340,000, producing a benefit–cost ratio of 5.5.[15]

These findings are directly aligned with the National Agreement on Closing the Gap, particularly Priority Reforms One - Formal partnerships and shared decision-making, Two – Building the Community-controlled Sector, Three – Transforming Government Organisations which emphasise shared decision-making, strengthening the Aboriginal and Torres Strait Islander health workforce, and transforming government systems to deliver equitable outcomes.[16] Community needs analyses consistently show that Aboriginal and Torres Strait Islander peoples, rural and remote populations, and aged care residents experience disproportionately high rates of preventable hospitalisation and delayed access to care due to persistent medical workforce shortages. NP models are frequently established in direct response to these unmet needs, providing culturally safe, community-based care where GP supply is limited or unstable.[15]

Despite the strong evidence base, the KPMG analysis also identified systemic funding and policy barriers that constrain the sustainability and scalability of NP models. These include fragmented funding arrangements, limited access to Medicare Benefits Schedule items, and the absence of explicit, recurrent public-sector funding for NP positions. As a result, many NP roles rely on short-term grants, discretionary funding, or narrow reimbursement mechanisms that undermine workforce stability, restrict scope of practice, and limit service continuity, particularly in ACCHS and public health settings where community need is greatest.[15]

Explicit public-sector investment in NP roles represents a fiscally responsible and evidence-based strategy to strengthen the health workforce, improve access to care, and accelerate progress against Closing the Gap targets. Dedicated NP funding would support workforce growth, recruitment and retention, succession planning, and training pathways, while enabling NPs to practice to full scope within public and community-controlled services. The KPMG evidence demonstrates that such investment not only improves health outcomes and equity but delivers measurable and immediate savings to Commonwealth and state health budgets through reduced downstream hospital and emergency care costs.

Urgent Care Centres

Australia continues to face significant gaps in access to timely urgent care, particularly in rural, regional and remote communities. Minor injuries and non-life-threatening illnesses that could be managed in community settings are instead driving patients into already

overstretched hospital emergency departments. In response, the Australian Government committed to establishing 137 Medicare Urgent Care Clinics (UCCs), with 87 currently operational. However, the effectiveness of this initiative is being undermined by workforce shortages and restrictive operational policy.[17]

A key barrier is the UCC Operational Guidelines requirement that a medical practitioner always be onsite. This requirement limits the ability of clinics to remain open when GPs are unavailable, leading to reduced operating hours or temporary closures, particularly in areas where medical workforce supply is most constrained. As a result, patient access is reduced and pressure on emergency departments increases, directly contradicting the intent of the UCC program.[17]

Nurse Practitioners represent a highly skilled, nationally regulated, and underutilised workforce capable of safely delivering urgent care autonomously. NPs are Masters-prepared clinicians with extensive advanced clinical experience and a legislated scope of practice that supports independent decision-making. There is strong national and international evidence demonstrating that NP-led models provide safe, effective, and patient-centred urgent care, particularly in underserved settings.[17]

Current UCC staffing rules are increasingly misaligned with contemporary health workforce policy. The Australian Government's Nurse Practitioner Workforce Plan 2024–2034 explicitly prioritises expanding NP-led services, enabling full scope of practice, and improving access in areas experiencing medical workforce shortages. Preventing NPs from leading care in UCCs directly undermines these objectives. The restriction also appears inconsistent with the removal of mandatory "collaborative arrangements" in 2023, a reform intended to eliminate outdated barriers to NP practice.[9,17]

Importantly, existing exemptions already demonstrate feasibility. Nurse practitioner-led Canberra Walk-in Centres, now operating under the UCC framework, have been permitted to function without an onsite doctor and continue to deliver safe and accessible care. These exemptions highlight inconsistencies within current policy and establish a clear precedent for reform.

Medicare UCCs are designed to provide walk in, bulk billed urgent care in extended hours, reducing pressure on hospital emergency departments. **However, the MBS architecture funds after hours urgent primary care largely through GP specific after hours attendance items, while NPs have a separate and much smaller professional attendance set with no after hours equivalents.** In UCCs, where no out of pocket costs are an explicit program requirement, this creates a predictable after hours viability gap: the period when wages and overheads are highest is also the period when NP-led activity attracts materially lower Medicare revenue than GP after hours items. The impact is most acute in MMM2–MMM7 communities, where GP services per person are already lowest in MM6–MM7 and where reduced UCC after hours coverage can translate directly into travel burdens and avoidable ED presentations.

This after-hours funding gap is compounded by a procedural MBS gap in urgent care settings. UCCs are expected to independently manage wounds and minor burns, and often need to provide procedural care (e.g., laceration closure, debridement, immobilisation) within scope and credentialing. Current MBS funding restrictions on NP-delivered services means that common MBS wound closure items are ineligible for reimbursement, whereas they are funded when performed by a GP. Nurse Practitioners do have a small number of procedural items (e.g., burns dressing items 82226–82227), but these are narrow and do not cover other routine presentations in UCCs. The list of procedural items performed in urgent care is extensive, and the costs of performing those procedures is expensive. The limited MBS access that NPs have with procedural items is compounding access and affordability of this workforce in UCCs.

Conclusion

The ACNP strongly supports Medicare reform that prioritises equitable, affordable, and timely access to high-quality primary care for people living in rural, regional, and remote Australia. This submission has demonstrated that current Medicare settings are not aligned with contemporary models of care and are contributing to reduced access, increased out-of-pocket costs, and avoidable pressure on hospital systems.

The evidence presented shows that NPs are already functioning as primary care providers across diverse settings, including rural and remote communities, aged care, and outreach models supported by telehealth. NP service delivery has expanded significantly in recent years, yet policy and funding settings have not kept pace with this growth. Instead, recent changes introduced on 1 November 2025 have reinforced structural barriers that limit access to care and constrain effective workforce utilisation.

These barriers operate through three key mechanisms: exclusion from core Medicare funding incentives, restrictive telehealth eligibility settings, and the continued design of continuity-of-care frameworks that do not recognise NP-led services. The result is a system that funds provider type rather than clinical function, creating inequity for patients, inefficiency for providers, and fragmentation in service delivery.

The consequences are already evident. Patients in rural and remote communities are facing higher out-of-pocket costs, reduced access to continuity-of-care services, and increased reliance on emergency departments for conditions that could be managed in primary care. At the same time, a substantial proportion of the NP workforce remains underutilised, not due to lack of capability or demand, but due to policy constraints that limit their ability to practice to full scope within funded models.

This represents a missed opportunity. The submission provides consistent evidence that NP-led models of care are clinically effective, improve access, and deliver strong economic value, including significant reductions in avoidable hospital presentations and admissions. In high-need settings, these models are already addressing service gaps and supporting more efficient use of health system resources.

The core issue is therefore not workforce supply, but system design. Medicare policy settings must evolve to support models of care that are already operating effectively in practice. Reform should focus on enabling equitable funding across provider types, supporting continuity-of-care telehealth, recognising NP-led practices within primary care frameworks, and investing in sustainable workforce models that improve access in underserved communities.

Meaningful reform arising from this inquiry has the potential to improve access to care, reduce avoidable hospital utilisation, and deliver measurable benefits to both Commonwealth and state health systems. It also presents an opportunity to better align Medicare with broader national priorities, including Closing the Gap, rural health equity, and health system sustainability.

The ACNP appreciates the opportunity to contribute to this important inquiry and welcomes continued engagement with the Committee. We remain available to provide further data, analysis, and expert advice to support the development and implementation of reforms that ensure all Australians can access high-quality primary care, regardless of location.

Yours sincerely,

Adj Assoc Prof Chris Helms

Chief Executive Officer

Australian College of Nurse Practitioners

References

1. Middleton S, Gardner A, Gardner G, Della PR. The status of Australian nurse practitioners: the second national census. Aust Health Rev. 2011;35(4):448–454.
2. Lowe G, Tori K, Jennings N, Schiftan D, Driscoll A. Nurse practitioner work patterns: a cross-sectional study. Nurs Open. 2021;8(2):966–974.
3. Wilson E, Hanson LC, Tori KE, Perrin BM. Nurse practitioner–led model of after-hours emergency care in an Australian rural urgent care centre: health service stakeholder perceptions. BMC Health Serv Res. 2021;21(1):819.
4. Benjamin P, Bryce R, Oyedokun T, Stempien J. Strength in the gap: a rapid review of principles and practices for urgent care centres. Healthc Manage Forum. 2023;36(2):101–106.
5. van Dusseldorp L, Groot M, Adriaansen M, van Vught A, Vissers K, Peters J. What does the nurse practitioner mean to you? A patient-oriented qualitative study in oncological/palliative care. J Clin Nurs. 2019;28(3–4):589–602.
6. Kleinpell RM, Grabenkort WR, Kapu AN, Constantine R, Sicoutris C. Nurse practitioners and physician assistants in acute and critical care: a concise review of the literature and data 2008–2018. Crit Care Med. 2019;47(10):1442–1449.
7. Kippenbrock T, Emory J, Lee P, Odell E, Buron B, Morrison B. A national survey of nurse practitioners' patient satisfaction outcomes. Nurs Outlook. 2019;67(6):707–712.
8. Aiken LH, Sloane DM, Brom HM, et al. Value of nurse practitioner inpatient hospital staffing. Med Care. 2021;59(10):857–863.
9. Department of Health and Aged Care (AU). *Nurse practitioner workforce plan*. Canberra: Australian Government; 2023. Available from: https://www.health.gov.au/sites/default/files/2023-05/nurse-practitioner-workforce-plan.pdf
10. Australian Institute of Health and Welfare. Rural and remote health [Internet]. Canberra: Australian Institute of Health and Welfare, 2025 [cited 2026 Jan. 5]. Available from: https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health
11. Royal Commission into Defence and Veteran Suicide. *Final report – Volume 4: Health care for serving and ex serving members* [Internet]. Canberra: Commonwealth of Australia; 9 Sep 2024 [cited 2026 Jan 5]. Available from: https://defenceveteransuicide.royalcommission.gov.au/system/files/2024-09/final-report-volume-4.pdf
12. Australian Government Department of Health (AU). *Unleashing the potential of our health workforce – scope of practice review* [Internet]. Canberra: Department of Health; 2025 [cited 2026 Jan 5]. Available from: https://www.health.gov.au/our-work/scope-of-practice-review
13. Australian Government (AU). *National Agreement on Closing the Gap: targets and outcomes* [Internet]. Canberra: Australian Government; [cited 2026 Jan 5]. Available from: https://www.closingthegap.gov.au/national-agreement/targets
14. Australian Bureau of Statistics (AU). *Socio-Economic Indexes for Areas (SEIFA)*, Australia, 2021 [Internet]. Canberra: ABS; 2023 Apr 27 [cited 2026 Jan 5]. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release

15. Australian Government Department of Health. *Cost-benefit analysis of nurse practitioner models of care* [Internet]. Canberra: Australian Government Department of Health; 2021 [cited 2026 Jan 18]. Available from: https://www.health.gov.au/resources/publications/cost-benefit-analysis-of-nurse-practitioner-models-of-care?language=en

16. Council of Australian Governments. *National Agreement on Closing the Gap: Priority Reform Areas* [Internet]. ClosingTheGap.gov.au; 2020 [cited 2026 Jan 18]. Available from: https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap/6-priority-reform-areas

17. Jennings, N., & Clothier, V. (2026). *Urgent care in Australia: Unblocking nurse practitioner capacity to address systemic access issues. International Emergency Nursing, 85,* Article 101741. https://doi.org/10.1016/j.ienj.2025.101741

Prepared by

Rebecca Sedgman, Policy Lead

Adj Assoc Prof Chris Helms, Chief Executive Officer

Publication Design

Nicole Scriva, Community Coordinator

Policy Assistance

Jodie Winks, Admin Assistant

Sincere thanks are extended to all contributors and ACNP members whose expertise and insights have supported and informed this submission.