Submission to the Rural, Regional and Remote Medicare Access and Funding

Rural and Regional Affairs and Transport References Committee Inquiry

20 March 2026

About Cancer Nurses Society of Australia

The Cancer Nurses Society of Australia (CNSA) represents nearly 2,200 cancer nurses across Australia. As the peak national body for cancer nursing, the CNSA strives to promote excellence in cancer care through the professional contribution of cancer nurses. To achieve this mission, CNSA acts as a resource to cancer nurses and all nurses who provide care to individuals living with cancer around Australia, regardless of geographical location or area of practice. We are the critical link between cancer nurses in Australia, the consumers of cancer services, and other health services and providers involved in cancer control.

Our Vision: Best possible outcomes and experiences for all people affected by cancer.

Our Mission: Promoting excellence in cancer care and control through the professional contribution of cancer nurses.

CNSA acknowledges and pays respect to the First Nations people as the traditional owners of the land. We pay our respects to Elders past, present and emerging and acknowledge the many nations across Australia on which we all live and work. CNSA will continue to work in partnership with Aboriginal and Torres Strait Island peoples to shape a health system that responds to the needs and aspirations of their communities.

CNSA welcomes the opportunity to address the Rural and Regional Affairs and Transport References Committee consultation and acknowledges the importance of reviewing current Medicare access and funding arrangements as they relate to people living in rural, regional and remote areas. CNSA is specifically interested in the impact on people affected by cancer and the importance of funding arrangements that support optimal models of care for these communities. CNSA remains committed to working with the Australian Government to ensure cancer care remains equitable, accessible and sustainable for all Australians. We thank our members for their valuable contributions to this important consultation.

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Executive Summary

In Australia, a reduction in rural-urban disparity in cancer outcomes, the delivery of simultaneous multi-disciplinary care (MDC), and the opportunity for enhanced monitoring on intensive treatments have been highlighted as key benefits of telehealth in cancer care.[1] There is clear evidence that telehealth can contribute to improving access to cancer care for rural, regional and remote communities, reducing disparities in cancer outcomes. In this submission, CNSA presents evidence of the serious potential consequences of telehealth restrictions on cancer outcomes, including increased inequities in access to care, particularly for people living in regional, rural, and remote communities who may not be able to access annual face-to-face consultations.

From 1 November 2025, a requirement was established for patients to have seen their local nurse practitioner (NP) face-to-face in the preceding 12 months to access MBS rebates for NP-directed telehealth services. This policy will have the unintended consequence of seriously disrupting access to essential, safe, and cost-effective cancer care services to disadvantaged and marginalised Australians who live in rural, regional and remote communities. This will risk ongoing delivery of fair, inclusive, and effective cancer care for all Australians. For people affected by cancer living in rural, regional and remote communities, the impact of current MBS reimbursement requirements for telehealth may:

- Limit telehealth access that had eased geographic barriers to accessing GP and non-GP specialist care
- Increase the need for costly travel to maintain eligibility for telehealth rebates
- Worsen disparities in communities with the worst cancer outcomes in Australia
- Increase financial and logistical burdens to accessing cancer treatment.

Recommendations

1. **Remove MBS telehealth eligibility exclusions for cancer care**
   CNSA recommends that MBS telehealth eligibility exclusions be amended to ensure rural, regional, and remote communities can continue to access MBS-funded telehealth services without the restrictive 12-month face-to-face rule, which currently limits continuity of cancer care. This change is essential to maintain timely review, symptom management, surveillance, and treatment planning for people affected by cancer who have no viable alternative to telehealth.
2. **Implement systemic reform to strengthen multidisciplinary care models**
   CNSA recommends that the Australian Government consider broader systemic reforms that support the sustainability of multidisciplinary cancer care models, particularly those that rely on virtual and hybrid care pathways, including funding, workforce flexibility, and policy settings that enable seamless coordination across services.
3. **CNSA recommends reducing structural barriers to cancer care in rural and remote communities by streamlining MyMedicare registration for people affected by cancer**
   This will enable Nurse Practitioner–led practices to register their services within MyMedicare to support continuity of care and equitable and improved access to longer MBS-funded telehealth consultations.

CNSA recommends that MBS telehealth eligibility exclusions be implemented to enable rural, regional, and remote communities to continue accessing MBS-funded telehealth services without the '12-month' rule limiting their ongoing cancer care. In addition, systemic reform should be considered that further supports multidisciplinary care (MDC) models and reduces barriers to accessing cancer care (e.g. facilitate MyMedicare registration for people affected by cancer living in remote and rural populations) that could help sustain telehealth as a tool for equitable cancer control.

Introduction

In Australia, around 28% of the population lives in rural or remote areas.[2] People living in remote areas of Australia are 1.3 times more likely to die from cancer and have a lower 5-year relative survival rate compared to those living in metropolitan areas.[3] Aboriginal and Torres Strait Islander peoples make up a large proportion of the population with increasing rurality.[2] Cancer incidence and mortality rates are higher among Aboriginal and Torres Strait Islander people, while survival rates are lower.[3] There is evidence of significant disparities in access to healthcare services for people living in regional, rural, and remote areas, which adversely impact cancer outcomes.[3, 4]

Poor cancer outcomes in regional, rural and remote parts of Australia may be related to several factors, including workforce shortages and barriers to accessing health care due to challenges of geographic spread, limited infrastructure and higher costs of health care delivery.[5] Access to timely use of healthcare services is imperative in optimising cancer outcomes. Around 43,000 Australians can't access primary health care within an hour's drive of their home, and 65,000 are unable to access a GP within the same distance.[4] There are also significant gaps in specialist cancer services, which increases the burden on general physicians, GPs, and non-chemotherapy-trained nurses to address this need in rural areas.

Travel requirements may be frequent for cancer diagnostics, treatment and follow-up, requiring some people to relocate from their homes.[6] Travel is a significant barrier to accessing health services and can lead to reduced access to high-quality care, which can further impact cancer outcomes.[2] Once diagnosed, many Australians in regional or rural areas face a difficult choice: relocate to be closer to a metropolitan cancer centre, make exhausting and expensive trips for appointments, or some may decline the recommended treatment if it requires ongoing travel or relocation.

People from rural and remote areas often also work in primary industries, such as farming and agriculture; these professions are associated with particular barriers to accessing cancer care felt disproportionately by people living in regional, rural and remote areas.[7]

These barriers include:[8]

- Travel and living away from home for cancer treatment may require the person affected by cancer and their family to take time out of the workplace or impact their childcare responsibilities.
- Travel removes people from their families, communities and broader support networks.
- Travel for cancer care is associated with significant personal and financial burdens.

Nurse practitioners (NPs) are often the sole primary care providers in their communities, relying on telehealth as a vital tool to maintain continuity of care when in-person access is not possible.[9] Telehealth enables NPs to address significant access issues in regional, rural and remote areas where cancer services may be unavailable, to overcome many of the challenges associated with delivering healthcare across vast geographic distances.[10] By supporting localised cancer care delivery, telehealth helps people with limited access to specialist services receive timely support while reducing the need for extensive travel. For people affected by cancer, this means less time spent away from family, work and community, and greater access to a wider range of support services and treatment options, all delivered close to home.

The expansion of telehealth MBS items during the COVID-19 pandemic broadened access, connecting more people to the best cancer care options regardless of where they lived.[11, 12] Providing remote (either via telephone or videoconferencing) care that isn't required in person, or can be delivered via local health professionals connected to specialist sites, has become an important model of care in cancer.[1, 10, 11, 13] Telehealth has become a core component of modern healthcare delivery, particularly for those in underserved communities, where in-person services may be limited or unavailable. These priority populations already experience disparities in access to cancer care and were identified in the Australian Cancer Plan as a focus for strategies required to address equity.[14] A key strategic action outlined in the Australian Cancer Plan (Action 4.5.2) was to expand access to digitally enabled cancer care to improve equity and quality of care, particularly in regional, rural, and remote areas. It emphasised the importance of considering funding mechanisms for telehealth services and of enabling a legislative and policy environment that supports access for this priority population.[14]

CNSA previously provided a submission to the Medicare Benefits Schedule Review Advisory Committee (MRAC) consultation on the draft report "Post-Implementation of Telehealth Items" in November 2023.[15] In that submission, CNSA raised serious concerns that the application of inflexible requirements on the use of telehealth would negatively affect access to care for vulnerable populations, including older people, people living with disability, and those residing in rural, regional and remote areas. These populations often rely on telehealth to access specialised cancer services delivered by non-GP specialists, or to support regular follow-up with their GP. CNSA was concerned that the subsequently introduced restrictions on 'eligible' telehealth providers would disrupt telehealth services, leading to increased travel burden, higher healthcare costs, and delays in care for patients who rely on the accessibility and convenience of telehealth. The MRAC noted in their final report that telehealth could help improve access to high-quality health care for some groups of people. MRAC considered that telehealth items and exemptions could enable access for several populations or situations, such as people in rural and remote settings, where the health care workforce may be limited.

Specific feedback based on the terms of reference

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

From 1 November 2025, MBS telehealth eligibility criteria were introduced for NP services. NPs are now required to have an established clinical relationship with their patient, or the service must be subject to an exception to be eligible for the MBS benefit.[16] This means patients wanting to claim an MBS rebate for a telehealth appointment will need to have had one face-to-

face consultation with their NP, or another practitioner at the same practice, within 12 months preceding the telehealth service.

In cancer care, telehealth is considered a safe and effective method to conduct pre-chemotherapy reviews, long-term treatment monitoring, routine follow-up, and palliative/supportive care consultations. These new restrictions now mean that people undergoing cancer care for longer than 12 months are forced either to take on the significant financial and logistical burden of travelling for a face-to-face appointment or to forego essential follow-up altogether. This not only creates inequities in access to services such as tele-chemotherapy and tele-trials but also places patients at greater risk of delayed monitoring, unmanaged symptoms, and disrupted treatment pathways—directly affecting their health, wellbeing, and overall cancer outcomes.

The imposition of these restrictions on reimbursement of NP MBS telehealth services now presents a significant barrier for people undergoing cancer or palliative care who cannot easily travel for a face-to-face visit. This policy negatively affects individuals who are unable to travel due to the cost of transport or because they are homebound, such as frail older people or those living with disability. It exacerbates existing healthcare disparities, particularly in regions where access to services is already limited and disproportionately affects people with chronic illness (including cancer and immunocompromised conditions), disability, or mental health challenges such as agoraphobia or trauma. It also disadvantages people who cannot travel due to work commitments or caring responsibilities.[17] As a result, many are forgoing care because of the travel burden and associated financial costs.[8] This rule, therefore, increases and reinforces existing inequities and imposes unnecessary burdens on those who already face the greatest barriers to accessing healthcare.

Quote from an NP working in cancer control

"Patients are having to travel into the HHS up to 100km away for a 20min consultation. Where possible, other appointments with other departments are attempted to be consolidated; however, not always possible."

NPs play a key role in developing, leading, and delivering nurse-led models of cancer care, including tele-chemotherapy.[13] Many patients in rural, regional and remote communities rely on NPs to deliver some aspects of their cancer care. Privately practising NPs can provide care under Medicare, the national scheme which provides free or subsidised access to clinically relevant medical, diagnostic and health services as specified in the MBS. Their ability to operate independently allows them to fill critical service gaps and provide continuity of care where no other provider is available.[18] NPs often work in sole provider roles and are central to delivering telehealth services in areas where no other primary care provider may be available. In rural, regional and remote areas with underserved communities with health workforce shortages, NPs play a vital part in enhancing access to timely and appropriate care. Their deep connection to communities, combined with advanced clinical expertise, enables NPs to deliver culturally safe, relationship-based care that is responsive to local contexts and population needs. This includes working in partnership with Aboriginal and Torres Strait Islander health services to support culturally informed practices and improve health outcomes in a culturally respectful and inclusive manner.

The role of NPs, particularly in the delivery of telehealth services, highlights their vital contribution in addressing Australia's evolving healthcare challenges. NPs' proactive use of telehealth services has enabled them to address workforce shortages by advancing access to primary care in areas where no services would otherwise exist.[9] The Nurse Practitioner

Workforce Plan is a strategic initiative aimed at improving access to timely, high-quality healthcare, especially for communities in rural, regional, and remote areas, by removing systemic barriers and enabling NPs to work to their full scope of practice.[19] This outlined targeted actions, including Action 4.14, which seeks to address legislative, policy, and funding limitations that currently restrict NP practice, to enable the full scope of telehealth delivery by 2026.

Currently, if an NP provides a telehealth review but hasn't seen the patient physically in 12 months (common in long-term survivorship or stable maintenance therapy), this service will no longer be rebated under the new restrictions. This would force people to travel more frequently and undermine the efficiency of nurse-led models of care. The impact of these restrictions will reduce the ability of NPs to deliver cancer care services in the community, especially for priority populations with the poorest cancer outcomes, including Aboriginal and Torres Strait Islander peoples and those people living in rural, regional, and remote areas, which will increase existing equity issues. For many people living in rural and remote areas, telehealth is not a convenience, but the only feasible mode of access. The 12-month face-to-face requirement has already limited access to timely review, delayed investigations and disrupted established care pathways, particularly where no local alternative clinician exists.

These restrictions will significantly impact NPs who work in private practice outside of primary care. The number and breadth of NP-billable MBS items remain constrained compared to other medical practitioners (GPs or specialists). NPs can support consults, symptom monitoring, and some anticipatory care, but may be unable to independently bill for a full range of oncology assessment or management consultations without using specific NP MBS items. NPs can refer patients for pathology and imaging diagnostic investigations critical in cancer pathways (e.g., some imaging or tests) as clinically appropriate, but referral and requesting rights are defined by MBS explanatory notes and can be narrower than for other medical practitioners and sometimes require coordination with GPs or specialists. This can lead to patients needing to travel to attend appointments with other healthcare professionals or associated out-of-pocket costs for patients if bulk billing is not viable, which is a barrier for people in lower socioeconomic or remote contexts.

Quote from an NP working in cancer control.

"Patients incur higher out-of-pocket costs due to no rebate, or more alarmingly, disengage from services altogether. I am particularly concerned about those who are on prostate cancer surveillance and will no longer have this monitored. I have suggested they can see their local GP, but they always respond that the wait list to see the GP is 2-3 months and doesn't provide the specialty care that I provide."

The impacts of current MBS funding arrangements across the cancer continuum include the following:

Cancer screening and risk assessments:

- NP telehealth screening advice requires an established clinical relationship, reducing opportunistic engagement in rural and remote areas.
- Screening-related consults may attract lower Medicare benefits and increased patient out-of-pocket costs or deter utilisation of NP-led services.
- This means reduced capacity for NP-led screening outreach and missed opportunities for early engagement and follow-up of abnormal results.

Symptom assessment & diagnostic imaging:

- NPs can request many tests, but some imaging or specialist referral pathways are narrower than for doctors, requiring GP or specialist involvement.
- Complex diagnostic assessment time is not always adequately captured under NP item descriptors.
- This may result in potential delays in diagnosis for rural and remote patients, where NPs may be the only clinician available, and in fragmentation of care if patients are required to see multiple providers solely to meet MBS requirements.

Treatment planning and MDC:

- NPs cannot claim MDC case conference items, even if they are core contributors to planning and coordination.
- Formal treatment planning rebates are generally limited to doctors.
- Under-recognition of NPs' contribution to MDC can lead to reduced sustainability of NP-led coordination roles in private practice.

Active treatment and side effect management:

- NPs can prescribe many supportive medications, but not all cancer-related or adjuvant medicines, requiring additional prescriber involvement.
- Lengthy, complex symptom-management consults may not be fully reimbursed.
- Limits ongoing remote monitoring unless face-to-face visits are maintained 12-monthly.
- This means there is a greater reliance on GPs or specialists for prescriptions or billing when NPs are clinically managing patients in remote and rural areas. This also means reduced flexibility for telehealth-based toxicity monitoring, which is crucial for these patients on chemotherapy.

Survivorship & chronic cancer care:

- Survivorship care is not explicitly recognised in NP item descriptors.
- NPs have limited access to items designed for long-term structured care.
- Survivorship consults may not be financially viable without patient co-payments.
- Survivorship care risks being medicalised or fragmented, rather than delivered through NP-led continuity models, which is a missed opportunity to leverage the role of NPs to reduce GP and specialist workload.

Palliative and end-of-life care:

- Some advance care planning and coordination items are restricted to specific medical practitioners.
- Many palliative care medicines require a medical practitioner's prescription.
- Limits flexible end-of-life support via telehealth if there is no existing clinical relationship.
- This results in limited ability for NPs to act as primary coordinators of palliative cancer care in the community.
- There is an increased burden on patients and carers to travel and engage with multiple care providers.

NPs frequently provide longitudinal follow-up for patients across the cancer continuum, including symptom monitoring, treatment toxicity management and coordination of care with tertiary services.[20] Current Medicare restrictions and the recent telehealth changes risk delaying detection of cancer recurrence, fragmented care and avoidable escalation to acute services, with potential for significant patient harm. These factors all limit the outreach and multi-site

cancer NP model of care that is particularly suited to people affected by cancer living in rural and remote areas. This threatens the sustainability of NP-led private cancer services and limits opportunities for MDC coordination across different health services that could address current workforce issues and enable care closer to home for people affected by cancer.

In January 2026, a national member survey was conducted by the ACNP and CNSA to better understand the needs of NPs. Most respondents reported they find telehealth very important, and they frequently rely upon these services to overcome issues of distance or service availability. They commonly provide telehealth services to people affected by cancer who live regionally, who are older patients, people with disabilities or mobility limitations, and palliative care patients. Many reported that they spend time during consultations managing multiple conditions, which can complicate MBS billing for a consultation. For instance, this could include opportunistic cancer screening and managing both physical and psychological symptom management, medication management and follow-up treatment planning.

Quote from a NP working in a regional country health service.

"*I can comment that it is an unrealistic requirement for patients being managed by NPs via telehealth to travel to locations for a face-to-face review annually. It fails to consider cultural sensitivity and impacts for the most vulnerable (Aboriginal and Torres Strait islander and culturally and linguistically diverse people, and those who are care providers and cannot travel away from home). Many cancer patients receive ongoing treatment through virtual-led services, like the tele-chemotherapy service. This provides expert-led disease and symptom management but allows patients to remain on country and receive care close to home. In many of our rural and remote locations, there are significant disparities in screening, care, treatment and overall outcomes. If we add to the burden the requirement to travel to a location to have a face-to-face consult, we penalise these patients, add burden to the healthcare system and create financial impacts in terms of providing accommodation and travel costs through PATS. Many patients in rural and remote communities, our most vulnerable patients, do and would refuse care if they were/are required to travel from their communities. This is why the cancer outcomes are so much poorer in the remote regions of Western Australia. Insisting on this does not support delivery on the Strategy set down by Cancer Australia*."

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

No information available.

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

Compared with those in metropolitan centres, more than 7.3 million rural and remote residents face a greater risk of shorter life expectancy, higher rates of preventable illness, and more frequent avoidable hospitalisations.[2, 5] These disparities are driven by workforce shortages, service gaps, and the long distances many must travel to access care. Restricting access to telehealth services through the 'established clinical relationship' requirement risks exacerbating health inequities, delaying treatment, and increasing hospital admissions.

NPs can play an important role in the prevention of hospitalisations in the cancer emergency setting by supporting patients to self-manage treatment-related toxicities. Studies have shown

that NPs can play a role in managing acute cancer toxicities, which can reduce emergency presentations by 17%[21] in six months and 24% over three years[22].

Telehealth services can help to minimise unnecessary demand on emergency departments and hospitals.[9] Research led by Flinders University demonstrated that telehealth reduces hospitalisations, improves mental health, reduces pain, and promotes social connection. [17] Telehealth offers a range of benefits for people living in rural locations and facilitates greater access to services closer to home. This was particularly evident when there was a lack of specialist support in these areas. These opportunities meant that rural people could receive the timely care that they required, without the burden of travelling significant distances to access health services.[23]

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

For people living with cancer in rural, regional and remote communities, the right person to treat their condition may not be available locally, requiring them to travel significant distances to access appropriate treatment. People living in regional and rural locations should have access to a full MDC team relevant to their cancer type.[24] In the case of cancer, the MDC team will likely involve a local GP, a regional NP, and a metropolitan specialist.[24] MBS items for MDC are often claimable only by treating medical practitioners — i.e., those formally diagnosing or treating cancer.[24] Therefore, this restricts the ability of local healthcare providers to facilitate cancer care in outreach clinics to continue the clinical relationship and provide care that would otherwise require them to travel to metropolitan cancer centres.

While NPs practice independently, they also play an integral role within MDC teams. They act as key coordinators to ensure seamless, patient-centred care for individuals requiring input from multiple services, ensuring effective communication, continuity, and, where appropriate, escalation of care. The role is particularly important in cancer care, which often requires referral to specialist services, shared decision making and transitions of care between hospital and community settings. However, there is a lack of referral processes to NPs within the MDC team and gaps in onward referrals to other services to support cancer care and survivorship plans.[20]

Telehealth is a strategy for delivering coordinated MDC across different cancer centres and local health services. Telehealth can be used to link health professionals across distances to ensure MDC input to the care of patients. Telehealth enables people to seek non-GP specialist care to discuss their condition and any test results to identify their care options before deciding, and travelling, for treatment or interventions requiring face-to-face contact. Telehealth can also link patients with medical specialists not available in their area.

CNSA recognises the importance of innovative models of care (e.g., nurse-led and MDC approach) in delivering cancer care to meet the diverse needs of people living in rural, regional and remote areas. The current healthcare system is struggling to meet growing demand, and the recent Strengthening Medicare Taskforce report highlighted the need for innovative solutions, including expanding the NP workforce and enabling NPs to work at the top of their scope of practice.[25] It is important to acknowledge that healthcare professional supply and distribution challenges in rural, regional, and remote areas require models of care appropriate to that setting.

This aligns with the National Rural Health Alliance recommendations to decentralise specialised cancer care wherever feasible, using innovative models where necessary (including digital healthcare), to ensure equitable access to high-quality, comprehensive care for rural populations. The Alliance proposed methods to incentivise secondary telehealth, including increasing patient-end Medicare rebates and ensuring telehealth services are adequately rebated.[26]

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

No information available.

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

CNSA recommends introducing exemptions to the MBS telehealth requirements for people affected by cancer living in rural, regional and remote communities, including those in Modified Monash (MM 3–7) areas and patients receiving cancer-related care such as treatment, survivorship, symptom or supportive care, and palliative care. Clinicians should be able to document clinical risk or need where telehealth is necessary, and face-to-face attendance is unsafe or impractical, for example, for immunocompromised patients or people with disabilities that prevent travel, so that this justification can support future exemption applications and associated rebate claims.

These exemptions would align with the strategic objectives of the Australian Cancer Plan to increase equity of access to care for people in priority populations.[14] This would help to reduce the impact of the '12-month' rule on continuity of care. This should include an exemption for the requirement for a prior face-to-face visit, provided the service relates to cancer screening, follow-up, diagnostic assessment, treatment planning, toxicity management or survivorship care. This could mirror existing exemptions used for other vulnerable cohorts. This would maintain continuity of care, reduce unnecessary travel to preserve telehealth eligibility and support participation in cancer screening for earlier detection.

CNSA would also recommend advancing MBS reforms that would enable greater access to telehealth and other reimbursable services related to the role of the MDC in cancer care. This should be accompanied by the implementation of a proactive approach to MyMedicare registration for people affected by cancer. This could act as an enabler to help support people living in rural, regional and remote communities who require access to MBS items and telehealth services that support MDC. This should be accompanied by initiatives to enable accredited NP-led practices to access MyMedicare and the bulk billing incentive program, to strengthen and ensure the sustainability of high-quality NP-led models of care. This approach would help people affected by cancer who live in these areas to coordinate their MDC, especially if they are required to undertake care between different locations with different healthcare professionals.

Australian NPs experience challenges related to legislative barriers at the national and jurisdictional levels of government. Specifically, funding of public healthcare is determined by the Medicare Benefit Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), both of

which currently restrict access to reimbursement and prescribing rights, thereby limiting Australian NPs' ability to work to their full scope of practice. Consideration should be given to how to improve current health funding models to enable NPs to work to their full scope of practice.

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