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

Adjunct Professor Chris Helms
CEO, Australian College of Nurse Practitioners

Australian College of Nurse Practitioners
A St Kilda Rd Towers, Suite 502, 1 Queens Rd, Melbourne, VIC, 3004
E admin@acnp.org.au P 1300 433 660 W acnp.org.au

Emma Barritt
Chief Executive Officer
CRANAPlus

Daniel Lightowler
President
Gastroenterological Nurses College of Australia

Claire Johnson
Acting Executive Director
College of Emergency Nursing Australia

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

Dr Margaret Faux
Chief Executive Officer
Synapse Medical Services

Dr Brendan Clifford
Vice-President
Drug and Alcohol Nurses Australasia

Melissa Caruso
President
Australia and New Zealand Urological Nurses Society

Jemma Still
Chief Executive Officer
Cancer Nurses Society Australia

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

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

Dr Kathryn Zeitz
Chief Executive Officer
Australian College of Nursing