Submission by the Australian Nursing and Midwifery Federation

Senate Standing Committee on Rural Regional Affairs and Transport: Rural, regional and remote Medicare Access and Funding

27 March 2026

Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Catelyn Richards
Federal Assistant Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

Key Points

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and personal care workers (PCWs) across the country. The ANMF welcomes the opportunity to provide feedback to the Senate Standing Committee on Rural and Regional Affairs and Transport References Committee's inquiry into rural, regional and remote Medicare access and funding.

1) Remuneration and Medicare Benefit Schedule (MBS) funding and access parity

The ANMF is a strong advocate for achieving financial and professional equity for nurse practitioners (NPs). Here, parity in remuneration is critical to ensure the financial viability and sustainability of NP models of care.

a) Nurse practitioners should be granted the same access to MBS items and telehealth opportunities as their medical colleagues.

b) Nurse practitioners should receive equivalent MBS payments when providing the same care as doctors, as current limitations hinder their ability to work sustainably.

2) Funding Model Reform

The current "fee-for-service" Medicare model is insufficient, particularly for Rural, Regional, and Remote (RRR) areas. Proposed alternatives include:

a) Block funding: Implementing block funding models for nurses and midwives to cover complex areas like mental health, chronic disease management, and preventative care.

b) Workforce Incentive Program (WIP): Increasing the WIP to better remunerate nurses and support their roles within multidisciplinary teams.

c) Value-based funding: Shifting funding criteria to reflect time, clinical responsibility, and case complexity rather than standard medical billing structures.

3) Scope of Practice and Workforce Support

Nurses and midwives must be supported to work to their full scope of practice to ensure accessible, equitable, and high-quality care in RRR areas. This is vital for:

a) Improving community health outcomes and ensuring the sustainability of primary healthcare.

b) Reducing Emergency Department (ED) presentations through timely diagnosis and treatment facilitated by NPs, nurses, and midwives.

c) Establishing and sustaining nurse- and midwifery-led clinics through long-term funding.

d) Creating better pathways for professional engagement, education, and career progression in primary health care

4) Addressing Rural Health Disparities

To close the access equity gap between metropolitan and rural areas, the ANMF recommends a move away from one-size-fits-all approaches. Key recommendations include:

a) Community input and leadership: Allowing local communities to have greater say in the types of services delivered to meet their unique needs.

b) Rural Stress Testing: Implementing nationwide "stress testing" of Medicare in RRR communities to identify system breaking points and prevent the collapse of local care.

c) Formal recognition of nursing roles in general practice: Formally recognising practice roles within Medicare structures to better align with national workforce strategies.

Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and personal care workers (PCWs) across the country.

2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

5. The ANMF thanks the Senate Standing Committee on Rural and Regional Affairs and Transport References Committee for the opportunity to provide feedback on the *Rural, regional and remote Medicare access and funding Inquiry.* Effective primary health care is foundational to a strong and sustainable health system. It delivers better health outcomes for patients, carers and families, reduces overall health costs, and eases growing pressure on hospital emergency departments.[1](1)Primary health care is also integral to the delivery of effective, timely preventative care that is critical for keeping people healthier for longer and reducing both the burden of ill-health and reliance on hospital systems.

[1] Australian Government Department of Health and Aged Care 2023, *Strengthening Medicare Taskforce Report*, December 2022, Commonwealth of Australia, Canberra.

Section a) Impact of 1 November 2025 Medicare changes on access to primary health care

6. People living in rural, regional, and remote (RRR) areas deserve genuine choice, equitable access, and continuity of care. Although some measures have been a positive step forward, there is much more required to ensure that all Australians are able to access equitable, quality care wherever they live and work.

7. Nurse practitioners (NPs) are limited by the availability of the Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) item numbers they can access. For the items they can access, the funding very often is significantly lower than the cost of providing the service, or the same service provided by a general practitioner. This results in poor uptake and sustainability for otherwise safe, effective NP models of care and services, even when community members and other clinicians regularly utilise and access these services.

Access to Telehealth services

8. People who reside in RRR localities experience limitations on access and currently do not have equity in healthcare experiences and outcomes. Some of these constraints include fewer specialist services and limited infrastructure. They also face high expenses associated with accommodation and lost income due to difficulties accessing quality primary health care. (2)

9. The changes to telehealth regulations implemented in November 2025 continue to restrict the ability of NPs to provide high quality care, particularly for RRR areas. From November 2025, both GPs and NPs must meet “established clinical relationship” requirements to claim Medicare rebates for telehealth services.

[2] Australian Institute of Health and Welfare (AIHW) (2025) *Rural and remote health*, AIHW, Australian Government, 20 November 2025. Available at: https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

10. For NPs, this requirement can only be met through the patient attending a face-to-face consultation with the patient within the previous 12 months, which can be burdensome and costly for people living in RRR areas.(3) Further, due to the challenges of sustaining NP-led services and models of care as a result of worse access and funding for MBS and PBS item numbers, the assurance that an NP service will still be available for patients to attend a face-to-face appointment with the same NP might be limited.

11. Telehealth restrictions impact consumers who cannot afford to travel long distances to attend yearly face-to-face appointments with their NP. The report from the Australian College of Nurse Practitioners (ACNP) *The Hidden Cost of Policy Change: Patient Impact of the 12-MonthFace-to-Face Telehealth Rule* describes that 82.9% of its members report their patients will struggle to meet the face-to-face requirement. (4) One example provided in this report is of a patient who regularly has telehealth appointments with a NP to manage their diabetes. Due to changes to Medicare requirements, the patient can no longer access this care and is unable to travel the 400km required to see an alternative specialist healthcare provider.(4)

12. Consumers should not be disadvantaged where timely access to their usual GP or NP is not possible. In RRR areas, limited appointment availability often means patients must consult whichever provider is available, regardless of whether they have seen that clinician within the previous 12 months.(5) Although the recent changes partially address continuity, they fail to provide clear alternative pathways for patients to access NP care where no prior consultation has occurred within that timeframe. In contrast, GPs can provide Medicare-rebated telehealth services to patients who are enrolled in a MyMedicare-registered practice, even if they have not had a face-to-face consultation within the previous 12 months.

---

[3] Medicare Benefits Schedule (2025) *MBS Telehealth: Quick reference guide – Nurse Practitioner Telehealth* [PDF]. MBS Online. Available at: https://www.acnp.org.au/client_images/2864456.pdf

[4] Australian College of Nurse Practitioners (ACNP) (2025) *The Hidden Cost of Policy Change – Patient Impact of the 12-Month Face-to-Face Telehealth Rule*. Policy Impact Analysis submitted to the Hon. Mark Butler MP. Available at: https://www.acnp.org.au/npadvocacy

[5] Lamp Editorial Team (2023) *With the training to diagnose, test, prescribe and discharge, nurse practitioners could help rescue rural health*. The Lamp, 17 February. Available at: https://thelamp.com.au/professional-issues/public-health/with-the-training-to-diagnose-test-prescribe-and-discharge-nurse-practitioners-could-help-rescue-rural-health/

This creates an alternative and unjustified eligibility pathway for GPs and a clear structural difference in consumer access to GPs and NPs even when an NP is the person's regular clinician. The ANMF acknowledges that there are limited exemptions in place for certain cases including for people under the age of 12 months, people experiencing homelessness, or community members affected by a natural disaster,[6] however the current policy perpetuates easily rectifiable barriers to healthcare for patients accessing care from NPs.

13. Nurse practitioners are highly skilled healthcare professionals who provide complex, high-quality care and can treat and diagnose complex conditions. They must be awarded the same telehealth access opportunities as their medical colleagues to improve access, continuity, and quality of care where health systems are often stretched and general practitioners are not available.

14. Nurse practitioners should be afforded the same access to telehealth MBS items as their general practitioner counterparts without the face-to-face requirement. If the patient is registered under MyMedicare, there should also not be restrictions placed on the NP to provide that essential care.

15. Further to this specific item under the MBS, NPs must be afforded the ability to claim a equivalent amount from like-MBS items as their medical colleagues. By unreasonably restricting NPs ability to access sufficient renumeration for the care they provide, their ability to sustainably work to their full scope of practice and provide care to patients is unfairly limited which negatively impacts community member health and wellbeing outcomes and access to care.

---

[6] Australian Government Department of Health, Disability and Ageing. (2025) *AskMBS advisory – MBS telehealth eligible telehealth practitioner (previously known as established clinical relationship) requirements – Clarification of exemptions* Available at: https://www.health.gov.au/sites/default/files/2025-11/askmbs-advisory-mbs-telehealth-eligible-telehealth-practitioner-previously-known-as-established-clinical-relationship-requirements-clarification.pdf

16. The role of the NP is versatile and highly skilled and NPs are utilised very effectively in many international jurisdictions, particularly in primary health settings. Despite the introduction of the NP role to Australia in 2000, there has been a widespread lack of uptake and utilisation. Currently there are 2,664 nurses endorsed as NPs in the workforce, only 1,871 are employed in NP roles.[7] This is because many barriers still remain for NPs to achieve their true potential in the workforce. Supporting NPs to work to their full scope of practice and allowing them equal access to MBS items and remuneration will be critical to support them to support the wider primary health workforce as the role was intended to do.[8]

Recommendations:

1. Nurse Practitioners should be granted the same telehealth access opportunities as medical colleagues. This includes access to the same MBS items as general practitioners without being subject to face-to-face requirements.
2. For patients registered under MyMedicare, there should be no restrictions placed on NPs providing essential care.
3. Nurse Practitioners should be able to claim equivalent amounts from MBS items as their medical colleagues as current restrictions on remuneration limit the ability of NPs to work sustainably to their full scope of practice, which negatively impacts community health outcomes.
4. It is critical to remove the remaining barriers that prevent NPs from reaching their full potential in the workforce. Supporting NPs to work to their full scope of practice through equal MBS access and remuneration is essential for supporting the broader primary healthcare workforce.

[7] Australian Government Department of Health and Aged Care (n.d.) *Nursing and Midwifery Workforce Dashboard (National Health Workforce Dataset)*. Available at: https://hwd.health.gov.au/nrmw-dashboards/index.html

[8] Rossiter, R., Phillips, R., Blanchard, D., van Wissen, K. & Robinson, T. (2023) 'Exploring nurse practitioner practice in Australian rural primaryhealth care settings: a scoping review', *Australian Journal of Rural Health*, DOI: 10.1111/ajr.13010

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

17. Emergency departments (ED) are seeing historically high presentation numbers, leading to longer wait times, increased ramping, and high volumes of patients awaiting inpatient beds for extended periods of time. At the same time, clinicians working in EDs are managing consumers who could be safely and effectively seen and treated in primary health care. Without major primary health care reform and investment, the health system will continue to be overwhelmed and both community members and clinicians will bear the burden and consequences of this inaction.

18. Emergency Department demand continues to exceed capacity across metropolitan, regional, and remote areas. While people living in RRR areas account for just 3.6% of ED presentations in 2024-2025, they experience the highest presentation rates of 664 per 1,000 people in Remote areas and 686 per 1,000 in Very Remote areas.[9] Concurrently, RRR communities face a growing burden of chronic disease and increasingly complex care needs, driving avoidable emergency presentations and hospital admissions. Residents of these areas experience substantially higher avoidable illness that would be reduced by accessing primary health care services.[10] It is evident that urgent reform is needed to sustain Australia's healthcare system.

[9] Australian Institute of Health and Welfare (AIHW) 2025, *Emergency department presentations*, Australian Institute of Health and Welfare, Canberra, https://www.aihw.gov.au/hospitals/topics/emergency-departments/presentations

[10] Australian Institute of Health and Welfare (AIHW) 2025, *Rural and remote health*, https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

19. A sustainable primary health care workforce is critical to reducing avoidable ED presentations and hospital admissions in RRR communities. Too often, people present to emergency departments because there is no accessible primary health care in their community. In many RRR areas, the local ED or Multi-Purpose Centre (MPS), which attends to emergency presentations, is often the only point of care, particularly out of hours.(11) The ED is not always the most suitable, effective, or safe environment to accommodate these presentations. This places unsustainable pressure on hospital services, overwhelms staff capacity, and fuels burnout and workforce attrition, further entrenching access gaps and system strain.

20. Preventative primary health care is essential to alleviating the pressures on secondary and tertiary health services. Nurses and midwives are integral to this initiative, however, reforms have not gone far enough to support them to practice to their full capacity. Funding and bureaucratic constraints, such as inconsistent rules across states and territories, prevent these health professionals from working to their full scope of practice, undermine community-based care, and drive workforce attrition.(12) Retaining staff in RRR areas is crucial to the viability of a health service and while funding incentives to support service delivery remain inadequate, retention issues will remain.

21. The barriers to NP care discussed above, as well as challenges for the wider nurse and midwifery primary health care workforce to work to their full scope of practice remains a significant concern for all jurisdictions. Any future funding system must link in with a medical centre; and align with medical professionals associated with the same service type.(13) Current Medicare settings and reforms have also been insufficient to alleviate the pressures on emergency departments.

[11] Unwin, M., Crisp, E., Rigby, S. and Kinsman, L. (2018) 'Investigating the referral of patients with non-urgent conditions to a regional Australian emergency department: a study protocol', *BMC Health Services Research*, 18, p. 647. Available at: https://hdl.handle.net/102.100.100/541088

[12] Australian Government Department of Health and Aged Care 2024, *Unleashing the potential of our health workforce: Scope of practice review – final report*, Commonwealth of Australia, Canberra.

[13] Robinson et al (2025) *Enhancing healthcare access: Optimising nursing workforce utilisation in primary health care.* Collegian 6 November 2025 https://doi.org/10.1016/j.colegn.2025.11.001 1322-7696 Published by Elsevier Ltd on behalf of Australian College of Nursing Ltd.

22. Implementing *Unleashing the Potential of our Health Workforce: Scope of Practice Review* recommendations without delay and ensuring that nurses and midwives are recognised for their roles outside of the GP practice setting is essential to effective reform.(12)

23. Rural, regional, and remote communities have individual, context-specific requirements and should have the opportunity to have choice and access to equitable primary health care. These communities should not be left with ED as their only means of accessing health care after-hours, nor should they have to wait weeks to see a GP for chronic disease management. Nurse- and midwife-led care can alleviate the pressures on these communities by providing holistic care that encompasses what the community requires. These models can provide care that includes but is certainly not limited to health promotion, disease prevention, and models that prioritise continuity of care and therapeutic person-centred interventions.(14) Murrumbidgee Primary Health Network demonstrated in their nurse-led pilot program that by offering a complementary source of healthcare for patients in an area where GP appointment availability may be limited, patients were able to access high-quality care in their regions.(15) This and other such models are essential to equitable access to primary health care.

24. Nurses and midwives are central to the sustainability of primary health care and must be supported to work to their full scope of practice through block funding models that recognise their immense value and contribution to the communities they practice in. The current fee-for-service Medicare funding model does not support access to primary health care in RRR. These communities should be afforded access to quality, effective primary health care supported by a fit for purpose funding model where care does not need to come solely from a GP. NPs play a critical role in facilitating timely diagnosis and treatment.

[14] Paier-Abuzahra, M., Posch, N., Jeitler, K., Semlitsch, T., Radl-Karimi, C., Spary-Kainz, U., Horvath, K. and Siebenhofer, A. (2024) 'Effects of task-shifting from primary care physicians to nurses: an overview of systematic reviews', *Human Resources for Health*, 22, p. 74. Available at: https://link.springer.com/article/10.1186/s12960-024-00956-3

[15] Schoonmaker, M. (2025) *Innovative nurse-led clinics boost healthcare access in regional Australia*. Murrumbidgee Primary Health Network, 15 October. Available at: https://mphn.org.au/blog/2025/10/15/innovative-nurse-led-clinics-boost-healthcare-access-in-regional-australia

Evidence indicates that NP-led care is central to reducing delays in intervention, decreasing avoidable ED presentations, and mitigating the progression and severity of disease outcomes.(16)

25. Local communities must have the opportunity to have greater input about the type of and how services are provided to address the significant disparity in health services able to be accessed by individuals living in remote and very remote areas.(1) For example, in the Murrumbidgee PHN pilot above, 18 General Practices were supported to develop individual models of care specific to the needs of their own communities.(15)

Recommendations:

1. The current fee-for-service Medicare model does not adequately support access to primary health care in RRR areas. Instead, block funding models should be implemented to recognise the value of nurses and midwives and provide these communities with a fit for purpose funding model.
2. Nurses and midwives must be supported to work to their full scope of practice to ensure the sustainability of primary health care. This includes acknowledging the critical role of NPs in facilitating timely diagnosis and treatment, which helps reduce ED presentations and disease progression.
3. Local communities should be given the opportunity for greater input regarding the types of services provided and how they are delivered. This is essential for addressing the significant disparity in health services available in remote and very remote areas. Rather than a one-size-fits-all approach, developing individual models of care that are specific to the unique needs of each community is critical.

[16] Htay, M. and Whitehead, D. (2021) 'The effectiveness of the role of advanced nurse practitioners compared to physician-led or usual care: A systematic review', *International Journal of Nursing Studies Advances*, 3, p. 100034. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC11080477/

Section 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.

26. Midwives must be explicitly included in this inquiry's the terms of reference. They are essential primary health practitioners within RRR communities. Effective rural health care relies on multi-disciplinary teams (MDTs) where midwives work alongside general practitioners, NPs, nurses, allied health professionals and visiting specialists.

27. The Medicare system was devised to ensure that those residing in Australia have access to equitable, affordable healthcare. Unfortunately, this system is no longer fit for its original intended purpose. Australian society has transformed and grown since Medicare's inception.[17] The system is currently fragmented and does not optimally support those working within it to provide effective care. This is partly because the historically strong medical focus of the funding system is not an accurate depiction of the contemporary state of the healthcare system, its workforce, or its consumer group and is not progressive enough to achieve a sustainable health system for all.

28. The *Strengthening Medicare Taskforce Report* calls for reforms to strengthen Australia's primary health care system and improve equitable access. [1] A key priority - modernising primary health care - remains unmet, with policy levers still centred on GP-led practices. Presently, primary health models often overlook the critical role of MDTs, including nurse- and midwifery-led clinics and NPs.[18]

[17] Baker, N. and Quince, A. (2023) *Medicare has been under pressure for years. So is it broken and can it be fixed?* ABC News, 19 April. Available at: https://www.abc.net.au/news/2023-04-20/the-history-of-medicare/102232344

[18] Fedele, R., 2024. *Advanced practice nurses need more support to run nurse-led clinics*. *Australian Nursing & Midwifery Journal*. Available at: https://anmj.org.au/advanced-practice-nurses-need-more-support-to-run-nurse-led-clinics/

29. Nurses and midwives are the largest healthcare professional group in Australia. They, account for up a significant proportion of the primary health care workforce, yet they are consistently prevented from working to the extent of their scope. *Unleashing the Potential of our Health Workforce: Scope of Practice review* identified entrenched barriers including restrictive funding and payment models, legislative and regulatory constraints, poor role recognition and clarity, as well as inadequate preparation and support for primary health care roles.[12] Reforming Medicare to fund the care nurses and midwives already provide and backing broader system reforms that enable them to practise to their full scope would significantly strengthen primary health care delivery, particularly in RRR communities.

30. Current Medicare funding arrangements remain largely oriented toward GP-centric, episodic care. This limits the successful implementation and financial viability of nurse-led models of care.[19,20] Expanding, updating, and reforming Medicare to support shared care, streamlined referral pathways, delegation, coordination and continuity of care across professional groups is critical to realising the full potential of nurse- and midwife-led models and the sustainability of roles for nurse and midwives across the primary healthcare workforce.

31. Nurse Practitioners and endorsed midwives have the necessary qualifications, clinical experience, training, and lawful authority to safely and holistically prescribe, interpret diagnostic tests, and implement patient-centred treatment plans. Commitment to their sustained employment via overdue expanded Medicare support through effective block funding models:

    a) Permits the nursing and midwifery workforce to work to their full scope of practice which in turn improves RRR Medicare access and funding generating greater workforce attraction and retention.

[19] Terry, D., Hills, D., Bradley, C. & Govan, L. 2024, 'Nurse-led clinics in primary health care: A scoping review of contemporary definitions, implementation enablers and barriers and their health impact', *Journal of Clinical Nursing*, vol. 33, no. 5, pp. 1724–1738. https://doi.org/10.1111/jocn.17003

[20] Beks, H., Clayden, S., Wong Shee, A., Binder, M.J., O'Keeffe, S. & Versace, V.L. 2023, 'Evaluated nurse-led models of care implemented in regional, rural, and remote Australia: A scoping review', *Collegian*, vol. 30, no. 3, pp. 480–489. https://doi.org/10.1016/j.colegn.2022.09.003

b) Develops strong professional and trusting relationships with the community, instilling culturally sensitive and tailored care, as well as mixed-team models of care.

c) Supports chronically under-resourced medical practitioners and fragmented MDT models of care. Specifically, it permits nurse/midwifery-led clinics to be implemented, improving access to timely and local care and supporting NPs and endorsed midwives to work alongside general practitioners and allied health professionals to provide comprehensive care.

d) Ensures cost-effectiveness, as NP and endorsed midwives can often provide high-quality care at a lower cost compared to other healthcare providers, as they are able to conduct health assessments independently. This also enhances early intervention.

32. The current funding structures and ingrained culture of the primary health care system remains focussed on the care that GPs provide with limited acknowledgement of the benefits of MDTs and particularly nurse and midwife led care. Reform must take a holistic approach; it must consider the whole system and what an efficient, supportive contemporary primary health care system could look like. Where workforce shortages exist and impede patient access to care, multidisciplinary care maximises available skills and provides high quality, sustainable care. [12]

33. Funding arrangements focus largely on GP practices within primary health care practice, yet clearly, this is not the only form of primary health or healthcare provision that can be provided in RRR areas today. Nurse- and midwife-led models of care are an essential component to futureproofing the RRR health system and enable equitable access for those in geographically distanced areas. It must be understood that primary health care teams do not only just exist within GP practices. These services provide quality, local primary health care to those that may not have access if there are no GP services in the town.

34. The current MBS scheme does not adequately recognise or fund the contribution of these nurses and midwives in primary health. All practice nurses claim MBS item payments on behalf of the employing general practitioner. For example, recent evidence demonstrates that practice nurses frequently lead chronic wound management. In one study, nurses were found to hold primary responsibility for the assessment and management of venous leg ulcers. Despite this clinical leadership, such work remains under-recognised and insufficiently supported within the current primary health care funding structures.[21] Whilst practice nurses undertake patient assessment, complete examinations, educate, provide preventative advice and monitor clinical progress, the work of practice nurses is poorly renumerated via the MBS item which ultimately still must be approved by the employing GP.

35. This current requirement for nurses and midwives to claim MBS items under a GPs name continues to perpetuate the ingrained culture of GP-led primary health care. Nurses and midwives are highly educated, experienced, offer independent care to consumers and provide holistic, preventative and treatment-based care. They must not be thought of in conjunction with medical practitioners in reform, but considered as the independent clinicians they are. In many cases, nurses are not working to their full scope of practice in primary health care, with one-third regularly working 'front desk' of clinics and are undertaking tasks that do not utilise their skills.[22, 23]

36. The omission of NP and endorsed midwives from the Bulk Billing Incentive Program is a missed opportunity to improve access to NP and Midwife-led primary health care. Affordable and equitable access to primary health care is essential for improved health outcomes, as nurses are often the first point of call for community members, and particularly in RRR areas, sometimes the only option of care.

---

[21] Weller, C. D., Richards, C., Turnour, L., Patey, A. M., Russell, G., & Team, V. (2020). Barriers and enablers to the use of venous leg ulcer clinical practice guidelines in Australian primary care: a qualitative study using the theoretical domains framework. *International journal of nursing studies*, *103*, 103503.

[22] Fedele, R. (2024) *Nurses in GP clinics stuck 'doing paperwork' instead of treating patients*. Australian Nursing & Midwifery Journal, 11 June. Available at: https://anmj.org.au/nurses-in-gp-clinics-stuck-doing-paperwork-instead-of-treating-patients/

[23] Breadon, P. and Jones, D. (2026) *We're wasting the skills of our nurses*. Grattan Institute, 3 March. Available at: https://grattan.edu.au/news/were-wasting-the-skills-of-our-nurses/

Nurse practitioners and endorsed midwives must have access to the Bulk Billing Incentive Program to be able to provide equitable care for communities, without this, these clinicians must include a fee for their service, which undermines the service they are wanting to provide. This exclusion further reduces patient access to primary health care and will further undermine NP and Endorsed Midwife recruitment and retention due to a limited bulk-billing capacity compared with GPs.

37. Decisive and sustainable funding reform must occur for meaningful long-term change. Block funding that includes safeguards to ensure nurses and midwives work to their full scope of practice and sustainable funding models for nurse- and midwife-led care should be considered as a fundamental reform. Further reform of the funding system must be designed to future-proof and build capacity in the RRR health system. Block funding models that ensure that nurses and midwives are funded to provide care to their full scope of practice would support the improvement of the primary health care system overall. Medicare supported nurse- and midwife-led care structures will help address service gaps, reduce fragmentation, and enhance continuity of care for all communities across rural, regional and remote Australia.(24)

38. Appropriately structured funding that is inclusive of the full primary health care team, incentivises participation and collaboration, improves workforce retention and provides best care to communities is vital for a successful primary health care system.(23) Aligning funding reform through block funding to adequately safeguard the role of nurses and midwives in primary health care as well as appropriate funding strategies to support nurse- and midwife-led models is therefore not only a workforce recruitment strategy, but also a necessary mechanism to improve equitable access and health outcomes.(8)

[24] Lowe, G., Tori, K. and Jennings, T. (2019) *Nurse practitioners filling in the gaps in care delivery*. Australian Nursing & Midwifery Journal, 30 May. Available at: https://anmj.org.au/nurse-practitioners-filling-in-the-gaps-in-care-delivery

39. Funding that supports the sustainability of highly skilled and cost-effective NPs, rural and isolated practice registered nurses and endorsed midwives in RRR settings as part of multidisciplinary models of care must be an urgent consideration of this inquiry. Currently, NPs face financial barriers to practice through a lack of recurrent funding, inadequate reimbursement on the MBS and inappropriate funding models.[8] These healthcare professionals can provide comprehensive care in areas where there may be a shortage of medical officers or GPs, particularly in RRR communities, which are typically underserved due to geographical spread and transportation limitations. The ANMF calls for NPs to be able to access the equivalent reimbursement of item numbers provided on the MBS to their GP counterparts.

40. Lastly, any new funding needs to include incentives that provide NPs with the resources that facilitate their autonomous practice and enables them to work to their full scope of practice.

41. Health system needs have changed over the years. As such, model of care structures and Medicare settings must change with it to continue to provide care to communities. Nurse- and midwifery-led clinics already deliver high-quality primary health care and must be formally recognised and supported with sustainable funding models that support the long-term viability of the model. These models do not replace existing primary health care providers, only build upon the care that exists and allow for accessible high-quality care in communities where access is limited.

42. The current Workforce Incentive Payment (WIP) that exists to incentivise GP clinics to employ MDTs does not go far enough to support nurses and midwives to be appropriately renumerated and allow them to work to their full scope of practice. This payment must increase to ensure quality, multidisciplinary teamwork.

43. Block funding is an approachable form of funding that would increase the use of MDT in GP clinics. This is a progressive and positive change; however, it is not sufficient to allow for nurse- and midwife-led clinics or care to have long term success. Any new funding models must look to include these models to truly increase accessibility for RRR communities and build the health workforce.

44. Nurse practitioners must not be limited by the item numbers they can access on the MBS. They must have parity with their medical colleagues. If they are providing the same care items, they must be able to claim sufficient renumeration for this. As well as this, NPs and Endorsed midwives must be included in the Bulk Billing Incentive Program, this will allow them to provide necessary care to all in the RRR communities and allow communities greater choice and access.

45. The limitations of current Medicare settings continue to perpetuate the access equity gap for RRR health consumers as compared to those in metropolitan locations. Such disparity cannot be addressed by a singular reform, such as the use of Telehealth, or through existing models of care that cannot be sustained by current workforce shortages. Reforms that support NPs, endorsed midwives, nurses, and midwives to be funded and financial support for nurse-led models must be part of the discussion and the solution.

Recommendations:

1. Nurse- and midwifery-led clinics should be supported with long-term funding to ensure their viability and to provide accessible care in areas where access is currently limited.
2. Reform of Medicare settings and models of care must occur as the health system must adapt its structures to meet changing needs to ensure that current Medicare settings do not continue to perpetuate the "access equity gap" between rural and metropolitan areas.
3. The current WIP should be increased to better remunerate nurses and midwives and support them in working to their full scope of practice within multidisciplinary teams.

4. Block funding is a feasible way to increase the use of multidisciplinary teams in GP clinics, though it must be coupled with support for nurse-led models for long-term success.
5. Nurse Practitioners should not be limited by the item numbers they can access. If they provide the same care as medical colleagues, they should receive parity in remuneration.
6. Both NPs and endorsed midwives should be included in the bulk billing incentive program to improve choice and access for patients in RRR communities.

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

46. Australia currently faces patient access challenges in RRR areas due to their inability to attract and retain health professionals. Policy reform is critical to unlocking the full potential of the nursing and midwifery workforce and addressing healthcare system pressures in Australia. The recruitment of health professionals to these regions remains a sustained and complex challenge for organisations, irrespective of scale.

47. Thin markets in RRR Australia drive clear market failure in primary health care. Too few providers and too much geographical distance means that essential services are under-supplied. Communities face limited access, workforce instability, and service gaps that worsen preventable illness and inequity. Expecting market forces to deliver equitable primary health care in these settings is unrealistic, unsustainable, and unfair for communities and healthcare professionals. Sustained public investment and tailored service models are not optional, but necessary to guarantee access to care regardless of postcode.

48. The current GP workforce plan limits access to timely safe care particularly in RRR areas where medical workforce shortages persist. With the current Medicare rules, NPs, nurses, and midwives are not being given opportunities to lead care. Despite the beneficial removal of collaborative arrangements, barriers remain which prevent NPs to lead care.

The *Nurse Practitioner Workforce Plan* set out priorities to increase NP-led services across Australia, improve patient access particularly in underserved areas, and promote culturally safe person-centred care.[25] Sadly, that work has stalled. It must immediately be re-commenced with the recommendations implemented.

49. Our members advise us that there are fewer professional advancement opportunities, limited clinical support, and high levels of professional isolation, particularly for early career nurses and midwives. Large corporate providers might be able share resources and maximise their staffing as they operate across many sites. If the workforce or workplace is disengaged or don't feel appreciated this will impact how staff perform their role, regardless of the size of the organisation.

50. A change towards nurse- and midwifery-led care in these areas would facilitate the conditions for this essential workforce to run small practices, clinics, and offset workforce challenges. In addition to other factors driving workforce attrition, if nurses and midwives are not allowed or able to work to their full scope of practice, they become disengaged and leave the workforce.

51. Large providers may have structured employment models and/or recruitment bonuses making them more attractive. Financial incentives alone have limited impact without accompanying support for working conditions and career development which our members advise can be limiting when employed in RRR areas. There is much evidence to suggest that staff employed in these areas are overworked, understaffed, and have limited access to leave relief. Burnout rates are also considerably higher in comparison to our members employed in metropolitan settings.

[25] Australian Government Department of Health, Disability and Ageing 2023, *Nurse Practitioner Workforce Plan*, Australian Government Department of Health, Disability and Ageing, Canberra, https://www.health.gov.au/our-work/nurse-practitioner-workforce-plan

52. The ability to upskill and work in advanced practices roles, for example as a NP or endorsed midwife, not only increases retention but benefits a whole community by increasing their access to high quality care. While some programs and subsidies do exist, they are not enough. Nurse- and midwife-led clinics are critical for increasing primary health care access for communities. With the large geographical spread that nurses and midwives cover, increasing opportunity for nurse and midwife-led care with better resourcing, sustainable, long-term funding for ongoing viability of the service will improve the outcomes of a community.

Recommendations:

1. There must be increased opportunities for learning, education, professional engagement, and career progression in primary health care in RRR areas.

Section 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.

53. Significant reforms are needed to ensure that Medicare is fair, workable, and sustainably funded for RRR Australia. Currently Medicare is medically centric, despite nurses and midwives delivering a large proportion of primary, preventative chronic and maternity care. Effective reform is unlikely without fully utilising the nursing and midwifery workforce. Without changes that enable nurse and midwives to practice to full scope, be fairly renumerated, and work in safe supported models of care, access to health services will continue to decline and workforce shortages will worsen.

54. Medicare settings significantly influence employment conditions, service models, and workforce sustainability in non-hospital care, yet it remains poorly aligned with nursing and midwifery practice. Medicare continues to prioritise a medical billing structure. This limits professional recognition, employment opportunities and nurse and midwifery-led services. Nurses and midwives are often the most accessible health professionals, especially in RRR communities.

55. Nurse practitioners and endorsed midwives need access to funding that will allow them to effectively work to their full scope of practice with renumeration. Changes to the current funding models will empower NP and endorsed midwives, by enabling their full scope of practice, and formally recognising NPs and endorsed midwives as an essential provider within broader health funding networks. If these changes are made this will improve access to timely care for people who reside in RRR areas across Australia. Funding reform also strengthens advance practice nursing and midwifery workforce and supports long term system resilience.

56. Medicare rebates for nurses and midwives do not reflect clinical responsibility, risk, or complexity of care. Nurses and midwives in RRR often provide advanced extended care in settings with limited medical support. Improved funding and support for nurse- and midwifery-led team-based care will allow nurses and midwives to be accessible leading providers in sustainable, cost-effective, high quality, models of care. A progressive move to introduce nurse and midwife block funding for preventative care, chronic disease management, mental health and women's health would allow funding to be based on time, complexity, and clinical responsibility.

57. Practice roles should be clearly recognised within Medicare structures. Medicare reform needs to align with national nursing and midwifery workforce strategies. Increasing access to MBS items for NPs, changes to GP funding through block funding or increased access to the Workforce Incentive Payment (WIP) would ensure that funding is used better used to sustain employment of nurses and midwives in primary health care and ensure they are encouraged to work to their full scope of practice.

58. The ANMF is also supportive of the incorporation of planned nation-wide rural stress testing of Medicare in RRR communities. The government must ensure Medicare is fair, workable, and sustainably funded for RRR communities and that any changes will operate safely. Healthcare services in RRR communities are structurally different from metropolitan services and rural stress testing should identify future reforms and reveal community breaking points to support future planning and service delivery.

59. Failures in RRR Medicare systems leads to further system wide costs, as when local care collapses, patients present later, sicker, and ED become the default first site of care. The longer this persists, the longer and more costly it is to break out of these negative feedback cycles. These communities have historically had fewer resources and supports available to buffer the impact of such changes compared to metropolitan areas. We also know that people who reside in RRR areas have a higher incidence of disability and chronic illness, with less access to specialised care. Rural stress testing is an effective governance measure that can prevent failures in healthcare systems.

Recommendations

1. Change current Medicare funding structures to allow NPs and Endorsed Midwives to work to their full scope of practice with appropriate remuneration. This includes increasing their access to MBS items.
2. Introduce block funding for nurses and midwives to cover services such as preventative care, chronic disease management, mental health, and women's health. This would allow funding to be determined by time, complexity, and clinical responsibility rather than a standard medical billing structure.
3. Provide improved funding and support for team-based care models led by nurses and midwives, which are described as sustainable and cost-effective.
4. Adjust GP funding through block grants or increased access to the WIP to ensure funds are better used to sustain the employment of nurses and midwives in primary health care.

5. Formally recognise practice roles within Medicare structures and ensure that Medicare reforms align with national nursing and midwifery workforce strategies.
6. Implement nationwide rural stress testing of Medicare in RRR communities to identify system breaking points, prevent the collapse of local care, and support future service delivery planning in areas that have less resilience than metropolitan regions.

Any other related matters

60. There are many barriers which exist outside Medicare rules which impact healthcare professionals choosing to maintain or commence employment in RRR areas. This a combination of affordable or available housing, childcare availability, and cost of living when employed and living in RRR areas.

61. Improving infrastructure in RRR areas is beneficial for the community and the professionals that look to relocate. For long term sustainability of the healthcare workforce in RRR communities, infrastructure must exist for the health practitioners to establish community connections and be supported to stay there. This involves access to healthcare, schooling for children and affordable, quality housing, cost of living support, tax changes and incentives.

62. Harmonisation between federal and state and territory governments is essential to ensure Medicare funded services operate seamlessly within state and territory health systems.

Conclusion

63. Access to equitable, quality primary health care is limited in the RRR areas of Australia. Stronger reforms to the Medicare system are required to achieve the goal of equitable primary health care and improved health outcomes. Primary health care must first be understood to not only be provided by GPs and the medical workforce, but by the full multidisciplinary spectrum of healthcare providers with nurses and midwives making up a great proportion of the workforce. Once this is an accepted notion of primary health care, then effective, meaningful reform can occur.

64. Medicare cannot be sustainable without a sustainable health workforce. Nurses and midwives are essential to the future of accessible high-quality care, yet current Medicare settings undermine the capacity and capability of the workforce.

65. Primary health care is crucial for the sustainability of the whole health system. Nurses and midwives are perfectly positioned to provide this necessary care to the RRR community. These professionals have a wide geographical spread and a vast range of highly valuable skills that benefit a community. They must be supported to work to the extent of their scope and have access to funding that supports this. Currently, the funding system is skewed to GP practices due to historical policy settings and an outdated understanding of the healthcare space. The ANMF calls for stronger reforms to the Medicare system to ensure all Australians have access to safe, quality health care regardless of their postcode.