COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

RURAL AND REGIONAL AFFAIRS AND TRANSPORT REFERENCES COMMITTEE

Rural, regional and remote Medicare access and funding

(Public)

TUESDAY, 7 APRIL 2026

ALBURY

BY AUTHORITY OF THE SENATE

[PROOF COPY]

RURAL AND REGIONAL AFFAIRS AND TRANSPORT REFERENCES COMMITTEE

Tuesday, 7 April 2026

Members in attendance: Senators Colbeck, Dolega and Steele-John

Terms of Reference for the Inquiry:

That the following matter be referred to the Rural and Regional Affairs and Transport References Committee for inquiry and report by 30 June 2026:

The Government's changes to rural, regional and remote Medicare access and funding, with particular reference to:

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

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

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

d. the adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities, including the roles of general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists;

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

f. reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians, including the requirement for rural stress-testing of future changes; and

g. any other related matters.

WITNESSES

McMILLAN, Ms Jackie, Senior Project Officer, Women's Health NSW [by video link]

NICHOL, Ms Marge, General Manager, Women's Centre for Health and Wellbeing Albury-Wodonga

ACTING CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses giving evidence to Senate committees has been provided to you. Marge, we might go to you first, if you'd like to make an opening statement, and we'll come to you shortly, Jackie.

Ms Nichol: Thank you, Chair and committee members, for welcoming me here today. The Women's Centre for Health and Wellbeing Albury-Wodonga is also known locally as the women's centre. I'm appearing here with Jackie, who we've worked closely with as a part of our peak body. I'm not just here as a service provider; I'm also here as the voice of women in our community who can't be here, don't feel their voices are heard and are too stressed, too exhausted or too invisible to advocate for themselves. The women's centre is a local cross-border service and not-for-profit organisation serving women and girls from both Albury-Wodonga and further abroad in our region. We're not a clinical health service, but we are a place that women come to when the health system fails them, turns them away or places them on long waitlists too long to matter. Then they come and say to us: 'What do we do? Where do we go? I need help.' We're an early intervention service, and we are a service that people come to when they're in crisis, particularly family and domestic violence and sexual assault victims-survivors. And we are, frankly, a pressure valve for the Medicare system that is struggling to meet the needs of the most vulnerable.

Thanks to the core funding increase from the New South Wales government at the last elections, we've been able to meaningfully expand our counselling, intake, referral and case management capacity to all the women that need it. Our figures show that we've increased our occasions of service by 255 per cent in this time and the women that we work with by 108 per cent. We have no time limit on how long we work with these women. It's directed by their needs and their wants and how long they want to work with us. So, if they have a mental healthcare plan, that doesn't matter to us; we just work with them. It could be year after year or one off, one on—whatever they like. But we're trauma informed, we're safe, we're client centred and we're a women's-only safe place.

This is where I want to stress to the committee that we can't do this alone as a service provider, and we shouldn't have to. We do not have the funding to employ a nurse or a nurse practitioner or a GP. The need is there for us to do that, but we do not have the funding. We have the space for it, but we don't have the funding, which is really sadly lacking. It's the cost that is prohibitive for us to do that without extra funding. So, when our clients need medical care, we refer them on and out to the GPs or wherever they need to go. And, time and again, we watch the referrals go nowhere.

Why do they go nowhere? Because they can't afford it. The barriers are not small inconveniences. They are systemic. Women are encountering bulk-billing GP waitlists that stretch weeks or months. For women from culturally and linguistically diverse backgrounds, the absence of multilingual GPs is not a minor inconvenience. It's a wall. It's a stumbling block. So many of these women make a rational, if devastating, calculation: the health system is not for them. And they've told me that personally in a bowel cancer study that we did recently with them. 'We just don't go,' they say. 'It's too hard.' Apart from not understanding the system, it's just too hard. They disengage. They go without. Their health deteriorates quietly and invisibly at significant cost—personal, social and ultimately economical. This is the inequity I'm asking the committee to confront.

In Albury-Wodonga, where we live, it's a regional community that, for all its strengths, is not Sydney and is not Melbourne. The tyranny of distance is real. Travelling to the metropolitan centres for specialist care is not a minor inconvenience for the women we serve; it's simply impossible. Limited local choice combined with the cost and complexity of accessing Medicare services means that geography compounds disadvantage. Women in regional areas are not receiving equivalent access to care, and the Medicare system as currently structured does not account for this.

Things that I'd like you, as a committee, to consider with regard to the Medicare framework are, firstly, properly funding and incentivising bulk-billing in regional and cross-border communities and removing the arbitrary 10- or 20-minute appointments constraint that forces GPs to choose between thoroughness and throughput. I've been there when they've said, 'It's 10 minutes now; I can't do the next thing and the next thing and the next thing.' You've then got to come back and you've got a long waitlist to get back in to see that GP. Consider having only out-of-pockets, if any, payable at the time of service to the provider, rather than having the entire cost paid and then having to wait for the Medicare refund. Recognise and support multilingual and culturally safe general practice. And acknowledge the critical role that community based not-for-profit services play in early intervention and fund them accordingly.

Every woman who cannot access affordable, timely, respectful health care is a woman whose potential contribution to her family and community is diminished. This is not just a personal tragedy; it's a policy failure. We need a Medicare system that is genuinely fair—not just in principle but in practice—where a woman in Albury-Wodonga has the same access to dignified, adequate health care as a woman in any capital city, not because it's aspirational but because it's right. I thank you all for supporting us in making a difference and for listening to my little spiel.

ACTING CHAIR: Thank you. Jackie?

Ms McMillan: Women's Health NSW is the peak body for 21 non-government women's health centres and special purpose services operating in New South Wales. We really appreciate the opportunity to appear here today before the committee alongside our member Marge Nichol, who's made a great case for the women of Albury.

The women's health sector plays an important role in health equity. This was recognised recently, as Marge told you, by the New South Wales government, with a $34.3 million core funding increase spread across four years in the 2023-24 state budget. The increase to core funding recognised the essential nature of community based health care and the domestic violence support that our members provide to women and children. When core funding doesn't keep pace with the demand upon our services, more pressure is placed on the public health hospital system. The New South Wales Minister for Women, the Hon. Jodie Harrison, put it like this:

These centres are vital in providing a safe place for women who might otherwise fall through the cracks and are critical in removing barriers to health care by providing women the care they need in their own communities.

In the last financial year, the core funding increase enabled our members to provide more than 114,000 occasions of service to women, incorporating more than 223,000 presenting health issues, and 59 per cent of our clients were in rural, regional or remote locations.

Women's Health centres exist to get women the health care they need when and where they need it, but, as Marge told you, we don't do that work in isolation. Around each of our centres there's a network of health and allied health services, including GPs, that our members establish and maintain to ensure that women get a good connection to the mainstream health system. Sometimes we're lucky enough to be able to bring those GPs in-house, where we can resource them with the time they need to address women's complex and intersecting health issues. Other times we need to rely upon external services, particularly warm referrals to GPs who we know can provide culturally sensitive and trauma informed care.

We need a Medicare system that encourages and rewards GPs for delivering that complex, time-consuming multidisciplinary care that our women need, where they need it. Women's Health and our members contributed to this inquiry because the women that we see sit at the pointy end of health inequity in Australia. Most of the women accessing our services experience greater barriers to optimum health than your average Australian. Our statewide remit has shown us that these barriers are even more pronounced in rural, regional and remote locations. In our submission, we also drew attention to inequities in particular healthcare services, including sexual and reproductive health and mental health, where regional, rural and remote workforce shortages are deeply affecting the health and wellbeing of the women we see. We really thank you for your time and the work that you'll do in narrowing these gaps in health equity.

ACTING CHAIR: Thank you, Jackie. Senator Dolega.

Senator DOLEGA: Thank you for your attendance today and for your submissions. I might ask you, Ms McMillan, about your New South Wales lens. Obviously, the federal government has invested quite a lot in Australia's first endometriosis and pelvic pain clinics across all states and territories. In New South Wales, what are you hearing about those clinics? Are they making much of a difference? I appreciate, Ms Nichol, that there's one in Wagga but not here.

Ms Nichol: Before Jackie goes on to that, are you aware that Albury Wodonga Health doesn't really sit in any state? That's why some of the stuff that is put in at state level doesn't come here, so we're disadvantaged by that as well, locally. Sorry, Jackie; go on.

Ms McMillan: Two of our members were lucky enough to receive funding. There's Coffs Harbour Women's Health Centre, who already provide a pain clinic and endometriosis services, and, opening just next week, Central Coast Community Women's Health Centre is another of the funding recipients. We're yet to see what that work does in the Central Coast, but we're very excited about it and very appreciative. However, as a peak body, we do field inquiries from all over the state. I spoke to a woman from Armidale, and, when I looked up which bulk-billed service was closest to her, it was in Coffs Harbour. That's a very long way for her to travel. That was a very difficult conversation—to tell that woman that that's her closest service.

Senator DOLEGA: With the increased bulk-billing incentives across general practice, are you seeing more women being able to see a GP because of the increased bulk-billing?

Ms McMillan: It wasn't what they reported to us when we were making this submission. There were still quite strong problems with bulk-billing. I think Wagga told us that only eight of the 21 practices in the area were offering bulk-billing, and all of our members reported very long waits in those practices or GPs closing their books to new clients, which made referrals very difficult for us. We haven't seen a big change to that, but we have heard some positive things about the urgent care clinics.

Senator DOLEGA: So, in UCCs but also across general practice, are you seeing more women being able to take up the option to attend, or are you saying that, because of the bulk-billing and the fact that bulk-billing practices have transitioned to full Medicare BB clinics, people can't get into them now—they've closed the books because the demand was so high?

Ms McMillan: Yes. Demand is outstripping services.

Senator DOLEGA: Would you encourage other GPs to get on board and become bulk-billing clinics?

Ms McMillan: Absolutely. We need more bulk-billing GPs. I think that you'll see the benefits in what we spend on health care in the long term if people are able and feel confident to visit the GP more often at the beginning of a problem rather than down the track when they don't have any other choices.

Senator DOLEGA: Going back to 2023, there was a new level E item for consultations of 60 minutes. Are you hearing anything from across your membership as to whether or not this is helping women? What would you recommend about that relatively new item?

Ms McMillan: We were delivering a project on strangulation and sexual choking, so we actually advertised that consultation level E to all of the doctors that we trained for that project. We were so excited because it was the first one that really gave GPs time to look at the referrals they needed to provide so that they were taking a holistic look at health. We did have a little bit of pushback—those consultations still tend to take up more than the allotted time, and you can actually make more money from Medicare by doing a number of short appointments. So, yes, we were excited by the change. Yes, we've been pushing it as a way—particularly when a woman is experiencing domestic and family violence. We've been asking women—when they've, for example, experienced strangulation—to ask the GP to book a consultation level E, but we're still seeing some hiccups in the rollout, and limited numbers of GPs are talking about doing those types of appointments.

Senator DOLEGA: Thanks. We noticed in your additional submission Ms Nichol's case study about strangulation and assault. It was quite a challenging read about the adverse health effects that women and people suffer as a result of this. What's your advice for the committee on how we can encourage women to come forward? Your case study involved a nurse who was in the system, and there was quite a bit of a stigma. What do you suggest to the committee that we can consider?

Ms McMillan: It's a tough one. When we rolled this project out, we found, in every area, we needed to come up with a different solution. For example, a shout-out to Campbelltown Hospital—they allowed us to send women to them up to nine months after the initial strangulation event, because their imaging is free. If a woman was experiencing neurological symptoms, she could attend her ED, even if the event was three months—up to nine months—earlier, and that allowed her access to care. One of the gaps we found was that, if we sent a woman to a GP to manage—and a GP is the person who should be managing primary care for her. If he sends her to get scans and there's no bulk-billing option available, she just won't go, and she may be lost to care entirely. You can see from Marge's case study, it's pretty devastating. A stroke is one of the injuries that could come from this.

In another area, up in the Northern Rivers, Women's Health Northern Rivers found that there were no services in their local area that could do a neurological assessment of a woman who'd experienced strangulation. They actually had to apply for a grant to get services to come to their centre. They solved the issue that way. To me, making neurological services cheaper and more accessible—I think it's about 3½ thousand dollars to have an assessment to work out whether you have a brain injury from strangulation, and it's a long assessment. I think you're looking at ways to solve this across the board, rather than at localised fixes, to make sure that we have access everywhere and, particularly, bulk-billing on scanning.

Senator DOLEGA: Being just a couple of blokes in the room here today who are asking you guys questions about this—I'm so sorry that I don't know the answer. Is this increasing? Are you hearing that there's more of this occurring in the community? Is this increasing or—

Ms McMillan: Perhaps the thing that's increasing is sexual choking among young people. We have some Australian research led by Professor Heather Douglas from the University of Melbourne. It found 57 per cent of young people have engaged in sexual choking. That's strangulation with consent in a sexual context. So we're

going to see more injuries if people are engaging without understanding that strangulation can lead to a brain injury. It is a significant health issue. Often, when women also have experiences of trauma—say the strangulation has occurred in the context of domestic and family violence—you're going to see overlap between symptoms of complex trauma, brain injuries and strangulation. You might not recognise the brain injury.

One of the things that we did was train service providers to look for a mechanism of injury: Has the woman been strangled? Has she had a hit to the head? If so, and if she's experiencing neurological symptoms—we created a referral letter that you can hand to a GP. The service provider fills out the referral letter and gives it to the woman. She takes it to the GP, and it tells the GP exactly what we'd like investigated: 'She's experiencing these symptoms. She was strangled this long ago. She still has headaches. She's still having trouble sleeping. Can you please look at these things for her?'

Senator DOLEGA: Thanks very much for that. I might pass the call over.

ACTING CHAIR: Thanks. I would add my comment to Senator Dolega's with respect that we're three blokes, with Senator Steele-John on the line. Thank you for guiding us through this, because it is an important but sensitive matter that we're dealing with, and making sure that we get the right perspective through the evidence is really important. Senator Steele-John, do you have any questions?

Senator STEELE-JOHN: Yes. Thank you very much for your evidence so far today. I'm interested in knowing more about what you experience, either as a service or what you hear from the community directly, in terms of the flow-through impacts of the service and healthcare deserts, which we've heard a bit about today. It's often spoken about in kind of wonkish policy terms, but I'm really interested in the human stories that you encounter and hold in your possession in relation to what this actually means in people's day-to-day lives.

Ms Nichol: I can tell you from a personal perspective about somebody that I know that has got diabetes, oedema. They want to give her a heart echo, they want to give her an MRI, and she's on Centrelink benefits. So, for her to investigate those to get the best health outcomes, she has to ask family, and, if they can't pay for her to have that, then she doesn't have it. It's affected her health dramatically, not being able to get the right diagnosis as a young woman to be able to live in a community and feel part of a community that she's contributing to, because her health doesn't allow it. There's also a shame, in a way, in saying: 'Well, I can't afford it. So how do I—I just say I can't make it.' There's that shame factor that comes in because they just can't afford something they really need to do, which is really sad.

Senator STEELE-JOHN: Cost is absolutely a barrier. When the wait time is so significant, or there simply isn't a professional or specialist in town that lines up with what you actually need—are you hearing from people that those things are also very much factors?

Ms Nichol: Absolutely. Sometimes people have to go to Melbourne from here, and that's not always easy. If you want to rely on the train—the train is not reliable. It can take you four hours; it can take you five hours. And then it doesn't get you to where you want. It's prohibitive, sometimes, travelling to Melbourne. If it's not Melbourne, or it's Canberra or it's Sydney, sometimes we're out of the zone; in the abortion space, you can't go to some of those places because we're out of the catchment, so then women don't even go down to that place because they can't do it, because it's just prohibitive. I guess there are lots of layers to it on. But it comes down to, sometimes, they just give up. They just think: 'Well, what's the point? Nobody trusts me. Nobody believes in me. Who am I?' That self-worth drops as well, so they don't even fight in the long run to have those good health outcomes.

Senator STEELE-JOHN: Yes, absolutely. Ms McMillan, would you like to add anything to what your colleague has shared?

Ms McMillan: Sure. Marge's experience in Albury is reflected in so many of the centres that we talked to about this submission. I remember talking to Wagga Wagga about abortion access, and women were going to Queanbeyan in Canberra, or even to the city, because that was the closest place that they could come. That comes with additional out-of-pocket costs that make it very, very expensive. Also, the delays for health care push women onto more expensive options for abortion. If it takes more than nine weeks, you're out of being able to have a medical abortion; you have to have a surgical abortion, and that's going to come with greater costs. There is really an unfair burden placed on rural, regional and remote women to access the same health care that we have in the city.

Senator STEELE-JOHN: In terms of the complex interplay of accessing these services, should they exist, we also heard a little bit earlier in the session concerns around privacy and the need to be able to access telehealth items and things like that or to speak with a specialist or a generalist specialist who isn't part of the community,

for fear of that private information leaking or being perceived to leak. Is that something that has been shared with you as a concern around privacy as well?

Ms Nichol: We've had some people, when there's been a referral made to us or from us, who have this perception that their whole story has been shared, but it hasn't been, and then they just back off from a service. That's happened recently, where people are saying, 'You've shared my story.' No, we haven't. We've just put you in a place where you knew that referral was going there because they pick you up. But, then, that stops them too because they're scared about who knows what. In particular, if you go into the First Nations community or the CALD community, they don't want people to know their stories as well.

Senator STEELE-JOHN: Absolutely. Thank you so much for your evidence this afternoon. It's been really useful for us to hear it as a committee, and, as I said to a previous witness, if you leave the table and, like I often do, think, 'Oh, I wish I had shared this,' you can provide additional evidence to us within the next two weeks. We'll include it in our report. Thank you very much for your time; I'll pass back to the chair.

ACTING CHAIR: I want to go back to the terms of reference and some of the elements there, which, through your submissions, really blend a lot of the different elements of the terms of reference together. The issue that we heard about first today really related to the restrictions around the utilisation of the telehealth service, particularly for mental health. But I'm taking, from what you're saying, that it has much broader implications than that because it could go into so many other things that would support the referrals that would be needed for that more holistic care that people will need out of some of the events—graphically demonstrated by the example that you've put in front of us with your supplementary submission. Would that be right?

Ms Nichol: Yes, you can't just deal with one aspect of that person's journey. You might have telehealth and mental health, but there are all those other aspects that come into play, and it's important to be able to cover all of it holistically—which we try to, as much as we can, where we are, to make sure that they're supported with different services. Is that what you're asking?

ACTING CHAIR: It does, but there would be other service types that would be available via telehealth which would also facilitate dealing with some of these other issues or ensuring that, as a part of that process, those appropriate referrals finally get made as you work your way through the system.

Ms Nichol: With telehealth—I'm going to talk from our perspective, with the clients that we deal with—sometimes it's not safe and secure for them to be in a telehealth position because you don't know who's going to walk into the room. It might be the perpetrator. It might be children. Some of that sensitive stuff needs to be face to face in a one-on-one space. My counsellors do offer telehealth or telephone calls, and sometimes the kids hear, or they say, 'Call me back because it's not safe.' We've got to look at it that way as well; it's not always the answer. There is a local clinic, now, that does telehealth a lot, on the weekends and from 10 till midnight, which might suit some of our women, to be able to have that in a private space, but they've got to know that they're safe to have that conversation at that time, and it's not always safe for them.

ACTING CHAIR: So there are a series of underlying things that sit with the group of people—the women that you're supporting—that are also absolutely necessary to deliver the appropriate outcomes or good outcomes.

Ms Nichol: If I think of my mum, at 92—she would never have done a telehealth one. She wouldn't know how to do it. She knew how to work computers, but she would never have trusted talking about herself into a screen. I think it's different for different demographics of people too.

ACTING CHAIR: Absolutely. There are a range of things that go through to that. There's the digitally disconnected demographic cohort, if you like. That brings in a range of things that you already talked about. More elderly Australians don't feel comfortable with the technology. They don't, necessarily, trust the technology. Do you actually facilitate the utilisation of telehealth at your service? Could someone come to your facility and then access a provider?

Ms Nichol: They can if they need to, yes. And sometimes, for safety, that's what we have to do. Absolutely.

ACTING CHAIR: Ms McMillan, can you run through those in the broader New South Wales sphere?

Ms McMillan: Women's Health Northern Rivers, that had the devastating floods, said that the restrictions really didn't work for their rural and regional context. People couldn't get to their services. Also, looking at the cost-of-living crisis and things like petrol, the more that you can open up telehealth for rural, regional and remote Australians, the better.

ACTING CHAIR: We had recommendations from other providers, particularly focused on mental health, with respect to having a change around the definition, based on the MMM classifications. They were suggesting

two to seven, which would cover some of those areas where direct accessibility or location availability doesn't exist and where it would open it up for them to access those services.

Ms McMillan: Absolutely. I do note that we looked at one women's health centre that we consider to be rural, regional and remote because it's in the Blue Mountains and they don't have the same access to service. They're graded as an MMM1 location, but they've struggled to attract and hold GPs too. So, yes, I would definitely be opening it from two to seven.

ACTING CHAIR: I'm happy to concede that the MMM system's not perfect.

Ms McMillan: Yes.

ACTING CHAIR: There have been attempts to massage it at times, but it's very, very difficult.

Ms McMillan: Possibly in your stress testing. One of the questions is whether women will actually take it up. Yes, they have services in Sydney that they could go to. But, through women's health centres, you could actually be asking whether they go to them. If they get a referral to a GP that's 100 kilometres away or a referral to a specialist, do they use it? For me, that's the question. We know that we can hand out those referrals, but, if women don't take them up, it's not successful.

ACTING CHAIR: You mentioned distance, which is an obvious barrier.

Ms McMillan: Yes.

ACTING CHAIR: What would be the other barriers that you would experience?

Ms McMillan: The cost of getting there—the out-of-pocket costs that are connected with seeing that specialist. I guess trauma informed care is often a barrier. One of the things that women's health centres do very well is talk to the services that they refer women to. When a woman is being referred, we call them up and introduce them on the phone. We tell them what the appointment is going to be like, what the waiting room looks like and what will happen in the appointment. That's one of the ways to make sure that people do connect to care at an unfamiliar service. We make sure that we talk about cost—that this service is going to charge you this much when you get there and you'll get this much back on Medicare. That's one of the things that Marge pointed out before that is a real barrier. Having to pay the full price of the service can be a massive barrier to people taking it up.

ACTING CHAIR: I think we might have been talking informally before the hearing started about how the private health insurance system works, where you hand over your card, the service takes the rebate and you pay the difference.

Ms McMillan: The gap.

ACTING CHAIR: I wasn't going to use the dreaded 'gap' word—Senator Dolega might get a bit edgy with me—but that's right. That's effectively what you're talking about. But, in terms of Medicare, since the advent of electronic payment systems in particular, you pay upfront and then have to wait that 24 hours to receive the Medicare rebate. So you know what the gap is, but the 24 hours might not be sustainable in terms of your overall finances to actually go through with that process. So you would be—

Ms McMillan: You might not have the money, so you might not have the initial payment. If it's a scan, that's an expensive medical item. So you might have to have a thousand dollars in your chequing account, and, if you don't have it, it doesn't matter what the bit that comes back is. You just can't pay for it.

ACTING CHAIR: My question was going to be about making the system cater for that, which would be of benefit and would assist the people that you're supporting?

Ms Nichol: Yes.

Ms McMillan: Yes.

ACTING CHAIR: I'll leave it to someone else to try and design it, but I just wanted to get that on the record. I thought it was a very salient conversation that we had earlier, and the fact that you're both saying the same thing is useful in terms of the broader conversation.

Ms Nichol: One of my staff members has two children with disabilities. Most often children are bulk-billed, but their referral to get an MRI or a scan for something recently was a private referral, but she didn't know till she went to the place. They said: 'No, you'll have to pay all this money now. But, if you get on the waitlist, go back to your GP and get the GP to refer, then it's bulk-billed.' That was just wrong.

ACTING CHAIR: So it's about the coordination and structure of the way the system works in supporting people actually accessing the service and, for those diagnostic things, the upfront out-of-pocket cost being basically an inhibitor to access of service for the people that you're supporting?

Ms Nichol: Yes.

ACTING CHAIR: Your submission recommends the removal of the restrictions on the telehealth provision. We've covered that a little bit. Is there anything else you'd like to add to that element? I think we've talked about some of the impacts and the inhibitors to the utilisation of telehealth, which is an important thing for us to consider. You also talk about the expansion of Medicare item numbers for nurse practitioners and midwives. We've had nurse practitioners in here. The health minister will be very nervous that we're now talking about midwives. Are there any further consultations that you think should be covered? They're all important elements of the system—

Ms Nichol: Jackie will probably have more to say to you on that.

Ms McMillan: Just the full range—not every nurse practitioner consultation can take place in six minutes to 20 minutes. Often, nurse practitioners are delivering health promotion and helping people manage complex conditions, so they need a few more item numbers that recognise the provision of complex care. That's what they're good at. I think the centres that talk, in the submission, about this say it's not possible for those, because you can't book your 20-minute appointments as one, one, one—because they always run over at women's health centres. So we can't make it sustainable to provide these services on what Medicare delivers back.

ACTING CHAIR: What I'm interpreting you're saying to me is that nurse practitioners play a very important part in the health delivery system—

Ms McMillan: Absolutely.

ACTING CHAIR: within the structure of your services in particular and as part of what we're talking about today in regional settings.

Ms Nichol: Yes.

Ms McMillan: Anything you can do to support them having an expanded role and being able to cater to the time needed when people have complex presentations or when they have a lot of intersecting health issues—as Marge said, when the GP says you've only got 10 minutes, you can only cover one of the things. Often, people come in with a shopping list of things that have been going wrong that they've been holding over for a long time. If we want to intervene in people's health, we want them not to wait until they have a full shopping list, and we want to get through that shopping list when they come with one.

ACTING CHAIR: It's all very well to expand the scope of practice for nurse practitioners, but you have to make sure the system compensates them for undertaking that scope of practice as part of the delivery of the broader health system.

Ms McMillan: Absolutely.

ACTING CHAIR: Thank you very much for coming in and talking to us today, and thank you for your submissions; they provide a very stark demonstration of the importance of what you do. Thank you for what you do in the communities; it's really important. I don't think you've taken any questions on notice, but if you have—or if, as Senator Steele-John said, you have anything else that you think we need to know—if we could have responses by 7 May we would appreciate that very much. Thanks very much for your evidence today.