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RACP submission: Inquiry into access to and affordability of medical specialists in Australia

October 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,600 physicians and 9,700 trainee physicians, across Australia and Aotearoa New Zealand.

The RACP represents the largest number of medical specialties which work within and across the private and public health sectors including general medicine, paediatrics and child health, cardiology, respiratory medicine, geriatric medicine, neurology, oncology, public health medicine, infectious diseases medicine, addiction medicine, occupational and environmental medicine, palliative medicine, sexual health medicine and rehabilitation medicine.

Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute to the House Standing Committee on Health, Aged Care and Disability's Inquiry into Access to and Affordability of Medical Specialists in Australia.

The RACP represents the majority of Australia's adult and paediatric specialist physician workforce. Our physicians and paediatricians deliver expert, evidence-informed care to people living with complex, chronic and serious health conditions across hospitals, community settings and specialist practices. This submission identifies the key barriers preventing Australians from accessing specialist care and proposes practical reforms to improve access, affordability and health outcomes.

Australia's challenge is not simply a shortage of medical specialists. Rather, Australia faces an access-to-specialist-care challenge arising from a combination of workforce maldistribution, constrained public specialist service capacity, increasing complexity of patient need, affordability barriers, and fragmented referral pathways.

Timely access to specialist care is fundamental to achieving better health outcomes, preventing avoidable deterioration in health, reducing hospital demand, supporting workforce participation and promoting equity across the health system. Delays in access can result in disease progression, increased emergency department presentations, avoidable hospitalisations, reduced quality of life and increased healthcare expenditure.

While these challenges affect the broader population, they disproportionately impact:

- Aboriginal and Torres Strait Islander peoples
- people living in rural, regional and remote Australia
- children and young people
- older people
- people with disability
- migrants, refugees and people seeking asylum
- culturally and linguistically diverse communities
- people experiencing socioeconomic disadvantage.

The RACP considers that improving access requires action across specialist service capacity, workforce planning, funding arrangements, referral systems and models of care. Increasing specialist workforce numbers alone will not resolve current access challenges unless accompanied by expansion of publicly funded specialist services and reforms that improve how specialist care is delivered.

Priority Reform Areas

The RACP fully supports the Australian Government’s drive to make specialist services available and affordable and proposes a suite of priority reform areas to make the greatest difference to improving access to specialist care in Australia.

Strengthen specialist access monitoring

Australia currently lacks nationally consistent data on specialist access, outpatient waiting times and unmet demand.

The Australian Government should establish a National Specialist Access Monitoring Framework to support transparent reporting of specialist service availability, waiting times, workforce distribution and patient outcomes across public and private settings.

Expand public specialist service capacity

Long waiting times increasingly reflect insufficient public specialist capacity rather than simply a shortage of specialists.

Governments should expand specialist outpatient clinics, ambulatory services and multidisciplinary models of care, supported by sustainable workforce and infrastructure investment.

Modernise referral pathways

Referral systems should support timely and appropriate access to care.

Governments should invest in nationally consistent electronic referral pathways, specialist advice services, referral tracking systems and interoperable digital infrastructure that improves coordination between primary and specialist care.

Improve affordability

Increasing out-of-pocket costs are creating barriers to accessing specialist care.

Reform should include review of Medicare funding arrangements, support for multidisciplinary care and measures that reduce cost-shifting to patients.

Improve workforce distribution

Workforce shortages remain most acute in rural, regional and remote Australia.

Governments should strengthen rural training pathways, specialist outreach programs and recruitment and retention initiatives that support long-term workforce sustainability.

Support innovative care models

Telehealth, outreach services, shared-care arrangements, hub-and-spoke networks and multidisciplinary care models can improve access, where implemented effectively.

These models should be scaled nationally and supported through appropriate funding arrangements.

Improve equity of access

Specialist services must be culturally safe, accessible and responsive to the needs of priority populations.

Attention should be given to Aboriginal and Torres Strait Islander-led solutions, disability-inclusive care, interpreter access and community-based models that reduce barriers to care.

Introduction

Access to specialist care is a national health system challenge

Australia's health system relies on timely access to specialist medical care to diagnose, manage and treat complex, chronic and acute health conditions. However, patients across Australia are increasingly experiencing delays in accessing specialist assessment and treatment. These delays occur across both public and private settings and are being driven by a combination of workforce, funding and capacity constraints.

Importantly, access challenges cannot be understood solely through specialist workforce numbers.

The RACP considers that Australia does not have a specialist care problem; Australia has an access-to-specialist-care problem.

Access is shaped by multiple interacting factors, including:

- Specialist workforce supply
- Workforce distribution
- Public specialist service capacity
- Affordability of care
- Referral processes and system navigation
- Availability of multidisciplinary services
- Digital and infrastructure capability
- Cultural safety and accessibility.

Focusing on any one of these factors in isolation risks overlooking the broader structural issues limiting patient access.

Delayed specialist care affects individuals, communities and the broader economy

Specialist care plays a critical role in preventing complications, reducing avoidable hospital presentations and supporting long-term health outcomes.

When specialist access is delayed:

- Health conditions may deteriorate
- Treatment options may become more limited
- Preventable hospitalisations may increase
- Disability and functional decline may worsen
- Participation in education and employment may be affected
- Healthcare costs increase across the system.

These impacts extend beyond health and influence economic productivity, workforce participation and broader social wellbeing. Timely specialist care should therefore be considered both a health system priority and an economic priority.

Access challenges are not experienced equally

The impacts of restricted specialist access are not distributed evenly across the population.

People living in rural, regional and remote Australia frequently face long travel distances, limited specialist availability and greater costs associated with accessing care. Aboriginal and Torres Strait Islander peoples continue to experience significant barriers to accessing culturally safe specialist services and often face compounding challenges relating to geographic access, affordability and continuity of care.

Children and young people may experience developmental, educational and health consequences when specialist assessment and treatment are delayed. People with disability may face additional barriers navigating healthcare systems, accessing appropriately equipped services and coordinating care across multiple providers. Migrants, refugees, people seeking asylum and culturally and linguistically diverse communities may encounter language, cultural and system-navigation barriers that further restrict access.

Importantly, specialist access challenges are no longer confined to rural Australia. Many outer metropolitan growth corridors now experience similar workforce shortages, long waiting lists and affordability pressures despite geographic proximity to major health services.

A systems approach is required

Improving access to specialist care requires coordinated reform across governments, health services and professional groups.

The RACP considers that priority attention should be directed toward:

- Expanding public specialist and outpatient care capacity
- Improving workforce planning and distribution
- Strengthening referral pathways
- Reducing affordability barriers
- Supporting innovative models of care
- Improving access for priority populations
- Enhancing data collection and accountability.

It is time for specialist services to be made structurally integral to the health system design instead of straddling Commonwealth and State/Territory funding and policy responsibilities.

The consequence of Commonwealth and State/Territory governments not integrating specialist physician services into the design, funding and governance of the health system is that specialist care operates as a disconnected component between primary care, hospitals and community care, creating bottlenecks, inequitable access, avoidable costs and poorer patient outcomes.

The following sections outline views from our RACP members against each of the Terms of Reference and identify practical reforms that can improve access and affordability while supporting a sustainable specialist workforce.

If Australians are to live full and productive lives and enjoy high quality of life, this Inquiry must address how specialist health care can be delivered equitably across Australia's diverse communities and its vast geography.

Terms of Reference A: Current access to medical specialists in cities, regional and rural communities

Access to specialist care is shaped by multiple system factors

Access to specialist care is influenced by more than the number of specialists working within the health system. While workforce supply remains important, access is ultimately determined by the interaction between workforce availability, workforce distribution, public specialist service capacity, referral systems, funding arrangements and models of care.

The House of Representatives inquiry itself recognises workforce distribution, waiting times, affordability and referral pathways as interconnected determinants of access to specialist care.[1]

Workforce distribution data should be publicly reported at regional and local levels. Transparent reporting of specialist physician, nursing and allied health workforce-to-population ratios would assist governments and health services to identify areas of under-supply and target investment where it is most needed.

Linked administrative data would enable governments to identify access barriers, service bottlenecks and emerging workforce pressures, while supporting more effective workforce planning and resource allocation.

Current initiatives involving the RACP, including workforce modelling, specialist training reform and data sharing initiatives with governments and health services, represent important steps towards a more coordinated national approach. These efforts should be expanded and linked to long-term specialist access and workforce planning objectives.

The RACP considers that current access challenges reflect systemic constraints across all these domains. Efforts to improve access should focus on both increasing capacity and ensuring specialist expertise is available where and when it is needed.

Workforce supply remains important but is only part of the solution

Australia's specialist workforce has continued to grow over time. However, increasing workforce numbers alone will not resolve access challenges if specialists are unable to practice in settings where patient demand is greatest. National workforce planning increasingly recognises the importance of matching workforce supply with population need, geographic distribution and service demand.[2]

The RACP strongly supports the workforce planning commitments contained in Schedule G of the National Health Reform Agreement, particularly efforts to strengthen health workforce data and establish a national evidence base for strategic workforce planning.

Many specialties report increasing demand associated with:

- Population growth
- Population ageing
- Rising rates of chronic disease
- Increasing clinical complexity
- Advances in diagnostic and therapeutic interventions
- Growing expectations regarding timely access to care.

[1] Inquiry into access and affordability of medical specialists – Parliament of Australia
[2] Whole of Medical Workforce Supply and Demand Compendium Report_June 2026

At the same time, specialist practice has become increasingly complex, requiring greater time for multidisciplinary care, coordination, documentation, teaching, supervision and quality improvement activities.

Workforce growth remains an important component of improving access to specialist care. However, increasing specialist numbers alone will not address access challenges unless workforce planning is matched by investment in public specialist service capacity, consultant physician positions and sustainable models of care. Effective workforce planning must focus not only on the number of specialists being trained, but also on where they practise, how they are supported and whether patients are able to access their expertise in a timely manner.

Recommendations to the Committee:

- Develop a nationally coordinated specialist workforce strategy.
- Align specialist training, workforce and consultant physician growth with projected population need.
- Expand public specialist service capacity to improve access to care.
- Strengthen recruitment and retention in rural, regional and underserved communities.
- Ensure workforce planning reflects service demand, patient complexity and contemporary models of care.

Aboriginal and Torres Strait Islander Workforce and Specialist Access

Growing the Aboriginal and Torres Strait Islander physician workforce should be recognised as a key specialist access strategy. Increasing Aboriginal and Torres Strait Islander participation in medicine and specialist training can strengthen workforce capacity, improve cultural safety and support better engagement with communities experiencing the greatest barriers to specialist care.

These barriers are particularly significant in regional, rural and remote Australia, where Aboriginal and Torres Strait Islander peoples bear a higher burden of disease while often facing limited specialist availability, long travel distances and significant financial and logistical barriers to care. Delays in accessing specialist services can contribute to poorer health outcomes and widening health inequities.

Consistent with the National Agreement on Closing the Gap, improving access requires Aboriginal and Torres Strait Islander-led solutions, stronger partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs), and greater Aboriginal and Torres Strait Islander leadership in workforce planning, service design and governance. Investment in culturally safe outreach, telehealth and multidisciplinary models of care will be critical to improving access.

Recommendations to the Committee:

- Grow the Aboriginal and Torres Strait Islander physician workforce through strengthened education, training and leadership pathways.
- Support culturally safe training, workplaces and specialist services.
- Strengthen partnerships between specialist services and ACCHOs.
- Expand culturally safe outreach, telehealth and multidisciplinary specialist services.
- Improve travel, accommodation and navigation support to reduce access barriers.
- Ensure specialist workforce and access reforms are co-designed with Aboriginal and Torres Strait Islander communities and organisations.
- Increase Aboriginal and Torres Strait Islander leadership in specialist workforce planning and service design.

Workforce maldistribution is a major driver of inequitable access

The distribution of specialists remains one of the most significant barriers to equitable access.

Approximately one-quarter of Australians live outside major metropolitan centres. People living in rural, regional and remote Australia experience poorer access to health services and poorer health outcomes than people living in major cities.[3]

Regional, rural and remote communities experience lower specialist availability and fewer local service options than metropolitan centres. This maldistribution is reflected in the physician workforce itself. RACP workforce data indicate that approximately 91% of physician trainees undertake their training in metropolitan settings, while only around 11% of physician members (trainees and Fellows) reside in non-metropolitan locations. This imbalance contributes to reduced specialist service availability and ongoing workforce shortages outside major cities. In many areas, access depends upon visiting healthcare services, outreach clinics or telehealth consultations.

Workforce maldistribution is driven by multiple factors including:

- Concentration of training opportunities in metropolitan centres
- Limited specialist positions outside major hospitals
- Professional isolation
- Workforce sustainability concerns
- Infrastructure limitations
- Predominantly metropolitan-based training pathways and career opportunities
- Challenges accessing multidisciplinary teams and support services.

The result is that patients frequently experience longer waiting times, greater travel requirements and higher out-of-pocket costs. In some communities, patients may delay seeking care, travel long distances to access specialist services or rely on general practitioners to manage conditions that would otherwise benefit from specialist review. Reduced access can contribute to delayed diagnosis, missed opportunities for prevention and early intervention, and avoidable hospital admissions.

National workforce mapping continues to demonstrate significant disparities in health workforce availability between metropolitan and non-metropolitan communities.[4] National workforce data continue to demonstrate significant disparities in workforce availability. For example, very remote areas have substantially fewer medical practitioners per capita than major cities, highlighting the ongoing challenges associated with attracting and retaining medical specialists outside metropolitan centres. In 2024, very remote areas had 2.7 full-time equivalent medical practitioners per 1,000 population compared with 4.8 per 1,000 in major cities.[5]

Importantly, access challenges are no longer confined to rural communities. Many outer metropolitan growth corridors face significant shortages of specialist services despite being located within major cities. For example, outer-growth corridors around Sydney, Melbourne, Brisbane, Perth and Adelaide have sustained above-average growth for more than a decade. Population growth in these areas has often outpaced growth in health infrastructure and specialist service capacity. Consequently, when outer suburban residents must use inner city emergency departments, the results are overcrowding and longer waiting times, especially for lower acuity but urgent presentations. Where there are catchment restrictions, patients from outer metropolitan areas may experience significantly longer waiting times, delayed diagnosis, delayed treatment, poorer continuity of care, reduced specialist choice (or geographic inequity).

[3] Rural health workforce | Australian Government Department of Health, Disability and Ageing
[4] Rural Health Workforce Mapping Tool – National Rural Health Alliance
[5] Rural and remote health - Australian Institute of Health and Welfare

Training and employment pathways continue to influence future workforce distribution. Opportunities to undertake training and establish long-term specialist careers remain concentrated in metropolitan centres, reinforcing workforce shortages in regional communities.

Addressing workforce maldistribution requires more than recruitment. Long-term solutions must support recruitment, training, employment and retention through sustainable career pathways, supervision, professional support and community integration.

A national approach to workforce distribution should address both rural and outer-metropolitan workforce needs. For an overview of physician workforce shortages in regional, rural and remote Australia along with suggestions to improve access, see the RACP's Australia's regional, rural and remote healthcare crisis (September 2026).

Recommendations to the Committee:

- Strengthen policies that support equitable distribution of the specialist workforce.
- Expand specialist training and consultant physician positions in underserved communities.
- Invest in rural, regional and outer-metropolitan specialist workforce pathways.
- Ensure forward planning for the range of health services needed for high growth outer metropolitan areas takes account of specialist services and the need for continuity of care.
- Support recruitment and retention through targeted incentives and professional support.
- Improve access to multidisciplinary, outreach and digitally enabled models of care.
- Prioritise workforce and service investment in communities experiencing the greatest access gaps.

The role of the Specialist Training Program

The Specialist Training Program (STP) is the Australian Government's primary mechanism for supporting specialist training outside metropolitan hospitals and plays a critical role in building the future regional, rural and remote specialist workforce.

While the program has expanded training opportunities in non-metropolitan settings, challenges remain. These include funding constraints, workforce shortages in training locations, difficulties attracting and retaining supervisors, and barriers such as housing, travel and relocation costs. Reform of the STP represents an important opportunity to strengthen specialist workforce distribution and improve access to care in underserved communities.

The RACP supports a more flexible and sustainable approach to specialist training that strengthens regional training networks, aligns training positions with community need and supports innovation in rural and non-traditional training settings. Programs such as the Flexible Approach to Training in Expanded Settings (FATES) demonstrate the value of linking specialist training, workforce planning and long-term regional employment opportunities.

Recommendations to the Committee:

- Strengthen the Specialist Training Program to support sustainable specialist training in regional, rural and remote communities.
- Align specialist training positions with areas of greatest workforce need and unmet demand.
- Increase support for trainees and supervisors, including measures that address practical barriers to rural training and practice.
- Expand innovative and flexible training models that support regional workforce development.
- Strengthen regional training networks and pathways that encourage long-term specialist practise outside metropolitan centres.

- Support Aboriginal and Torres Strait Islander specialist training pathways, including training delivered in partnership with ACCHOs.

Public specialist service capacity is a critical constraint

Throughout the consultation process, our RACP members consistently identified inadequate public specialist service capacity as a major contributor to delayed access. Long waiting times frequently reflect insufficient outpatient capacity rather than an absolute shortage of specialist expertise.

Concerns regarding specialist waiting times and delayed access have been identified by both the Australian Bureau of Statistics and the Inquiry. For many physician specialties, access challenges reflect insufficient public service capacity rather than a lack of specialist expertise. RACP members report a willingness to provide additional public specialist services, including in regional and rural outpatient settings, where funding and service capacity permit. Limited public outpatient capacity can leave patients facing lengthy waiting times despite the availability of appropriately qualified specialists. For patients with complex and chronic conditions, public specialist services often provide access to multidisciplinary care, interpreter support and hospital-based services that may not be readily available in private practice. Australians reporting specialist wait times longer than they considered acceptable have increased over the past decade.[6]

Many specialists are willing and able to provide services but work within systems where:

- Clinic capacity is limited
- Outpatient infrastructure is insufficient
- Administrative resources are constrained
- Multidisciplinary support is unavailable
- Funded specialist positions do not match demand.

As a result, increasing specialist workforce numbers alone will not necessarily improve patient access unless public specialist service capacity also expands. This issue is particularly evident in public outpatient services where patients may wait extended periods for initial assessment and follow-up care.

Delayed outpatient access contributes to disease progression, avoidable emergency presentations, increased hospital admissions, poorer long-term outcomes and increasing costs to the health system. Inadequate specialist capacity can also create system-wide inefficiencies. Long waits for specialist review and subacute services may contribute to delayed discharge, prolonged hospital stays and avoidable use of acute hospital resources. Strengthening outpatient and specialist service capacity should therefore be viewed as both an access reform and a health system efficiency measure. **Investment in specialist outpatient services should be recognised as a central access reform.**

Recommendations to the Committee:

- Expand public specialist outpatient capacity to reduce waiting times and improve timely access to care.
- Increase funded consultant specialist physician positions within public health services.
- Invest in multidisciplinary, community-based and ambulatory specialist care models.
- Ensure public specialist service capacity keeps pace with population need and service demand.
- Establish nationally consistent reporting of outpatient waiting times, unmet demand and service capacity.
- Target investment to specialties and communities experiencing the greatest access barriers.

[6] Access to health services | Australian Bureau of Statistics

- Increase public specialist service capacity in specialties experiencing persistent workforce underutilisation and long waiting times.

Aboriginal and Torres Strait Islander peoples face persistent barriers to specialist access

Aboriginal and Torres Strait Islander peoples continue to experience poorer health outcomes and higher rates of chronic disease, while often facing greater barriers to accessing specialist care.[7] Access barriers may include:

- Geographic isolation
- Affordability challenges
- Transport difficulties
- Fragmented referral pathways
- Limited local specialist availability
- Experiences of racism within healthcare settings
- Lack of culturally safe services.

Consistent with the National Agreement on Closing the Gap and the National Aboriginal and Torres Strait Islander Health Plan 2021-2031, improving access requires solutions developed in partnership with Aboriginal and Torres Strait Islander communities and organisations. Community-controlled services, shared decision-making and culturally safe mainstream services are recognised as key reform priorities. The RACP strongly supports models that:

- Strengthen partnerships with ACCHOs
- Support culturally safe specialist services
- Increase Aboriginal and Torres Strait Islander health workforce participation
- Improve care coordination
- Support continuity of care across primary, community and specialist settings.

Community-led approaches are essential to ensuring specialist services are responsive to local priorities and needs. A stronger Aboriginal and Torres Strait Islander health workforce can improve cultural safety, strengthen engagement with healthcare services and support more responsive and accessible specialist care.

Improved data collection, reporting and monitoring are also needed to identify service gaps, monitor progress and support accountability for Closing the Gap priorities relating to specialist healthcare access.

Recommendations to the Committee:

- Support Aboriginal and Torres Strait Islander-led and community-controlled approaches to specialist care.
- Strengthen partnerships between specialist services and ACCHOs.
- Expand culturally safe specialist outreach and telehealth services.
- Grow the Aboriginal and Torres Strait Islander health workforce.
- Improve care coordination and patient navigation.
- Embed cultural safety and anti-racism across specialist services.
- Monitor specialist access outcomes for Aboriginal and Torres Strait Islander peoples.

Children and young people experience unique specialist access challenges

Timely specialist care is particularly important for children and young people, where early diagnosis and intervention can have lifelong impacts. Delays in access may affect developmental outcomes, educational participation, mental health, family functioning and long-

[7] First Nations people and the health system - Australian Institute of Health and Welfare

term health trajectories. Health service design should reflect the distinct developmental, educational and family-centred needs of children and young people.

Many paediatric specialties report growing demand alongside increasing complexity of presentations. Families may face challenges navigating fragmented systems across health, disability, education and social services. Families often spend considerable time navigating referral pathways and coordinating services across multiple sectors, highlighting the need for improved care coordination and patient navigation support.

These challenges are particularly evident in developmental paediatrics, adolescent health and services supporting children with complex developmental and behavioural conditions. Long waiting times for developmental paediatric and adolescent health services can delay access to diagnosis, treatment and supports during critical periods of development.

In rural and regional areas, access to paediatric specialists may require significant travel or extended waiting periods. Improving paediatric specialist access should be recognised as an investment in long-term population health.

Recommendations to the Committee:

- Expand paediatric specialist capacity and reduce waiting times.
- Prioritise early access to care for children with developmental, behavioural and complex health needs.
- Strengthen paediatric outreach, telehealth and multidisciplinary models of care.
- Improve coordination across health, disability, education and community services.
- Enhance care navigation and support for children and families with complex needs.
- Expand developmental paediatric health services.
- Expand adolescent health services, supporting the availability of complex adolescent healthcare services as distinct from paediatric healthcare.
- Promote equitable access to specialist care for all children and young people.

Workforce Sustainability, Wellbeing and Retention

Sustainable specialist workforce capacity depends not only on recruitment and training, but also on retaining experienced physicians within the health system. While workforce planning often focuses on increasing medical school places and specialist training positions, improving access to specialist care also requires addressing the factors that influence workforce retention and sustainability.

Australia's specialist physician workforce is under increasing pressure from growing patient demand, workforce shortages, rising patient complexity and expanding administrative requirements. Many specialist physicians spend significant time on documentation, compliance, accreditation, reporting obligations and navigating complex funding and referral systems. These activities reduce time available for direct patient care and contribute to workforce dissatisfaction.

Workforce sustainability is influenced by more than workload alone. Physicians report increasing pressure associated with governance and compliance requirements, clinic waiting-list management, documentation obligations, supervision responsibilities and maintaining clinical competence within an evolving healthcare environment. Limited administrative support can reduce time available for direct patient care and contribute to burnout and workforce dissatisfaction.

Increasing workloads, expanding outpatient waiting lists and system capacity constraints can also contribute to burnout and moral distress. Physicians may face situations where they are unable to provide patients with timely access to care because of workforce shortages, insufficient service capacity or long waiting times for specialist and diagnostic services. These pressures can affect professional wellbeing and job satisfaction.

The consequences are increasingly evident across the health system. Some specialists reduce their clinical hours, transition away from public practice, take early retirement, or leave particular areas of practice altogether. In rural and regional communities, the departure of a single specialist can significantly affect local service availability and patient access. The loss of experienced specialists reduces system capacity, places additional pressure on remaining clinicians and further exacerbates access challenges.

Recruitment and retention challenges may be particularly acute in rural and regional communities, where housing availability, childcare, partner employment opportunities, professional isolation and relocation costs can affect workforce sustainability. Supporting long-term specialist careers requires attention to both workplace and community factors.

Workforce sustainability should therefore be recognised as both a workforce issue and an access issue. A specialist workforce that is supported, retained and able to work to its full scope of practice is essential to ensuring timely, equitable and affordable access to specialist care.

Retaining experienced specialists is as important as training new ones. Addressing burnout, moral distress, excessive administrative burden and workforce attrition will strengthen specialist workforce capacity and improve access to care for patients across Australia.

Recommendations to the Committee:

- Recognise workforce sustainability and retention as core specialist access issues.
- Reduce unnecessary administrative burden on specialist physicians.
- Invest in workforce and service capacity to address growing demand and workload pressures.
- Support sustainable specialist career pathways through flexible employment models, professional development opportunities and adequate administrative support.
- Strengthen workforce wellbeing and professional support.
- Improve retention in rural, regional and underserved communities.
- Address practical barriers to rural and regional specialist retention, including housing, relocation and professional support.
- Incorporate workforce sustainability measures into national workforce planning and monitoring.

Public specialist consultant capacity: a critical workforce bottleneck

While increasing medical school places and specialist training positions is important, workforce growth alone will not improve access to specialist care unless there are sufficient funded consultant positions within the public health system. Australia faces a growing mismatch between the number of qualified specialists and the availability of permanent public hospital specialist roles, particularly in outpatient and community-based services.

Many specialist physicians complete advanced training only to encounter limited opportunities for ongoing employment in public hospitals. As a result, specialists are often compelled to move into private practice, despite significant and growing demand for public specialist services. This contributes to lengthy outpatient waiting lists, reduced access for patients who cannot afford private care, and increasing inequity across the health system.

RACP members report that funding constraints have limited the growth of consultant specialist positions in some hospital-based specialties despite increasing patient demand. As a result, some early-career specialists experience underemployment or are unable to secure ongoing public hospital positions, particularly in specialties that rely heavily on public hospital infrastructure and multidisciplinary services.

The challenge is therefore not simply one of training more specialists; it is ensuring that health services have the capacity and funding to employ them. Without sufficient investment in

consultant physician positions, Australia risks underutilising its specialist workforce while public demand for specialist care continues to rise.

The distribution of the specialist workforce is also influenced by employment opportunities. While most specialist training occurs within the public health system, a substantial proportion of specialists ultimately move into private practice. Expanding consultant physician positions within public hospitals would increase patient access while strengthening supervision, training and workforce sustainability.

Expanding public specialist capacity would deliver multiple benefits, including:

- Reducing outpatient waiting times and improving timely access to care
- Increasing access for people experiencing financial disadvantage and those living in rural, regional and outer metropolitan communities
- Supporting multidisciplinary and team-based models of care
- Improving supervision and training capacity for future specialist physicians
- Strengthening workforce retention by providing sustainable and attractive career pathways within the public health system.

Workforce shortages and access challenges cannot be addressed solely by increasing the pipeline of medical graduates and trainees. Governments must also invest in funded consultant specialist positions and public outpatient services to ensure that specialist expertise is available where patients need it most.

Recommendations to the Committee:

- Increase funded consultant specialist physician positions in the public health system.
- Expand public outpatient capacity to reduce waiting times and improve access to care.
- Align workforce planning and consultant workforce growth with projected service demand.
- Support sustainable public-sector specialist career pathways.
- Expand permanent consultant specialist physician positions in specialties experiencing persistent public-sector workforce shortages and long waiting times.
- Ensure workforce planning addresses transition points between specialist training and consultant employment.
- Improve national reporting on consultant workforce capacity, vacancies and unmet demand.

Nationally Consistent Measurement and Reporting of Specialist Access

A significant barrier to improving access to specialist care is the absence of nationally consistent data on outpatient demand, waiting times and access to specialist services. While Australia routinely reports on emergency department performance and elective surgery waiting times, there is no equivalent national framework for measuring and reporting access to specialist outpatient care.

As a result, policymakers, health services and the public have limited visibility of the scale and distribution of unmet need. Existing data collection and reporting arrangements vary significantly between jurisdictions, specialties and health services, making it difficult to accurately assess demand, benchmark performance, identify service gaps or evaluate the effectiveness of policy interventions.

In many parts of Australia, patients may wait months or years to see a specialist physician, yet these delays are often not systematically measured or publicly reported. Similarly, there is limited national data on the time between a referral being made and a patient receiving a specialist appointment, despite this being one of the most important indicators of access to care.

Although concerns regarding specialist waiting times are widely reported, Australia currently lacks nationally consistent reporting of specialist access across both public and private sectors. As a result, the scale of unmet demand and variation between specialties, locations and patient populations is not fully understood.

The absence of consistent reporting can obscure unmet demand and make it difficult to direct investment to where it is most needed. Patients who remain on waiting lists for extended periods, whose referrals are not accepted, or who disengage from care because waiting times are excessive may not be visible within existing datasets. This creates a significant gap in understanding the true scale of access challenges across the health system.

Improving access to specialist care requires a stronger evidence base. Nationally consistent monitoring and reporting would enable governments to identify emerging pressures, target resources more effectively, evaluate reform initiatives and improve accountability for specialist access outcomes.

Australia cannot effectively address specialist access challenges if it does not consistently measure them. A robust national approach to monitoring specialist access is essential to identifying unmet demand, improving transparency, guiding investment and ensuring Australians receive timely specialist care regardless of where they live.

Recommendations to the Committee:

- Establish a national framework for measuring and reporting specialist access.
- Collect and publish nationally consistent data on referral-to-specialist waiting times and unmet demand.
- Use specialist access data to guide workforce, service and infrastructure investment.
- Introduce nationally consistent outpatient access benchmarks and waiting-time targets.
- Report specialist access outcomes across public and private sectors where feasible.
- Strengthen transparency and accountability for specialist access outcomes.

Summary

Current access challenges are best understood as the result of interconnected workforce, infrastructure and system-design issues. While workforce growth remains important, increasing specialist numbers alone will not resolve current access barriers. Improving access requires coordinated action to:

- Strengthen workforce distribution
- Expand public specialist service capacity
- Improve access for Aboriginal and Torres Strait Islander peoples
- Support children and young people
- Strengthen workforce sustainability
- Ensure specialist services are available where population need is greatest.

The Committee should recommend the establishment of a nationally consistent specialist access reporting framework, recognising that what is not measured cannot be effectively managed. Greater transparency regarding referral-to-specialist waiting times, outpatient demand and unmet need is essential to informing workforce planning, targeting investment and improving equitable access to specialist care across Australia.

A coordinated national approach across these domains will provide the strongest foundation for improving equitable and timely access to specialist care.

Refer to Appendix 2 for examples of some specialty specific barriers to access.

Terms of Reference B: Referral Pathways and System Navigation

Effective referral pathways are critical to timely specialist access

Referral pathways are a fundamental component of Australia's health system. They determine how patients move between primary care, specialist services, hospitals and other healthcare providers, and play a significant role in determining the timeliness, equity and quality of care. The Inquiry Terms of Reference specifically identify referral pathway effectiveness, transparency and equity as key determinants of access to specialist care.

While referral requirements serve important clinical and governance functions, many current arrangements create unnecessary administrative burden, duplication and delays for patients and clinicians. The RACP considers that referral processes should facilitate access to care rather than become barriers to care. Improving referral systems requires action across referral design, digital infrastructure, care coordination and communication between healthcare providers.

To assist the Committee, a detailed description of the confounding issues relating to referrals both for patients and specialists is offered in the 2026 RACP submission Modernising referral pathways. It proposes realistic reforms to address these issues developed from physician input.

Patients frequently experience fragmented referral pathways

Patients often report difficulty understanding and navigating referral pathways, particularly when specialist services are delivered across multiple providers and sectors. Challenges may include:

- Uncertainty regarding referral requirements
- Limited visibility of waiting times
- Lack of information about alternative service options
- Repeated referrals due to referral expiry requirements
- Delays associated with incomplete referrals
- Difficulties coordinating care across public and private services.

These barriers can disproportionately affect people with disability, Aboriginal and Torres Strait Islander peoples, older people, migrants, refugees and people seeking asylum, culturally and linguistically diverse communities and people living in rural and remote areas.

For many patients, navigating referral systems requires considerable health literacy, administrative capacity and confidence interacting with healthcare systems. Patients with complex needs are often required to navigate multiple services simultaneously, increasing the risk of delayed or fragmented care.

Referrers often have limited visibility of specialist availability, expected waiting times and alternative service options. Improving transparency would support more informed referral decisions and help patients access the earliest appropriate care.

Recommendations to the Committee:

- Improve transparency and consistency of specialist referral pathways.
- Strengthen patient navigation and care coordination for people with complex needs.
- Simplify referral and triage processes across specialist services.
- Expand digital referral systems and referral tracking capabilities.
- Improve coordination across primary, community, hospital and specialist care.
- Ensure referral pathways are accessible, culturally safe and responsive to diverse patient needs.
- Improve visibility of specialist service availability and waiting times.

Electronic referral systems can improve access and efficiency

Referral processes remain highly variable across jurisdictions, healthcare services and specialties. The continued use of paper-based, (fax-based still in some services) and non-integrated referral systems creates inefficiencies for providers and patients. Fragmented referral systems can also limit information sharing between providers, reduce visibility of referral progress and create unnecessary administrative burden for patients and clinicians.

Modern electronic referral (eReferral) systems have the potential to:

- Improve referral quality
- Reduce administrative burden
- Increase transparency regarding waiting times
- Support more consistent triage
- Facilitate communication between providers
- Improve referral tracking and accountability.

Effective referral systems should enable both referring clinicians and patients to understand whether a referral has been received, where a patient is on a waiting list, whether further information is required and expected timeframes for assessment. Improved visibility can reduce uncertainty and improve patient experience while supporting more efficient management of specialist waiting lists. Nationally consistent and interoperable referral systems would also support better service planning, performance monitoring and equitable access to specialist care across jurisdictions and care settings.

Emerging technologies, including artificial intelligence, may support referral quality by identifying incomplete referrals, assisting with triage processes and directing referrals to the most appropriate service based on clinical need and availability.

Recommendations to the Committee:

- Invest in nationally consistent and interoperable eReferral systems.
- Enable referral tracking and waiting-list visibility for patients and referrers.
- Establish national standards for electronic referral and triage processes.
- Improve interoperability across primary care, hospital and specialist services.
- Reduce administrative burden through streamlined digital referral pathways.
- Use referral and waiting-time data to support service planning and accountability.
- Explore the role of emerging digital technologies in improving referral triage, quality and system efficiency.
- Ensure equitable access to eReferral systems across all communities and care settings.

Referral quality and appropriateness should be strengthened

Improving access is not simply about increasing referral volumes. Referral systems should support patients to access the right care, at the right time, in the right setting. Many referrals can be improved through:

- Clearer referral criteria
- Better communication between primary care and specialists
- Access to specialist advice before referral
- Shared clinical decision-making
- Access to evidence-based referral tools.

Review patients often remain in specialist outpatient clinics longer than clinically necessary because of limited discharge pathways and insufficient shared-care arrangements. This can reduce capacity for new referrals and contribute to longer waiting times for initial specialist assessment.

Consistent referral expectations and referral standards can help reduce variation in referral quality, support more effective triage and improve timely access to specialist care. Specialists

and general practitioners frequently identify opportunities to improve referral completeness and appropriateness through earlier consultation and collaborative care arrangements. Referral reform should seek to improve both efficiency and quality.

Recommendations to the Committee:

- Strengthen referral quality through clearer referral pathways, guidance and clinical decision-support tools.
- Support nationally consistent referral standards where clinically appropriate.
- Expand access to specialist advice prior to referral.
- Promote collaborative models of care between primary care and specialist services.
- Improve referral completeness, appropriateness and timeliness of access to specialist care.

Specialist advice services can reduce unnecessary delays

Under current arrangements, general practitioners often have only two practical options: manage a patient independently or make a formal referral. The absence of accessible and funded mechanisms for obtaining timely specialist advice can contribute to unnecessary referrals, inefficient use of specialist appointments and longer waiting times for patients requiring comprehensive specialist assessment.

Not all patients require a formal specialist consultation. In many circumstances, access to timely specialist advice can support management within primary care while reducing unnecessary referrals and improving patient outcomes. Emerging models such as electronic specialist advice services (eConsults), advice lines and virtual case discussions can:

- Support general practitioners managing complex cases
- Facilitate rapid access to specialist expertise
- Reduce unnecessary waitlist growth
- Improve continuity of care
- Enable patients to receive care closer to home.

These models are particularly valuable in regional, rural and remote communities where specialist services may be less readily available. They can also improve access for patients experiencing mobility, transport or affordability challenges. To maximise their impact, specialist advice services should be supported by sustainable funding, integration within referral pathways and strong collaboration between primary care and specialist services.

Recommendations to the Committee:

- Expand access to specialist advice services, including eConsults and virtual care models.
- Support sustainable funding for non-face-to-face specialist advice and care.
- Strengthen collaborative care between primary care and specialist services.
- Embed specialist advice services within referral pathways to improve timely access to care.
- Scale successful specialist advice models in rural, regional and other underserved communities.

Referral validity requirements should be reviewed

Current referral validity requirements can create unnecessary administrative burden for patients, general practitioners and specialists. Patients with long-term or chronic conditions may require ongoing access to specialist care over many years. In these circumstances, repeated requirements to obtain renewed referrals can:

- Delay care
- Increase costs
- Create unnecessary administrative burden
- Add pressure to primary care services.

Where clinically appropriate, more flexible referral arrangements could improve continuity of care while maintaining appropriate clinical oversight. Similarly, specialist-to-specialist referrals support more efficient access in circumstances where patients require multidisciplinary specialist management.

In some cases, administrative referral requirements can become a barrier to timely access to care without improving clinical quality, particularly for patients with stable chronic conditions requiring ongoing specialist management. Any reforms should balance patient access, continuity of care and accountability within the healthcare system.

Current specialist-to-specialist referral validity requirements are often poorly aligned with contemporary multidisciplinary care, where patients may require ongoing management across multiple specialties over extended periods of time.

Recommendations to the Committee:

- Review referral validity requirements for people with chronic, complex and lifelong health conditions.
- Reduce unnecessary referral renewal requirements where ongoing specialist care is clinically indicated.
- Support more flexible referral arrangements that promote continuity of care while maintaining appropriate clinical oversight.
- Strengthen specialist-to-specialist referral pathways to facilitate multidisciplinary care and timely access to specialist services.
- Ensure referral policies minimise administrative burden and support patient-centred access to care.

Digital interoperability remains a significant barrier

Fragmented digital systems continue to impede communication across the healthcare system. Many clinicians are required to work across multiple software platforms that do not communicate effectively with one another. Poor interoperability contributes to:

- Duplicated testing
- Fragmented care
- Inefficient referral processing
- Communication failures
- Increased administrative burden.

Improved interoperability would support more efficient referral pathways and improve continuity of care. Greater interoperability would also reduce administrative burden, improve clinical decision-making and enable patients and clinicians to access the information they need at the point of care. Future reforms should seek to better integrate general practice systems, specialist practice systems, hospital systems, electronic referral systems and the national digital health infrastructure.

The My Health Record platform and other digital health initiatives provide opportunities to improve information sharing and continuity of care, provided they are supported by high-quality clinical workflows and widespread adoption.

Recommendations to the Committee:

- Establish interoperability as a core objective of digital health reform.
- Accelerate integration across general practice, specialist, hospital and referral systems.
- Improve secure information sharing to support continuity of care.
- Reduce duplication of clinical information, testing and administrative processes.
- Invest in interoperable digital infrastructure and standards.
- Promote adoption of connected digital systems across public and private healthcare settings.

Referral reform should support equity

Referral systems should be designed to improve access for all Australians, particularly those who currently experience the greatest barriers. Referral pathways that rely heavily on patient self-navigation may disadvantage individuals with lower health literacy, language barriers, cognitive impairment, disability-related support needs or limited resources to navigate complex systems.

Improving referral access requires more than technological solutions. Referral reforms should incorporate interpreter services, culturally safe navigation support, disability-inclusive processes, care coordination services and community-based support mechanisms.

These reforms are particularly important for Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, refugees, people seeking asylum and people living in regional and remote Australia.

Aboriginal and Torres Strait Islander leadership and involvement in referral pathway design can strengthen cultural safety, improve care coordination and support patient engagement throughout the referral process.

Without appropriate supports, referral systems can inadvertently widen existing healthcare inequities by placing greater responsibility on patients who already face barriers accessing and navigating care.

Recommendations to the Committee:

- Ensure equity is a core principle of referral system design and reform.
- Improve access to interpreter services, patient navigation and care coordination.
- Strengthen culturally safe, community-responsive referral pathways.
- Embed disability-inclusive and accessible referral processes.
- Target reforms to populations experiencing the greatest barriers to specialist care.
- Monitor referral access and outcomes across priority populations.

Summary

Referral pathways play a critical role in determining access to specialist care. Current systems are often fragmented, administratively burdensome and insufficiently transparent for patients and healthcare providers. Improving referral pathways requires coordinated reform across:

- eReferral infrastructure
- Specialist advice services
- Referral validity arrangements
- Digital interoperability
- Care coordination
- Equity-focused system design.

A modern, connected and patient-centred referral system would improve timeliness, reduce unnecessary delays and support more equitable access to specialist care across Australia.

Refer to Appendix 3 for examples of some specialty specific referral issues.

Terms of Reference C: Affordability of Specialist Services

Affordability is a growing barrier to accessing specialist care

Affordable access to specialist care is an essential component of an equitable health system. However, increasing out-of-pocket costs, growing demand for services, and constraints in public specialist capacity are making specialist care less accessible for many Australians.

The affordability of specialist care cannot be viewed solely through the lens of consultation fees. Patients frequently incur additional costs associated with diagnostic testing, procedures, medications, travel, accommodation, lost income and ongoing care requirements. The cumulative impact of these costs can create substantial barriers to accessing care, particularly for people with chronic and complex health conditions.

Affordability pressures are increasing. The proportion of Australians reporting that they delayed or did not see a medical specialist because of cost has increased over the past decade, while the proportion reporting waiting longer than they considered acceptable for a specialist appointment has also risen.[8]

Australia relies on a mixed public and private system of specialist care. However, for many physician specialties, patients with complex and chronic conditions are most appropriately managed within public specialist services because they require multidisciplinary care, longer consultations, interpreter support and access to hospital-based treatments and medicines. When public specialist capacity is inadequate, patients may have limited alternatives and can remain on lengthy waiting lists despite significant clinical need.

The RACP considers that affordability challenges are driven by three interconnected factors:

1. Increasing out-of-pocket costs
2. Insufficient public specialist service capacity
3. Growing pressure on both public and private models of care.

Out-of-pocket costs are affecting access to care

Many patients face substantial costs when seeking specialist assessment and treatment. These costs may include:

- Consultation fees
- Procedural fees
- Diagnostic investigations
- Pathology and imaging
- Pharmaceuticals
- Travel and accommodation expenses
- Parking and transport costs
- Lost income associated with attending appointments.

For patients with chronic disease, disability, rare disorders, cancer, neurological conditions and complex paediatric conditions, these costs may be incurred repeatedly over many years. Financial barriers may lead patients to defer recommended care, delay investigations, miss follow-up appointments, decline treatment or forgo specialist review altogether.

Delayed access may ultimately result in worsening health outcomes and increased demand on emergency departments, hospitals and primary care services. Cost remains a significant barrier to accessing medical specialist services.

[8] Access to health services | Australian Bureau of Statistics

Affordability barriers extend beyond specialist consultation fees and may accumulate across the patient journey, particularly for people with chronic and complex conditions who require ongoing investigations, treatment and follow-up care. Affordability barriers are also not limited to specialist consultations. Diagnostic imaging, pathology, specialist medicines and other investigations can generate substantial out-of-pocket costs and may ultimately determine whether a patient can proceed with recommended care.

Recommendations to the Committee:

- Improve affordability of specialist care across the patient journey.
- Reduce financial barriers to clinically necessary specialist care.
- Improve transparency of specialist costs and out-of-pocket expenses.
- Monitor specialist affordability and cost-related barriers to care nationally.
- Prioritise affordability reforms for people with chronic and complex health needs and those living in rural and remote communities.
- Address affordability barriers associated with specialist investigations, diagnostics and related services.
- Consider affordability impacts in the design of specialist access and workforce reforms.

Public specialist service capacity is a critical affordability issue

Affordability is often framed as a question of private consultation fees. However, for many Australians, the affordability of specialist care is fundamentally linked to the availability of timely public specialist services.

When public waiting times are prolonged, patients are often left with three options: pay for private specialist care, wait months or years for a public appointment, or go without care altogether. For those living with chronic illness, developmental conditions, neurological disorders and other complex health needs, each of these options can have significant health and financial consequences.

Many RACP members report that long outpatient waiting times increasingly influence patients' decisions to seek private care despite experiencing significant financial hardship. As a result, inadequate public specialist capacity can shift the cost of accessing care from the health system onto patients and families.

Improving affordability therefore requires investment in public specialist capacity alongside measures to reduce out-of-pocket costs. Increasing specialist workforce numbers alone will not improve affordability if public outpatient services remain unable to meet demand.

Public specialist service capacity should be recognised as both an access issue and an affordability issue. When public capacity cannot meet demand, the financial burden of accessing care is increasingly transferred from the health system to patients and families.

Recommendations to the Committee:

- Expand public specialist outpatient capacity to improve timely access to care and reduce affordability barriers.
- Increase investment in ambulatory, community-based and multidisciplinary specialist services.
- Reduce public outpatient waiting times for patients with chronic, complex and ongoing care needs.
- Improve transparency of public specialist waiting times, service availability and unmet demand.

- Strengthen access to public specialist services for patients experiencing financial disadvantage and other barriers to care.
- Ensure investment in public specialist services is a core component of specialist affordability reform.

Medicare funding arrangements should support contemporary specialist care

Medicare support for specialist consultations outside hospital settings is substantially lower than government support provided for many other parts of the health system. This places greater reliance on patient contributions and increases financial barriers to accessing specialist care.

Physician specialties are particularly affected by Medicare funding settings because their practice is largely consultation-based rather than procedure-based. Unlike procedural specialties, physician income is predominantly derived from consultation items. As patient complexity increases and consultations become longer and more resource-intensive, inadequate consultation rebates can have a disproportionate impact on the sustainability of physician services and the affordability of care.

Specialist practice has changed substantially over recent decades. Patients are living longer with increasingly complex conditions and often require multidisciplinary management involving multiple healthcare professionals across numerous care settings. At the same time, specialists undertake a significant volume of work outside direct patient consultations, including:

- Care coordination
- Multidisciplinary case discussions
- Communication with GPs and other providers
- Review of investigations
- Clinical documentation
- Supervision and teaching activities
- Quality and safety activities.

Many of these activities are critical to effective patient care but may not be adequately recognised within existing funding arrangements. Specialist physicians routinely undertake activities such as reviewing investigations and clinical records, providing advice to general practitioners and other health professionals, participating in multidisciplinary team meetings, coordinating care across multiple providers, and communicating with schools, disability services, aged care providers and other support services. These activities are often essential to ensuring safe, coordinated and effective patient care, particularly for people with complex, chronic or developmental conditions, yet they may occur outside traditional face-to-face consultations.

The value of specialist consultation rebates has also not consistently kept pace with the costs of delivering specialist care, including workforce costs, practice overheads and increasing clinical complexity. Appropriate and predictable indexation of specialist consultation items is important to maintaining affordable access to care and supporting the long-term sustainability of specialist practice. Medicare funding arrangements should ensure specialist consultation rebates adequately reflect the complexity and resources required to provide contemporary specialist care.

Sustainable specialist care requires funding arrangements that reflect the complexity of modern clinical practice and support high-quality patient care. Contemporary specialist care increasingly involves multidisciplinary collaboration, care coordination and clinical activities that occur outside traditional face-to-face consultations. Medicare funding arrangements should support these contemporary models of care while maintaining affordability and the sustainability of specialist practice. Refer to Appendix 1 for information on the RACP Paediatric MBS Proposal.

Recommendations to the Committee:

- Review specialist physician funding arrangements to reflect contemporary models of care and patient complexity.
- Support Medicare funding for multidisciplinary, coordinated and patient-centred specialist care.
- Recognise clinically necessary non-face-to-face specialist activities.
- Ensure specialist consultation rebates appropriately reflect the costs and complexity of care.
- Maintain appropriate and predictable indexation of specialist consultation items.
- Support funding models that promote quality, continuity of care and collaboration across healthcare settings.

Informed financial consent supports affordable and transparent care

The RACP supports informed financial consent for patients which should comprise clear, timely and explicit information about potential out-of-pocket costs. Patients should receive clear, timely and accessible information regarding expected costs before receiving specialist care. Effective informed financial consent supports patient choice, reduces unexpected costs and improves transparency throughout the patient journey.

The RACP supports increased transparency of physician fees and has endorsed the AMA's Guide to Informed Financial Consent, including its position that booking fees and split billing practices are not supported where they are inconsistent with ethical billing practices. The RACP's position is further discussed in the 2026 RACP submission to Fee Transparency in Health Care: Examining Informed Financial Consent and Split Billing Practices.

Recommendations to the Committee:

- Strengthen informed financial consent practices across specialist care.
- Improve transparency regarding expected out-of-pocket costs across the full episode of care.
- Support consistent patient information and cost disclosure processes.

A sustainable private specialist sector remains important

Increasing operating costs, workforce shortages and growing administrative requirements are affecting the sustainability of specialist practice in some communities. If specialist services become financially unviable, access may decline further and pressure on public services will increase.

Australia's health system relies on a mixed public and private model of specialist care. Private specialist practice plays a significant role in supporting access, reducing pressure on public services and expanding patient choice. However, private specialist practice is increasingly affected by:

- Rising operating costs
- Workforce shortages
- Increasing administrative requirements
- Infrastructure costs
- Growing complexity of patient care.

An affordable specialist system requires both public and private sectors to remain sustainable. If private specialist services become financially unviable, demand may shift into already constrained public specialist clinics and hospitals, further increasing waiting times and reducing system capacity. Accordingly, **policies intended to improve affordability should seek to strengthen overall system capacity rather than shift pressure between sectors.**

Reforms that improve affordability should be assessed for their impact on both public and private specialist service capacity. Sustainable access to specialist care depends on maintaining a balanced and well-functioning mixed system that supports patient choice while preserving public sector capacity.

Recommendations to the Committee:

- Recognise the complementary roles of public and private specialist services in improving access to care.
- Assess the impact of reforms on the sustainability of both public and private specialist sectors.
- Support funding, workforce and policy settings that maintain specialist service capacity.
- Ensure affordability reforms strengthen overall system capacity rather than shift demand between sectors.
- Monitor the impacts of reforms on access, affordability, workforce sustainability and patient outcomes.

Rural, regional and remote Australians face higher costs

People living in rural, regional and remote Australia often face additional barriers to affordable specialist care. These may include travel costs, accommodation expenses, time away from work, limited availability of local services, reduced public transport options and greater reliance on visiting specialist services.

The Australian Institute of Health and Welfare reports people living outside major cities continue to experience poorer access to health services than people living in metropolitan areas. Financial burdens associated with travel can be particularly significant for families of children requiring specialist care, people with disability and patients requiring frequent appointments. Telehealth, outreach services and hub-and-spoke models can help reduce these costs but are not universally available. Reducing the cost of specialist care for rural, regional and remote communities requires both financial support for patients and investment in sustainable local and outreach specialist services.

In addition to higher costs for patients, specialist practices in rural and remote communities may face higher operating costs, lower patient volumes and workforce shortages. Funding arrangements should recognise the additional challenges associated with delivering specialist services outside metropolitan centres. The Committee can also read further recommendations in our 2026 RACP submission to the Rural, Regional and Remote Medicare Access and Funding Inquiry.

Recommendations to the Committee:

- Reduce the financial burden of accessing specialist care for rural, regional and remote Australians.
- Expand specialist outreach, telehealth and other locally accessible models of care.
- Strengthen patient travel and accommodation support programs.
- Invest in multidisciplinary regional specialist services and hub-and-spoke care models.
- Ensure funding and workforce policies reflect the costs of delivering specialist care outside metropolitan centres.
- Consider targeted funding and incentive arrangements that support sustainable specialist practice in rural and remote communities.
- Promote equitable access to specialist care regardless of where people live.

Aboriginal and Torres Strait Islander peoples experience compounding affordability barriers

Addressing affordability for Aboriginal and Torres Strait Islander peoples requires a holistic approach that combines financial support, culturally safe care, strong community partnerships and improved access to specialist services closer to home.

Aboriginal and Torres Strait Islander peoples often experience multiple interacting barriers to specialist care, including affordability, distance, service availability and cultural safety.

Improving specialist access requires more than reducing financial barriers alone. It also requires culturally safe models of care developed in partnership with Aboriginal and Torres Strait Islander communities and organisations.

Consistent with the National Agreement on Closing the Gap and the National Aboriginal and Torres Strait Islander Health Plan 2021–2031, strengthening community-controlled services and culturally responsive healthcare remains a critical priority. Aboriginal and Torres Strait Islander communities should not face financial barriers to accessing specialist care because of geography, cultural barriers or socioeconomic disadvantage.

Recommendations to the Committee:

- Support Aboriginal and Torres Strait Islander-led and community-controlled approaches to specialist care.
- Strengthen partnerships between specialist services and ACCHOs.
- Reduce financial, geographic and cultural barriers to specialist care.
- Expand culturally safe outreach, telehealth and visiting specialist services.
- Improve care coordination and patient navigation.
- Ensure affordability reforms are developed in partnership with Aboriginal and Torres Strait Islander communities.
- Monitor specialist access and affordability outcomes for Aboriginal and Torres Strait Islander peoples.

People with disability face additional affordability challenges

People with disability often require ongoing specialist care across multiple disciplines. Many patients incur significant cumulative costs associated with:

- Multiple specialist consultations
- Allied health services
- Investigations
- Equipment and assistive technology
- Transport and support services
- Care coordination.

In addition to direct financial costs, patients may face substantial administrative burden navigating multiple systems including healthcare, disability and social support services. Accessibility barriers may further increase the difficulty and cost of accessing specialist care. Specialist access reforms should therefore adopt a disability-inclusive approach that considers affordability, accessibility and continuity of care simultaneously.

Improving affordability for people with disability requires specialist care models that are coordinated, accessible and responsive to the cumulative costs associated with ongoing healthcare and support needs.

Recommendations to the Committee:

- Ensure specialist access reforms adopt a disability-inclusive approach.
- Improve care coordination and navigation across healthcare, disability and support systems.
- Strengthen accessibility of specialist services.
- Support multidisciplinary care for people with complex and ongoing health needs.
- Reduce financial barriers to ongoing specialist care.
- Consider the cumulative healthcare and support costs experienced by people with disability in affordability reforms.

Migrants, refugees, people seeking asylum and culturally and linguistically diverse communities may face additional barriers

Affordability challenges are often compounded by language barriers, unfamiliarity with the health system and difficulties navigating referral pathways. Patients from culturally and linguistically diverse backgrounds may experience difficulties obtaining information about specialist referral pathways, available public services, expected costs and available support programs.

Interpreter services and culturally responsive care models play an important role in improving access and reducing inequities. Affordability initiatives should be accompanied by broader efforts to improve healthcare navigation and communication.

Addressing affordability for culturally and linguistically diverse communities requires more than reducing costs. Patients must also be able to understand, navigate and access specialist services in a way that is culturally appropriate, accessible and responsive to their needs.

Recommendations to the Committee:

- Improve access to interpreters and translated health information.
- Strengthen culturally responsive specialist care.
- Improve healthcare navigation support for culturally and linguistically diverse communities.
- Increase transparency of specialist referral pathways, costs and available support services.
- Ensure specialist access and affordability reforms are responsive to culturally diverse communities.
- Monitor specialist access and affordability outcomes across culturally diverse populations.

Delayed care often increases costs rather than reducing them

Patients may defer specialist care because they cannot afford it. However, delayed care frequently results in more complex health needs, more intensive treatment and higher costs across the health system. Untreated or poorly managed conditions may contribute to avoidable emergency presentations, hospital admissions, disease progression, increased disability, reduced workforce participation and poorer quality of life.

The broader costs of delayed care are not borne solely by individuals. They are also experienced by employers, carers, communities and governments. Improving affordability should be viewed as an investment in population health, workforce participation and health system sustainability.

Improving timely access to specialist care has the potential to reduce avoidable healthcare utilisation, improve health outcomes and support workforce participation, while reducing longer-term costs to patients, communities and the health system.

Recommendations to the Committee:

- Prioritise timely access to specialist assessment, diagnosis and treatment.
- Reduce affordability barriers to clinically necessary specialist care.
- Recognise early access to specialist care as an investment in population health and health system sustainability.
- Consider the broader economic and social costs of delayed care when assessing reforms.
- Support reforms that reduce avoidable disease progression, hospitalisation and lost workforce participation.
- Evaluate the long-term impacts of delayed specialist care on patients, carers and the health system.

Summary

Affordability is one of the most significant barriers to specialist care in Australia. The RACP considers that affordability challenges arise not only from specialist fees but also from limitations in public specialist capacity, gaps in funding arrangements, workforce pressures and the broader costs associated with accessing healthcare.

Improving affordability requires coordinated action to:

- Reduce out-of-pocket costs
- Expand public specialist service capacity
- Strengthen Medicare support for contemporary specialist care
- Support sustainable private specialist services
- Improve access for rural and remote communities
- Address inequities experienced by priority populations
- Prevent the long-term costs associated with delayed care.

Improving affordability is essential to achieving equitable and timely access to specialist care across Australia.

Refer to Appendix 4 for examples of some specialty specific affordability issues.

Terms of Reference D: Impacts of Delays Caused by Cost, Distance and Waiting Times on Patients and the Health System

Delayed access to specialist care has significant consequences

Timely access to specialist care is critical to achieving good health outcomes, preventing disease progression and ensuring efficient use of health system resources. The Inquiry Terms of Reference explicitly recognise that delays associated with cost, distance and waiting times affect patients, families and the broader health system.

While delays may arise from a range of factors, the consequences are often similar. Delayed specialist assessment and treatment can result in:

- Worsening disease severity
- Avoidable complications
- Increased emergency department presentations
- Avoidable hospital admissions
- Greater treatment complexity
- Reduced quality of life
- Higher healthcare expenditure.

The impacts of delayed care extend beyond individual patients and contribute to pressures across primary care, hospitals, public outpatient services and community-based care. The RACP considers that timely access to specialist care should be recognised as a key determinant of both health outcomes and health system performance.

When specialist care is delayed, primary care clinicians may be required to manage conditions beyond the scope of general practice for extended periods while patients await specialist review. This can contribute to worsening health outcomes, increased clinical risk, avoidable presentations to emergency departments and greater pressure on public hospitals.

Delays contribute to poorer health outcomes

For many conditions, timely specialist assessment is critical to early diagnosis, initiation of treatment and prevention of complications. When access to specialist care is delayed diseases may progress further before treatment begins, opportunities for early intervention may be missed, symptoms may worsen, patients may experience avoidable pain or disability, and treatment pathways may become more complex and expensive. The risks associated with delayed care are particularly significant for:

- Chronic disease
- Neurological disorders
- Cancer
- Developmental conditions
- Cardiovascular disease
- Respiratory disease
- Paediatric conditions
- Complex multi-system illnesses.

Specialist care often provides access to diagnostic expertise, multidisciplinary care and treatments that are not readily available within primary care. Delayed access can affect both diagnosis and ongoing management. Improving timely access to specialist care can prevent avoidable disease progression, support earlier intervention and improve long-term health outcomes for patients with both acute and chronic conditions.

Recommendations to the Committee:

- Prioritise timely access to specialist assessment, diagnosis and treatment.
- Reduce clinically inappropriate waiting times for specialist care.

- Improve access for people with chronic, complex and high-risk health conditions.
- Strengthen specialist service capacity to support earlier intervention and ongoing care.
- Target investment towards specialties and populations most affected by delayed access.
- Recognise timely access to specialist care as a key strategy for improving health outcomes and preventing avoidable complications.

Delays increase pressure on the broader health system

The impacts of delayed specialist care are frequently borne elsewhere within the health system. Patients unable to access specialist review may return repeatedly to general practice, urgent care services, emergency departments or hospital outpatient clinics.

In some circumstances, delayed care may contribute to preventable disease progression that ultimately requires hospital admission or more intensive treatment. This results in:

- Higher healthcare costs
- Increased pressure on emergency departments
- Greater demand for inpatient services
- Duplication of assessments and investigations
- Reduced health system efficiency.

The Inquiry has identified the impact of delayed care on hospitals, emergency departments and chronic disease management as a key area for examination. **Improving specialist access should be viewed not only as a workforce or patient access issue, but also as an important strategy for reducing pressure elsewhere in the health system.**

Improving timely access to specialist care can reduce avoidable demand on emergency departments, hospitals and primary care services, while improving health system efficiency and patient outcomes.

Recommendations to the Committee:

- Recognise timely access to specialist care as a key strategy for reducing avoidable pressure on hospitals and emergency departments.
- Expand specialist outpatient and community-based services to support earlier intervention and ongoing care.
- Strengthen integration between primary care, specialist services and hospitals.
- Reduce delays that contribute to avoidable disease progression and hospitalisation.
- Consider system-wide impacts when assessing specialist access reforms.
- Invest in specialist service capacity to improve health system efficiency and sustainability.

Delayed care can reduce workforce participation and economic productivity

The consequences of delayed specialist care extend beyond the healthcare system. Untreated or poorly managed health conditions can affect an individual's ability to remain in employment, participate in education, undertake caring responsibilities, participate in community life and maintain independence.

Long waiting times may result in prolonged periods of illness, uncertainty and reduced functional capacity. In some circumstances, delays may contribute to reduced workforce participation, increased reliance on income support, greater informal caring responsibilities and long-term disability.

The broader economic impacts of delayed specialist care are often overlooked in discussions regarding affordability and access. Improving access can support productivity, workforce

participation and social wellbeing while reducing longer-term costs associated with untreated illness.

Timely access to specialist care can help people remain in employment, continue their education, maintain independence and participate more fully in family and community life, while reducing the broader economic costs associated with untreated illness and disability.

Recommendations to the Committee:

- Recognise timely access to specialist care as a contributor to workforce participation, productivity and economic wellbeing.
- Incorporate economic and workforce participation impacts into specialist access policy decisions.
- Prioritise reforms that support early diagnosis, intervention and treatment.
- Reduce delays that contribute to avoidable disability and reduced workforce participation.
- Evaluate the workforce, productivity and social outcomes of specialist access reforms.
- Consider the broader economic and societal benefits of improving specialist access when assessing health system investments.

Children and young people may experience lifelong consequences

Timely specialist assessment is particularly important during childhood and adolescence. For children and young people, delays can affect developmental outcomes, educational engagement, mental health, family wellbeing, behavioural outcomes and long-term health trajectories. Early diagnosis and intervention can significantly improve outcomes for many developmental, neurological, behavioural and chronic health conditions.

Long waiting times for developmental paediatric services continue to be reported across Australia, with some jurisdictions reporting waits of many months or years for specialist assessment, delaying diagnosis, intervention and access to support services. Long waiting times for paediatric specialist services may result in delayed diagnosis and reduced opportunities for effective early intervention. Families frequently report substantial stress navigating fragmented systems while awaiting specialist review. Improving access for children should therefore be recognised as both a health and lifelong wellbeing priority.

Delayed access to paediatric specialist care can have consequences that extend well beyond childhood, affecting educational attainment, social participation, mental health, future employment opportunities and long-term health outcomes.

Recommendations to the Committee:

- Prioritise timely access to paediatric specialist assessment, diagnosis and treatment.
- Expand paediatric specialist capacity to support early intervention and reduce waiting times.
- Strengthen multidisciplinary care for children and young people with complex, chronic and developmental conditions.
- Improve care coordination and navigation support for children, young people and their families.
- Reduce inequities in access to paediatric specialist services across geographic regions.
- Recognise timely paediatric specialist care as an investment in lifelong health and wellbeing.
- Prioritise early intervention for children and young people at risk of poorer long-term outcomes.

Developmental paediatric and ADHD services require targeted attention

Access to developmental paediatric services remains a significant challenge across Australia. Children and young people requiring assessment and management for ADHD, autism and other developmental and behavioural conditions frequently experience prolonged waits for specialist care, with demand in many areas exceeding available specialist capacity.

Delays in specialist assessment can affect children's health, developmental, educational and wellbeing outcomes and may delay access to appropriate educational, disability and family supports. Long waiting periods can also contribute to increased stress and financial burden for families seeking to navigate fragmented care pathways while awaiting specialist review.

Improving access to developmental paediatric services requires a coordinated approach that expands specialist workforce capacity, supports multidisciplinary models of care and promotes more integrated pathways between specialist services, primary care, education and disability sectors. Early identification, assessment and intervention can improve long-term outcomes and should be recognised as an important investment in the health and wellbeing of children and young people.

The RACP supports evidence-based reforms to improve access to ADHD assessment and management, including implementation of the RACP National Model of Care for ADHD and broader initiatives that enable specialist expertise to be used more effectively within multidisciplinary systems of care.

Delayed access to developmental paediatric and ADHD services can have lifelong consequences for children and young people, reducing opportunities for early intervention and delaying access to education, disability and family supports that are critical to achieving optimal outcomes.

Recommendations to the Committee:

- Expand community based developmental paediatric and ADHD service capacity.
- Prioritise early identification, assessment and intervention for children and young people with developmental and neurodevelopmental conditions.
- Support implementation of evidence-based and multidisciplinary models of ADHD care.
- Strengthen integration between specialist, primary care, education, disability and community services.
- Improve access to developmental paediatric and ADHD services in rural, regional and underserved communities.
- Support innovative models that make better use of specialist expertise.
- Recognise timely access to developmental paediatric and ADHD services as an investment in lifelong health, educational and social outcomes.

Young people need developmentally appropriate specialist services

Adolescence and young adulthood represent a critical period in the life course, with many physical health conditions, mental health conditions and chronic illnesses emerging or requiring ongoing management during this time. Access to timely specialist care is important for preventing long-term health consequences and supporting participation in education, employment and community life.

However, young people can experience barriers navigating healthcare systems that are often designed around either paediatric or adult models of care. Developmentally appropriate specialist services can support better engagement, continuity of care and health outcomes, particularly during transition from paediatric to adult services.

Specialist services for young people should be designed to meet the unique needs of adolescents and young adults, including through age-appropriate care environments, coordinated transition pathways and multidisciplinary models of care. Strengthening data collection and performance reporting for adolescent and young adult health services would also support greater visibility of access barriers and service gaps experienced by young people. Refer to our RACP Youth Appropriate Health Care position statement for reform recommendations.

Poorly coordinated transitions and services that do not meet the developmental needs of young people can contribute to disengagement from care, poorer health outcomes and reduced participation in education, employment and community life.

Recommendations to the Committee:

- Recognise adolescents and young adults as a priority population in specialist access planning.
- Expand developmentally appropriate specialist services for young people.
- Strengthen transition pathways between paediatric and adult specialist services.
- Support multidisciplinary and youth-friendly models of care.
- Improve continuity of care during transition to adult services.
- Strengthen data collection and performance monitoring for adolescent and young adult specialist care.
- Address barriers that limit young people's engagement with specialist services.

Aboriginal and Torres Strait Islander peoples experience disproportionate impacts

Aboriginal and Torres Strait Islander peoples experience a greater burden of chronic disease and poorer health outcomes across many conditions. Improving access to timely healthcare is a key priority of the National Agreement on Closing the Gap and the National Aboriginal and Torres Strait Islander Health Plan 2021–2031.

When specialist care is delayed, existing health inequities may be further compounded. Barriers associated with geography, affordability, cultural safety, service availability and continuity of care can result in delayed diagnosis, delayed treatment and poorer health outcomes. Delays in accessing specialist care are particularly concerning given that a substantial proportion of deaths among Aboriginal and Torres Strait Islander peoples are considered potentially avoidable through timely and effective healthcare.

Evidence demonstrates that access to healthcare remains an important component of health system performance for Aboriginal and Torres Strait Islander peoples. Addressing delays requires culturally safe, community-controlled and Aboriginal-led approaches developed in partnership with Aboriginal and Torres Strait Islander organisations and communities.

Aboriginal Community Controlled Health Organisations (ACCHOs) play a critical role in improving access to care and supporting culturally safe models of service delivery. Community-controlled organisations are often best placed to identify local needs, coordinate care, support continuity of care and strengthen engagement with specialist services. Expanding specialist outreach, visiting specialist services and multidisciplinary models delivered in partnership with ACCHOs can improve access and health outcomes.

Improving specialist access also requires continued investment in the Aboriginal and Torres Strait Islander health workforce. Growth in the Aboriginal and Torres Strait Islander medical and health workforce can strengthen cultural safety, improve community engagement and support more responsive specialist healthcare services. Consistent with Closing the Gap principles, specialist access reforms should be designed, implemented and governed in partnership with Aboriginal and Torres Strait Islander peoples and organisations.

Improving specialist access for Aboriginal and Torres Strait Islander peoples requires sustained investment in culturally safe, community-controlled and Aboriginal-led models of care that address the multiple barriers contributing to poorer health outcomes.

Recommendations to the Committee:

- Support Aboriginal and Torres Strait Islander-led approaches to specialist access.
- Strengthen partnerships between specialist services and ACCHOs.
- Expand outreach, shared care and multidisciplinary specialist services delivered in partnership with ACCHOs.
- Grow the Aboriginal and Torres Strait Islander health workforce.
- Improve care coordination and continuity of care.
- Reduce geographic barriers to specialist care.
- Expand culturally safe specialist services.
- Ensure specialist access reforms are co-designed and delivered in partnership with Aboriginal and Torres Strait Islander communities.

People living in rural, regional and remote Australia face greater consequences from delayed care

People living outside major cities continue to experience poorer access to health services than metropolitan populations. Delayed access may be exacerbated by workforce shortages, long travel distances, limited local specialist availability, transport barriers and reduced availability of multidisciplinary services. Patients may postpone specialist consultations because of financial and logistical challenges associated with travel.

Where local services are unavailable, delays may become prolonged and result in preventable deterioration in health status. The cumulative impact can contribute to poorer health outcomes and widening disparities between metropolitan and non-metropolitan communities.

Improving access for rural, regional and remote communities requires reducing both the time and distance patients must travel to receive specialist care, while strengthening local service capacity and workforce sustainability.

Recommendations to the Committee:

- Prioritise equitable access to specialist care for rural, regional and remote communities.
- Expand specialist outreach, telehealth and other locally accessible models of care.
- Strengthen regional specialist service capacity and multidisciplinary care.
- Grow and sustain the rural, regional and remote specialist workforce.
- Reduce financial and logistical barriers to accessing specialist care, including travel and accommodation costs.
- Target investment to communities experiencing the greatest access barriers and longest delays in care.

People with disability face compounding impacts

People with disability frequently require ongoing specialist care from multiple providers and disciplines. When specialist access is delayed, impacts may include worsening functional outcomes, delays in diagnosis and treatment, reduced access to disability supports, increased care needs and greater burden on families and carers.

Access barriers may be compounded by communication challenges, service accessibility issues and fragmented coordination between health and disability systems. Timely specialist care is often essential to supporting independence, participation and quality of life.

Improving specialist access for people with disability requires coordinated, accessible and person-centred care that reduces fragmentation between health, disability and support systems.

Recommendations to the Committee:

- Ensure specialist access reforms adopt a disability-inclusive approach.
- Strengthen coordination between health, disability and support systems.
- Improve accessibility of specialist services and care pathways.
- Support multidisciplinary and coordinated models of care for people with disability.
- Reduce barriers to timely diagnosis, treatment and access to supports.
- Monitor specialist access outcomes for people with disability.

Delayed care disproportionately affects disadvantaged populations

The impacts of delayed care are often greatest for people already experiencing disadvantage. This includes culturally and linguistically diverse communities, migrants, refugees, people seeking asylum, people experiencing socioeconomic disadvantage and people with limited access to transport or support services.

The Australian Bureau of Statistics identifies cost, waiting times, service availability, distance and language barriers as important factors affecting access to healthcare.[9] As delays increase, these populations may be more likely to defer care, experience worsening health conditions and encounter barriers navigating healthcare systems. **Improving equity should be a central objective of specialist access reform.** Without targeted action, specialist access reforms may fail to address, or may inadvertently widen, existing health inequities experienced by priority populations.

Recommendations to the Committee:

- Embed equity as a core principle of specialist access reform.
- Improve access to interpreter services, patient navigation and care coordination supports.
- Strengthen culturally responsive and accessible specialist care.
- Support community-based approaches that improve access for underserved populations.
- Reduce barriers to specialist care for populations experiencing the greatest disadvantage.
- Monitor specialist access and outcomes across priority populations.

[9] Access to health services | Australian Bureau of Statistics

Summary

Delays in accessing specialist care have significant consequences for patients, families, communities and the broader health system. The impacts extend well beyond waiting times themselves and include:

- Poorer health outcomes
- Disease progression
- Increased hospital demand
- Reduced workforce participation
- Higher healthcare costs
- Widening health inequities.

These impacts are particularly significant for children and young people, Aboriginal and Torres Strait Islander peoples, people living in rural and remote communities, people with disability and other priority populations.

Improving access to timely specialist care should be regarded as a preventative health, health system sustainability and economic policy priority. The benefits of reducing delays extend beyond individual patients and contribute to a more equitable, efficient and sustainable healthcare system.

Refer to Appendix 5 for examples of some specialty specific impacts of delays.

Terms of Reference E: Innovative and Emerging Models of Care to Improve Access to Medical Specialists

Innovative models of care are essential to improving access

Traditional models of specialist care, based primarily on face-to-face consultations delivered from major hospital or metropolitan specialist settings, will remain an important component of Australia's health system. However, these models alone are increasingly unable to meet growing demand associated with population growth, ageing, chronic disease and workforce pressures.[10]

Many innovative models of care remain difficult to implement at scale because funding arrangements have not kept pace with contemporary models of specialist care. Activities such as care coordination, multidisciplinary case discussions, clinician-to-clinician advice and shared-care planning are often critical to achieving good outcomes but may not be adequately recognised within existing funding arrangements. Sustainable implementation of innovative models will require funding mechanisms that support collaboration, continuity of care and team-based care.

The RACP considers that improving access will require greater adoption and scaling of innovative models of care that increase service capacity, improve equity of access, support care closer to home, reduce waiting times, strengthen multidisciplinary care and make more effective use of specialist expertise. **Importantly, innovative models should complement, rather than replace, face-to-face specialist care, where clinically required.**

Telehealth has become an essential component of specialist care

Telehealth has significantly improved access to specialist services for many patients, particularly those living in rural, regional and remote communities. Telehealth can reduce travel requirements, accommodation costs, time away from work and education, delays in accessing specialist advice and geographic barriers to care.

For many consultations, particularly follow-up appointments, multidisciplinary case conferences and chronic disease management, telehealth can provide safe, effective and patient-centred care. Telehealth is particularly valuable for rural and remote communities, Aboriginal and Torres Strait Islander peoples, people with disability, older people, children and young people, patients requiring ongoing specialist follow-up and individuals facing transport or mobility barriers.

However, telehealth is not appropriate for all clinical circumstances and should complement in-person services rather than substitute them. Ongoing investment in telehealth can improve access, affordability and continuity of specialist care, particularly for people who face geographic, financial or mobility-related barriers to accessing services.

Recommendations to the Committee:

- Maintain and strengthen specialist telehealth as a core component of specialist care.
- Ensure telehealth funding supports clinically appropriate and patient-centred care.
- Improve equitable access to digital infrastructure and connectivity.
- Integrate telehealth within broader specialist care pathways.
- Support hybrid models that combine virtual and face-to-face care.
- Prioritise telehealth access for communities and populations experiencing barriers to specialist care.

[10] Whole of Medical Workforce Supply and Demand Compendium Report_June 2026

Specialist outreach services improve access to underserved communities

Outreach services remain one of the most effective mechanisms for improving specialist access in communities with limited local workforce capacity. Outreach models can reduce travel burdens, improve continuity of care, strengthen relationships between local and specialist providers, support workforce capability building and improve access to specialist expertise closer to home.

Outreach services are particularly important for:

- Rural and remote communities
- Aboriginal and Torres Strait Islander communities
- Regional growth areas
- Communities with limited specialist workforce availability.

Effective outreach programs require sustainable funding, administrative support and integration with local healthcare providers. Outreach services can improve equity of access by bringing specialist expertise closer to communities that would otherwise face significant geographic, workforce and service availability barriers.

Recommendations to the Committee:

- Expand specialist outreach services in communities experiencing the greatest access barriers.
- Prioritise outreach services for rural, regional, remote and Aboriginal and Torres Strait Islander communities.
- Strengthen partnerships between specialist services, local providers and ACCHOs.
- Improve integration and continuity of care between visiting specialists and local health services.
- Support multidisciplinary outreach models that build local capability and access to specialist expertise.
- Provide sustainable funding and administrative support for specialist outreach programs.

Hub-and-spoke models can increase specialist capacity

Hub-and-spoke models connect specialist expertise located within larger centres to surrounding regional and community-based services. Under these models complex care can be coordinated through specialist hubs, routine care can be delivered locally where appropriate, multidisciplinary expertise can be shared across regions and specialist capacity can be used more efficiently.

Hub-and-spoke arrangements can improve:

- Workforce sustainability
- Service coordination
- Access to multidisciplinary care
- Continuity of care
- Health equity.

These models are particularly well suited to chronic disease management, paediatric care, neurology, addiction medicine, rehabilitation medicine and other specialties where access challenges are significant. By enabling specialist expertise to be shared across regions and care settings, hub-and-spoke models can improve access, strengthen workforce sustainability and support more equitable delivery of specialist services.

Recommendations to the Committee:

- Expand hub-and-spoke specialist service networks in areas with limited access to specialist care.
- Strengthen regional specialist infrastructure and service capacity.
- Invest in digital connectivity and virtual care to support networked models of care.
- Strengthen partnerships between tertiary, regional and community-based services.
- Support multidisciplinary hub-and-spoke models in specialties experiencing significant access challenges.
- Scale successful hub-and-spoke models to improve access, equity and workforce sustainability.

Community-based specialist services can improve access

Many specialist services can be safely delivered in community settings rather than hospital outpatient departments. Community-based specialist services can improve geographic access, reduce pressure on hospitals and provide care closer to where patients live.

Examples include community-based endocrinology, rheumatology, cardiology and neurology services. These models may be particularly valuable for chronic disease management and patients requiring ongoing specialist follow-up.

Recommendations to the Committee:

- Expand community-based specialist services where clinically appropriate.
- Shift suitable outpatient activity into community settings.
- Improve access to specialist care closer to home.

Specialist advice services and eConsult models should be expanded

Many patients do not require a formal specialist appointment as the first step in care. Access to timely specialist advice can support management within primary care while reserving specialist appointments for patients requiring comprehensive specialist assessment.

Electronic consultation (eConsult) and specialist advice services can:

- Provide rapid access to specialist expertise
- Improve referral quality
- Reduce unnecessary referrals
- Reduce waiting list pressures
- Support GP capability
- Improve care closer to home.

These models also provide an efficient mechanism for sharing specialist expertise across geographically dispersed communities. Specialist advice services can improve patient access to specialist expertise, support primary care management, reduce unnecessary referrals and enable specialist capacity to be directed towards patients with the greatest clinical need.

Data from established eConsult programs demonstrate that many clinical questions can be resolved through specialist advice alone, reducing the need for face-to-face appointments and freeing specialist capacity for more complex patients.

Recommendations to the Committee:

- Expand access to specialist advice services, including eConsult models.
- Support sustainable funding for non-face-to-face specialist advice and care.
- Embed specialist advice services within referral pathways.
- Strengthen collaboration between primary care and specialist services.
- Scale successful specialist advice models to improve access, efficiency and equity.
- Use specialist advice services to improve access in rural, regional, remote and other underserved communities.

Shared care models can improve coordination across the health system

Many health conditions require ongoing collaboration between specialists, general practitioners, allied health professionals and community-based services. Shared care arrangements can improve continuity of care, reduce duplication, improve communication between providers, support chronic disease management and improve patient experience.

These models are particularly valuable for long-term conditions requiring ongoing management rather than episodic specialist intervention. Successful implementation requires clearly defined clinical responsibilities, effective communication systems, shared information systems and appropriate funding mechanisms. Well-designed shared-care models can improve patient outcomes, make more effective use of specialist capacity and support management of chronic and complex conditions closer to home.

The RACP supports integrated models of chronic disease management that strengthen coordination between primary care, specialist services and multidisciplinary teams. As the prevalence of chronic disease and multimorbidity continues to grow, specialist services should increasingly be designed around longitudinal care pathways rather than episodic interactions.

Recommendations to the Committee:

- Support shared-care models between specialists, primary care and multidisciplinary providers.
- Improve information sharing and care coordination across healthcare settings.
- Align funding arrangements with collaborative and team-based care.
- Strengthen shared-care pathways for people with chronic and complex conditions.
- Support implementation and evaluation of evidence-based shared-care models.
- Promote shared-care approaches that improve continuity of care and make more effective use of specialist capacity.

Multidisciplinary specialist services should be expanded

Increasing numbers of patients present with multiple chronic conditions, complex disability-related needs and overlapping physical and mental health concerns. Traditional single-specialty models may not adequately address these needs. Multidisciplinary models can improve care coordination, reduce duplication, improve patient outcomes, reduce patient burden and enable more efficient use of specialist expertise.

Multidisciplinary services are particularly important for children and young people with complex needs, people with disability, patients with chronic disease, Aboriginal and Torres Strait Islander peoples and older Australians. As patient complexity increases, multidisciplinary specialist services can improve outcomes, reduce fragmentation, support more coordinated care and make more effective use of specialist expertise across the health system.

Assessment clinics supported by advanced trainees, nurse practitioners and allied health professionals may help improve access in selected specialties while ensuring specialist expertise is directed towards patients with the greatest clinical need. Such models may be particularly valuable for high-volume conditions where lengthy waiting lists exist for initial specialist assessment.

Recommendations to the Committee:

- Expand multidisciplinary specialist services for people with complex and chronic health needs.
- Invest in multidisciplinary outpatient and community-based models of care.
- Strengthen integrated care pathways across specialist, primary care, allied health and community services.

- Support workforce and funding models that enable multidisciplinary practice and care coordination.
- Improve access to multidisciplinary care for priority populations.
- Evaluate and scale multidisciplinary models that improve outcomes, coordination and health system efficiency.

Innovative paediatric models should be scaled

The RACP notes the success of innovative paediatric models focused on reducing fragmentation and improving care coordination. Examples include integrated models that:

- support earlier intervention;
- improve links between primary and specialist care;
- integrate health, disability and education sectors;
- reduce duplication; and
- improve patient and family experience.

Programs such as integrated paediatric care pathways and community-based specialist services demonstrate how specialist expertise can be delivered closer to home while maintaining high standards of care. Innovative paediatric models demonstrate that integrated, community-based approaches can improve access, reduce fragmentation and support earlier intervention while ensuring specialist expertise is available closer to where children and families live.

Recommendations to the Committee:

- Expand evidence-based paediatric models that support earlier intervention and coordinated care.
- Strengthen community-based paediatric specialist services.
- Improve integration across health, disability, education and social support systems.
- Support coordinated developmental and behavioural care pathways.
- Reduce fragmentation and improve continuity of care for children and families.
- Scale successful paediatric models that improve access, equity and patient outcomes.

Innovative models must improve equity

Innovative care models should be assessed not only on efficiency, but also on their ability to improve equitable access. Models should support improved access for Aboriginal and Torres Strait Islander peoples, rural, regional and remote communities, people with disability, migrants, refugees and people seeking asylum, culturally and linguistically diverse communities and socioeconomically disadvantaged populations.

The principles of the National Agreement on Closing the Gap emphasise partnership, community control and culturally safe service delivery as essential components of improving outcomes for Aboriginal and Torres Strait Islander peoples. Innovative models should therefore be developed and implemented in partnership with communities and consumers. Innovative models of care should be evaluated on their ability to improve access, outcomes and equity for populations that experience the greatest barriers to specialist care.

Recommendations to the Committee:

- Embed equity within the design, implementation and evaluation of innovative specialist care models.
- Ensure innovative models improve access for populations experiencing the greatest barriers to care.
- Support community-led and co-designed approaches to service innovation.
- Strengthen culturally safe, accessible and inclusive models of specialist care.
- Apply the principles of partnership, community control and culturally responsive care in service design.

- Monitor outcomes across priority populations to ensure innovations reduce health inequities.

Digital innovation and data-driven planning should be strengthened

Technology offers opportunities to improve specialist access, service planning and patient outcomes. Digital innovations may include electronic referral pathways, virtual multidisciplinary case conferences, specialist advice platforms, telehealth, remote monitoring technologies and enhanced access monitoring systems.

The RACP supports the establishment of a National Specialist Access Monitoring Framework to improve visibility of waiting times, workforce distribution, unmet demand, outpatient activity and patient outcomes. Improved data collection and transparency would support more effective planning and evaluation of new models of care. Strengthening digital infrastructure, data collection and performance monitoring will support more informed workforce planning, service investment and evaluation of specialist access reforms.

Recommendations to the Committee:

- Establish a National Specialist Access Monitoring Framework.
- Improve national collection, reporting and transparency of specialist access data.
- Strengthen digital infrastructure that supports specialist access and service delivery.
- Use specialist access data to inform workforce planning, service design and investment.
- Support rigorous evaluation of innovative models of care.
- Scale evidence-based innovations that improve access, equity and patient outcome.

Flexible Approach to Training in Expanded Settings (FATES)

The RACP has piloted several initiatives to pilot change in regional, rural and remote settings, and to support the revised STP program to meet its aims including. The pilots are proving successful and significant progress has been made. These are:

- The FATES Round 2 funded WA Country Health Service (WACHS) project in collaboration with the RACP WA Rural Basic Physician Training Pathway (which is now successfully permanently established) and FATES Round 4 funded WACHS Basic Training Paediatrics and Child Health Rural Training Network (which has commenced development).
- A WACHS rural advanced training pathway (which has commenced planning for 2028)
- The FATES Round 2 Rural and Remote Institute of Palliative Medicine (RRIPM) funded project setting up a rural and remote palliative medicine training network. Currently, two integrated rural Advanced Training Palliative Medicine terms have been established through the Rural and Remote Institute of Palliative Medicine.
- The FATES Round 4 funded project GenMed Horizons aims to strengthen the future General Medicine workforce through national workforce mapping and a review of the RACP's General and Acute Care Medicine accreditation standards. The GenMed Horizons general and acute care medicine accreditation map is to be launched and a map on the General Medicine consultant workforce is to follow.
  These have generated interest and momentum and other jurisdictions have expressed interest in establishing rural training pathways, for example, NSW Health and Health Education and Training Institute (HETI) are advancing plans for a Basic Training Adult Internal Medicine Rural Training Network.

Summary

Innovative models of care will play a critical role in addressing Australia's access-to-specialist-care challenge. Expanding access will require a coordinated approach that combines:

- Telehealth
- Outreach services
- Hub-and-spoke networks
- Specialist advice services
- Shared-care arrangements
- Multidisciplinary care
- Digitally enabled service delivery.

These innovations should be implemented alongside investment in specialist workforce capacity, public outpatient services and equitable access initiatives.

The RACP considers that scalable, evidence-based and patient-centred models of care offer a significant opportunity to improve access, reduce waiting times and strengthen health system sustainability while ensuring specialist services remain accessible to all Australians.

Refer to Appendix 6 for examples of some specialty specific innovative models.

Conclusion

Australia has an access-to-specialist-care challenge that requires system-wide reform

The evidence presented throughout this submission demonstrates that access to specialist care is shaped by a complex interaction of workforce, funding, infrastructure and service delivery factors. While specialist workforce supply remains important, increasing workforce numbers alone will not resolve the challenges currently experienced by patients across Australia. The Inquiry itself has recognised the interconnected nature of workforce distribution, referral pathways, affordability, waiting times and innovative models of care.

Patients are increasingly experiencing delays in accessing specialist assessment and treatment due to a combination of:

- Workforce maldistribution
- Insufficient public specialist service capacity
- Affordability barriers
- Fragmented referral pathways
- Inequitable geographic access
- Growing demand arising from chronic disease and population ageing.

These challenges have significant consequences for patients, families and the broader health system. Delayed access can contribute to worsening health outcomes, increased hospital presentations, avoidable healthcare expenditure, reduced workforce participation and widening health inequities.

Importantly, the impacts of restricted access are not experienced equally. Aboriginal and Torres Strait Islander peoples, people living in rural, regional and remote Australia, children and young people, people with disability, culturally and linguistically diverse communities, migrants, refugees and people seeking asylum continue to face disproportionate barriers to accessing timely specialist care.

The RACP considers that improving access requires coordinated action across five strategic reform areas:

1. **Expand specialist service capacity**
   Increasing public outpatient, ambulatory and community-based specialist services is essential to reducing waiting times and improving equity of access.
2. **Improve workforce distribution**
   Specialist workforce investment should focus not only on workforce numbers, but also on ensuring specialists are available in communities experiencing the greatest unmet need.
3. **Modernise referral pathways**
   Nationally consistent referral systems, specialist advice services and interoperable digital infrastructure can improve efficiency, transparency and care coordination.
4. **Improve affordability**
   Reducing financial barriers requires reform across public capacity, Medicare funding settings and broader patient costs associated with specialist care.
5. **Scale innovative models of care**
   Telehealth, outreach services, hub-and-spoke networks, multidisciplinary care models and specialist advice services should be expanded where evidence demonstrates improved access and patient outcomes.

The RACP strongly supports the establishment of a national approach to monitoring specialist access, including improved visibility of workforce distribution, waiting times, outpatient activity and unmet demand. Better data will support evidence-based planning and more effective policy responses.

Principles for Evaluating Future Specialist Access Reforms

The RACP recommends that future reforms be assessed against the following principles:

- **Equity:** Does the reform improve access for populations currently experiencing the greatest barriers?
- **Timeliness:** Does the reform reduce clinically inappropriate delays and waiting times?
- **Quality and Safety:** Does the reform maintain or improve quality of care and patient outcomes?
- **Sustainability:** Does the reform strengthen long-term workforce and service capacity?
- **Integration:** Does the reform improve coordination across primary care, specialist care, hospitals and community services?
- **Patient-Centred Care:** Does the reform improve patient experience, navigation and continuity of care?
- **Cultural Safety:** Does the reform support culturally safe and responsive healthcare delivery?
- **Evidence-Based Practice:** Does the reform incorporate monitoring, evaluation and continuous improvement mechanisms?

Improving access to specialist care is not solely a healthcare objective. It is also an investment in prevention, health equity, workforce participation, productivity and long-term health system sustainability.

The RACP looks forward to working with governments, health services, patients and communities to improve equitable access to high-quality specialist care for all Australians. Our RACP Fellows and trainees are committed to being part of the effort.

The reforms outlined in this submission recognise that the access and affordability challenge is systemic and requires a coordinated response. The proposed recognise the interconnected drivers of the current crisis, including workforce distribution and sustainability, Medicare adequacy, referral pathway reform, investment in prevention, digital infrastructure, and support for innovative models of care.

The RACP is pleased to speak further with the Committee on any aspect of this submission. For further queries or information, please contact Policy@racp.edu.au.

APPENDIX 1: Paediatric MBS Reform (March 2026)

The Royal Australian College of Physicians (RACP) represents over 33,000 medical specialist physicians and trainees across Australia and Aotearoa New Zealand.

The RACP provides this proposal to inform the Department of Health, Disability and Ageing on necessary reforms to the Medicare Benefits Schedule (MBS) to better support paediatric and child health care.

The RACP expert physicians wish to raise the need for these important and essential MBS improvements with the Department.

In this document we:

- **Identify for the Department's MBS compliance team current issues from the RACP Paediatric and Child Health Division perspectives.**
- **Illustrate these issues across current contemporary paediatric care practices.**
- **Identify five (5) feasible steps whereby the diagnosis and management of infants, children, and adolescents requiring specialist paediatric care can be strengthened.**

Reforming MBS to more accurately reflect the realities of modern paediatric care is essential to ensuring equitable access to care and reducing long-term healthcare system costs.

Paediatric, child and adolescent health care has significantly changed over the years with an increased focus of care on complex and chronic conditions such as development, behaviour and mental health. Current MBS items do not adequately reflect modern practice and is contributing to significant financial impact on children, adolescents and their families. Similar chronic care is reflected in the MBS for other specialists such geriatrics, psychiatry, and recently gynaecology, but not in child and adolescent work.

Amendments to MBS item numbers will provide earlier intervention, more equitable access to paediatricians, and long-term cost savings for the healthcare system. The RACP recognises that MBS reform must also extend to adolescents. Throughout this document, the term 'paediatric' practice is used with the understanding that it encompasses infancy, childhood, and adolescence, acknowledging the continuum of care that is required across all developmental stages.

Current Challenges

1. **Increased complexity of paediatric practice**

The scope of paediatric practice has shifted markedly from predominantly acute presentations to the ongoing management of multifactorial neurodevelopmental, behavioural, and chronic conditions, including mental health.

These include attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), anxiety/depression, trauma-related difficulties, and complex chronic illnesses. Such conditions frequently present with comorbidities, often requiring multidisciplinary intervention for effective ongoing management.

Paediatricians hold a unique position within the healthcare system: responsible for evaluating a child's developmental abilities and temperament whilst remaining attentive to the interconnected matrix of people and services in the child's life.
The role of paediatricians includes the provision of ongoing assessments and reviews for individuals up to 18 years of age, and up to 25 years for those supposed by specialised youth

health training. Reflecting this complexity, **contemporary paediatric care now extends well beyond traditional diagnostic consultation**, and typically involves:

- Assessment and diagnosis, often requiring multiple consultations to establish a holistic developmental and medical profile. Often initial and follow-up appointments can be 60-90 minutes for appropriate comprehensive care of the child and their family.
- Therapeutic management extends beyond pharmacology to include medication initiation, titration, and ongoing monitoring, frequently involving communication with the child and family outside scheduled appointments.
- Collaboration with general practitioners (GPs), other specialists, allied health professionals and early education/teachers involved in a child's care, which occurs in a range of ways beyond a shared patient consultation and MBS case conferences, including email, phone discussions, school meetings, and review of assessments and reports.
- Education and social systems engagement and advocacy, to ensure the child is receiving adequate family support and schooling based on their developmental needs (including any necessary reports) and consider the perspectives of non-health professionals as relevant to ongoing paediatric care.
- Family engagement and support, recognising the psychosocial burden on primary and secondary caregivers.
- Ongoing reassessment, acknowledging that children's developmental trajectories evolve rapidly and management plans require adaptation.
- Advocacy, including supporting access to early intervention, NDIS reviews, and school-based supports.

2. Equitable access to paediatric care

Children from socioeconomically disadvantaged backgrounds experience a disproportionate burden of developmental, and behavioural conditions, often seen within families where multiple siblings are affected. These children are simultaneously the least able to access private care due to financial constraints.

For rural and regional families, these inequities are compounded by geographic isolation, where many communities are unable to access public paediatric clinics. As a result, public waitlists frequently exceed two years, leaving private care as the only viable option, which for many, is unattainable without adequate MBS support.

This reveals a significant child health equity issue, with the most vulnerable Australian families facing the greatest barriers to timely and appropriate care.

We note:

- Current MBS structures embed inequity from the start of life, leading to poorer outcomes for disadvantaged children.
- Children in bulk-billing practices are significantly less likely to be referred to specialists, despite presenting with higher levels of developmental and behavioural concerns[i].

3. Limitations of the current MBS framework

Existing MBS items are outdated and poorly aligned with contemporary paediatric practice. Other specialists have MBS items that reflect their complex work, see:
Item 296*: Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry.*
Item 291-299, 300-308*: A suite of psychiatry items that are tiered by time and complexity.*
Items 141, 143, 145, 147*: Comprehensive assessment and management plans for patients aged 65+, introduced to support complex care needs.*
This framework disadvantages children with complex needs, whose age and effective management requires time-intensive, multidisciplinary engagement. Currently, MBS items:

- Fail to capture the chronic and complex nature of paediatric care, which often involves multiple issues (learning, mental health, sleep, nutrition, medical conditions) and requires extended consultations of 60 minutes or more.
- Restrict the number of allowable claims, regardless of clinical needs, e.g. children returning for a review from a 132 item may have additional medical and wellbeing needs.
- Do not recognise essential components of paediatric care, including caregiver-only consultations, the range of engagement by paediatricians with other professionals beyond existing MBS case conferencing models (which are hospital discharge focused, e.g. items 832 to 834), and report preparation.
- Create significant uncertainty and MBS audit risk, due to vague wording and inconsistent application.
- Incentivise shorter, higher-volume consultations rather than comprehensive child-centred care.

4. Barriers to shared care

Shared care arrangements between paediatricians and General Practitioners (GPs) are central to ensuring continuity and coordination of care for children with neurodevelopmental and chronic health conditions. At present, the MBS does not provide the necessary structures to support this collaboration, limiting the capacity of both paediatricians and GPs to deliver integrated care.

We note:

- Specific MBS item numbers or amendments are needed for specialist paediatricians to participate in a range of multidisciplinary engagements with other professionals, beyond existing MBS case conferencing models (face-to-face and via telehealth (phone/videoconference)).
- Clear delineation of roles and responsibilities between GPs and paediatricians to ensure item numbers reflect accurate paediatric practices and support a shared-care model. Item numbers must also recognise the work undertaken by GPs in supporting these children within shared care arrangements. For example, ADHD follow-up assessments typically require a minimum of 60 minutes, yet current MBS items do not adequately cover the time and complexity of this work.

Risk mitigation measures

Aligning paediatric items with existing models (e.g. geriatric item 141) provides a tested framework. This reduces implementation risk by drawing on precedents that are already embedded within the MBS. The RACP acknowledges that any reform carries potential risk, however, notes that reform of paediatric MBS items can be implemented in a fiscally responsible and clinically effective manner, through:

- **Equity safeguards:** incorporating rural loadings and telehealth (video and telephone) parity to ensure reforms benefit disadvantaged populations.
- **Consistency with existing models:** by following precedents already embedded within the MBS, reform poses a low risk.
- **Targeted criteria**: Define clear eligibility requirements to ensure items are used correctly.
- **Monitoring and evaluation:** Establish mechanisms to track item outcomes and costs, supporting their refinement over time and ensuring reforms remain sustainable.

Proposed improvements

1. Amendment to MBS item numbers to sufficiently and flexibly cover:
a. The complexity of neurodevelopmental and chronic paediatric care.
b. Ongoing reviews and reassessments as children's needs evolve.
c. Multidisciplinary collaboration, direct paediatrician to other professional (both synchronous and asynchronous) and caregiver-only consultations.
2. Create new MBS item numbers (or review funding options for consistency) for paediatricians undertaking time-intensive neurodevelopmental assessments (e.g. ADHD, ASD, trauma-related difficulties).
3. Introduce rural loadings and telehealth parity to support service viability outside metropolitan centres.
4. Created new MBS items to adequately recognise the time paediatricians spend coordinating with GPs, allied health professionals, educators and caregivers. Introducing a broader range of specific MBS items for case conferencing / professional engagements would strengthen GP capacity, reduce duplication and improve continuity of care for children and families.
5. Recognition in relevant MBS items of time taken to undertake a range of critical tasks relating to paediatric care and liaison with other professionals, including detailed referrals and reports.

Specific recommendations for MBS reform

The reforms outlined below are designed to deliver high-impact, achievable, improvements in the short-term, whilst also setting the foundation for long-term structural change to the system. These recommendations seek to improve access and equity for children and families, particularly those in rural and underserved communities, and support sustainable paediatric practice by recognising the time, expertise, and multidisciplinary nature of care.

Bucket 1: Long-Term Structural Reform and Advocacy

1. Create dedicated MBS items for neurodevelopmental assessments.
2. Permit paediatric referrals under MBS mental health plans.
3. Introduce rural loading on rebates.
4. Include family group interventions in paediatric MBS items.
5. Establish a paediatric Medicare reform advisory group.
6. Collaborate with GPs on referral wording and shared care processes.
7. Develop a public and political messaging strategy to support understanding of need for reform.

Rationale:

- Enables appropriate billing for ASD/ADHD pathways and ensures families are not disadvantaged.
- Streamlines multidisciplinary access and integrates paediatrics into mental health care pathways.
- Improves service viability and workforce retention in under-served areas.
- Reflects real-world practice where family systems are central to child health outcomes.

Bucket 2: High Impact, Low Complexity to Implement

1. Increase allowable claims for **Item 133** (from 2 to 6 per year).
2. Permit annual billing of **Item 132** under indefinite referral for children with chronic health or developmental conditions.
3. Introduce a new annual review item for complex paediatrics (modelled on **Item 141**)
4. Allow rebates for caregiver-only consultations
5. Clarify and modernise wording of **Items 132**/**133**

Rationale:

- Enables ongoing review of complex, evolving cases and prevents treatment gaps.

- Reflects the natural progression of child development and reduces administrative burden.
- Aligns paediatrics with geriatrics, which have a comparable breadth of healthcare needs to consider, ensuring regular, comprehensive reviews for children with chronic and complex needs.
- Recognises the critical role of parent education, trauma-informed care, and planning in child outcomes.
- Reduces audit risk, improves consistency, and ensures alignment with contemporary paediatric practice.

Bucket 3: Moderate System Change

1. Remove requirements for new referral for every new issue.
2. Ensure telehealth parity with in-person consultations.
3. Introduce additional time-based items for paediatrics.
4. Introduce new item numbers to cover comprehensive reports / summaries of a child's medical and developmental challenges, supporting both multidisciplinary care teams and applications to the NDIS.

Rationale:

- Streamlines care, reduces duplication, and avoids unnecessary delays in treatment.
- Improves access for rural, remote, and neurodivergent children, supporting equity of care.
- Better reflects the complexity and time required for comprehensive paediatric consultations.
- Prevents unfunded after-hours work and supports sustainable practice.

Appendix 2: Specialty-Specific Barriers to Specialist Access

While many access challenges are systemic, their impacts are not evenly distributed across specialties, population groups and care settings. The examples below illustrate how workforce shortages, limited public service capacity, geographic barriers and fragmented care pathways can affect access to specialist care in different ways across the health system.

Paediatric Services

Access to paediatric specialist services, particularly developmental paediatrics and adolescent health services, remains a significant challenge in many parts of Australia. Demand for assessment and management of developmental, behavioural and neurodevelopmental conditions continues to exceed available service capacity.

Public hospital services are frequently focused on acute and inpatient follow-up, while community-based specialist services are often limited or unavailable. As a result, many children and families face a choice between lengthy public waiting lists, private assessments associated with significant out-of-pocket costs, or going without specialist care altogether.

Access could be improved through greater investment in publicly funded community-based paediatric specialist services, particularly for developmental and neurodevelopmental conditions. Improved integration between health, disability, education and community services, including school-based models of care where appropriate, may also reduce barriers to early assessment and intervention.

Geriatric Medicine

Access to geriatric medicine services remains challenging in many regional, rural and remote communities. Workforce shortages and the concentration of specialists in metropolitan centres can limit access to timely specialist assessment and ongoing management.

Formal networks linking metropolitan and regional services can improve access through a combination of outreach clinics, telehealth and shared-care arrangements. Strengthening regional placement opportunities during specialist training may also support future workforce distribution and improve long-term workforce sustainability.

Telehealth has improved specialist access for many older people. However, effective consultations often require support from carers, family members or healthcare workers to assist with technology, communication and access to clinical information.

For older people, particularly those living in residential aged care facilities, telehealth is most effective when integrated with local primary care, outreach services and multidisciplinary care models. Telehealth should therefore complement, rather than replace, face-to-face specialist services.

Neurology

Access to neurology services remains a significant challenge in many jurisdictions, particularly within public outpatient services. Long waiting times, limited outpatient clinic capacity, inadequate specialist nursing support and insufficient outreach services can contribute to delayed diagnosis and treatment.

Many neurological conditions require detailed clinical assessment and ongoing specialist review that cannot always be readily substituted through alternative models of care. Delays to

specialist assessment may affect symptom control, quality of life, workforce participation and family functioning.

Improving access to neurology services will require increased public outpatient capacity, strengthened multidisciplinary support and improved access to specialist services in regional and rural communities.

Addiction Medicine

Addiction medicine services remain unevenly distributed across Australia, despite substantial need in many communities. Workforce shortages can limit access to specialist assessment and treatment, particularly in regional, rural and remote areas and in communities experiencing high levels of alcohol and other drug-related harm.

Hub-and-spoke models offer a promising mechanism for improving access. Under these models, addiction medicine specialists can provide direct care for complex patients while simultaneously supporting general practitioners, hospitals, community health services and Aboriginal Community Controlled Health Organisations.

Improving access will require:

- stronger workforce planning for addiction medicine
- expanded specialist training opportunities
- increased specialist training positions
- greater availability of addiction medicine services in underserved communities
- wider implementation of hub-and-spoke care models.

Nuclear Medicine

Access to nuclear medicine services is influenced not only by workforce supply, but also by infrastructure, regulation and availability of specialised diagnostic and therapeutic resources.

Barriers to access may include:

- variation in radiation licensing requirements across jurisdictions
- limited availability of authorised facilities and equipment
- workforce training challenges in rapidly evolving areas of practice
- interruptions to radioisotope supply chains.

For rural and regional communities in particular, these barriers can limit outreach services and reduce access to specialised diagnostic and therapeutic procedures. Improving access will require coordinated national approaches to workforce planning, regulatory harmonisation, specialist training and infrastructure development.

Key Insight

These examples demonstrate that specialist access challenges extend beyond workforce numbers alone. Across specialties and population groups, access is influenced by the interaction between workforce availability, service capacity, infrastructure, funding arrangements, regulatory settings and models of care. Effective reform will therefore require both system-wide solutions and targeted approaches addressing the unique barriers faced by specific populations and specialties.

Appendix 3: Specialty-Specific Referral Issues

While many referral challenges affect the healthcare system broadly, some barriers have impacts on specific patient populations and specialties. The examples below illustrate how current referral arrangements can create unintended barriers to timely, coordinated and patient-centred care.

Paediatric Medicine

Children with developmental, behavioural, neurodevelopmental and chronic health conditions frequently require long-term specialist involvement alongside care provided by general practitioners, allied health professionals and community services. Unlike many acute conditions, paediatric conditions often evolve over time and require ongoing assessment, monitoring and management.

Current referral arrangements can create unnecessary administrative burden when new concerns emerge during the course of ongoing specialist care. Requirements for renewed referrals may delay access to specialist review, disrupt continuity of care and increase costs for families already navigating multiple health, disability and education services.

Referral arrangements should better support the realities of longitudinal paediatric care by promoting continuity, reducing unnecessary administrative requirements and enabling timely access to specialist services when children's needs change over time.

Key Considerations

- Support longer-term referral arrangements for children with chronic, developmental and complex health conditions.
- Reduce unnecessary referral renewal requirements where ongoing specialist involvement is clinically indicated.
- Promote continuity of care for children receiving long-term specialist management.
- Ensure referral arrangements support integrated care across health, disability, education and community services.

Addiction Medicine

Referral requirements can create barriers for people seeking treatment for substance use disorders. Many patients presenting for addiction medicine care do not have a regular general practitioner or may experience difficulties navigating referral pathways due to the impacts of substance dependence, social disadvantage, housing instability or co-occurring mental health conditions.

Current referral arrangements may therefore delay or prevent access to specialist addiction medicine services. Consideration should be given to whether a broader range of healthcare professionals could appropriately facilitate access to specialist addiction medicine care in specific circumstances, particularly where workforce shortages and service access barriers already exist.

Access to psychological treatment is also an important component of addiction care. Greater integration between addiction medicine specialists, primary care and mental health services may improve continuity of care and reduce barriers to evidence-based treatment.

Key Considerations

- Review referral arrangements to reduce barriers for people seeking addiction medicine care.
- Support integrated referral pathways between addiction medicine, primary care and mental health services.
- Improve access to multidisciplinary treatment, including psychological therapies.
- Strengthen referral models that improve access for underserved and high-need populations.

Gastroenterology

Many gastroenterology referrals can be effectively managed through enhanced communication between general practitioners and specialists. In some cases, timely specialist advice can support additional investigations, management in primary care or more appropriate triage before a formal outpatient appointment is required.

Specialist advice services and eConsult models have the potential to improve referral quality, reduce unnecessary outpatient appointments and ensure specialist capacity is prioritised for patients requiring endoscopy, complex assessment or ongoing specialist management.

Embedding specialist advice pathways within referral systems may therefore improve efficiency, reduce waiting-list pressures and support more timely access to specialist expertise.

Key Considerations

- Expand specialist advice and eConsult services within gastroenterology.
- Support funding arrangements that recognise non-face-to-face specialist consultation and advice.
- Improve referral triage processes and referral quality.
- Use specialist advice services to ensure patients are directed to the most appropriate care pathway at the earliest opportunity.

Key Insight

These examples demonstrate that referral reform should be flexible enough to accommodate the differing needs of patient populations and specialties. Referral pathways designed primarily around episodic care may be poorly suited to chronic, complex and multidisciplinary models of care. Improving referral systems will require greater flexibility, better integration between providers and a stronger focus on continuity, quality and patient-centred access.

Appendix 4: Specialty-Specific Affordability Issues

While many affordability challenges affect patients across the health system, some populations and specialties face distinctive barriers that require targeted policy responses. The examples below illustrate how affordability pressures can manifest differently across specialist services and patient groups.

Paediatrics and Adolescent and Young Adult Medicine

Children with developmental, behavioural, neurodevelopmental and complex chronic conditions often require lengthy assessments, multidisciplinary management, coordinated care planning and ongoing engagement with families, schools, disability services and other providers.

Current Medicare funding arrangements do not always adequately reflect the time and complexity associated with contemporary paediatric practice. This can create financial pressures for both families and specialist services, particularly where care extends beyond traditional consultation models.

Reforming paediatric funding arrangements to better recognise comprehensive assessment, care coordination, multidisciplinary management and family-centred care would support improved access and help ensure the long-term sustainability of paediatric specialist services, particularly in communities experiencing workforce shortages and limited service availability.

Key Considerations

- Funding arrangements should better reflect the complexity of paediatric specialist care.
- Medicare settings should support multidisciplinary and family-centred models of care.
- Investment in paediatric specialist services should support timely access to assessment and early intervention.
- Affordability reforms should recognise the long-term social, educational and health benefits of early specialist care.

Geriatric Medicine

Access to specialist care for older people is influenced by more than consultation fees alone. Travel requirements, transport availability, waiting times, support person availability and the ability of residential aged care facilities to facilitate appointments can all affect whether specialist care is practically accessible.

Many older people require assistance from family members, carers or aged care staff to attend appointments or participate in telehealth consultations. These additional requirements can create hidden costs and practical barriers that are not reflected in traditional affordability measures.

Improving affordability therefore requires consideration of the broader costs associated with accessing specialist care, particularly for older Australians with complex and ongoing healthcare needs.

Key Considerations

- Recognise the indirect costs associated with accessing specialist care for older people.
- Support specialist outreach and telehealth models integrated with aged care services.
- Improve access to specialist services for residential aged care residents.
- Strengthen support for carers and care providers facilitating specialist consultations.

Addiction Medicine

People requiring addiction medicine services often experience significant financial disadvantage, unstable housing, unemployment and complex health and social needs. Affordability barriers may therefore have a disproportionate impact on access to care.

Telehealth can improve access to addiction medicine services, particularly in rural, regional and remote communities, by reducing travel costs and supporting continuity of care. Funding arrangements that support ongoing review and follow-up care are particularly important given the long-term nature of many addiction treatment pathways.

Improving affordability requires funding models that support continuity of care, multidisciplinary treatment and flexible access arrangements for populations experiencing significant barriers to engagement.

Key Considerations

- Expand telehealth access within addiction medicine services.
- Support funding arrangements that facilitate continuity of care and ongoing review.
- Improve access to multidisciplinary addiction treatment, including psychological services.
- Reduce financial and geographic barriers to specialist addiction medicine care.

Neurology

Neurology services face significant access and affordability challenges, particularly in regional and rural communities where specialist workforce shortages are common. Limited local access can require patients to travel long distances for consultations, investigations and ongoing specialist management.

While telehealth can support follow-up care for many neurological conditions, neurological assessment often relies on physical examination and in-person clinical review. As a result, telehealth alone cannot fully address access challenges.

Patients may also face substantial costs associated with specialist investigations, including magnetic resonance imaging (MRI) and other diagnostic services that are essential to neurological diagnosis and management.

Key Considerations

- Expand specialist outreach services to complement telehealth.
- Improve access to neurology services in regional and rural communities.
- Strengthen regional access to diagnostic imaging and specialist investigations.
- Support training and workforce development initiatives that improve long-term neurology workforce distribution.

Nuclear Medicine

Access to nuclear medicine services depends not only on specialist workforce availability, but also on funding arrangements, specialised infrastructure and access to diagnostic and therapeutic technologies.

Nuclear medicine physicians undertake substantial clinical work throughout therapeutic pathways, including assessment, consent, treatment planning, monitoring, dosimetry and follow-up care. However, aspects of this work may not be adequately recognised within existing funding arrangements.

Where funding mechanisms do not reflect the full scope of specialist involvement, access to services may be constrained and affordability barriers may increase for patients requiring highly specialised diagnostic and therapeutic care.

Key Considerations

- Ensure funding arrangements adequately recognise the clinical work associated with nuclear medicine services.
- Improve equitable access to specialised diagnostic and therapeutic technologies.
- Support workforce development in rapidly evolving areas of practice.
- Consider affordability impacts associated with high-cost diagnostic and therapeutic pathways.

Key Insight

These examples demonstrate that affordability is not simply a matter of consultation fees. Across specialties and population groups, affordability is shaped by the interaction between funding arrangements, workforce availability, service capacity, care models, geography and patient support requirements. Effective affordability reform will therefore require both system-wide solutions and targeted action addressing the unique barriers faced by specific populations and specialties.

Appendix 5: Specialty-Specific Delay Impacts

While delays in accessing specialist care affect all Australians, the nature and consequences of those delays vary across populations and clinical specialties. The following examples illustrate how cost, distance, workforce shortages and waiting times can contribute to poorer patient outcomes and increased pressure on the health system.

Developmental Paediatrics

Early assessment and intervention are critical for children and young people with neurodevelopmental conditions.

Delays in access to developmental paediatric services can postpone diagnosis, treatment and access to education, disability and family support services. Long waiting times may affect developmental outcomes, educational participation, social functioning, mental health and long-term wellbeing.

Children with ADHD frequently have co-occurring conditions including autism spectrum disorder, anxiety, learning difficulties and trauma-related presentations. Delays in assessment and treatment may therefore affect multiple aspects of a child's development and increase demand across health, education and social support systems.

Similarly, delays in autism assessment and intervention can reduce opportunities for early support and increase the likelihood that children and families will require more intensive services later in life.

Adolescents and Young Adult Medicine

Adolescence is a critical period for physical, psychological and social development.

Delays in specialist care may contribute to worsening mental health, reduced treatment adherence, disengagement from healthcare services and poorer educational and employment outcomes. Young people with chronic health conditions are particularly vulnerable during transitions between paediatric and adult healthcare services.

Failure to identify and address physical and mental health concerns during adolescence may lead to poorer long-term health outcomes and greater demand for healthcare services throughout adulthood.

Addiction Medicine

Delays in access to addiction medicine services can have immediate and serious consequences for patients, families and communities.

People experiencing alcohol and other drug dependence often require timely access to specialist assessment, treatment and ongoing support. Delayed access may contribute to worsening physical and mental health, increased hospital utilisation, avoidable mortality and ongoing social harm.

Improved access to addiction medicine specialists is particularly important in regional, rural and remote communities, where workforce shortages and service gaps remain significant.

Hub-and-spoke models, specialist advice services and integrated specialist-generalist networks offer opportunities to improve access while strengthening local healthcare capability.

Neurology

Delays in access to neurology services can have significant consequences for patients with progressive and disabling neurological conditions.

Timely specialist assessment is essential for conditions such as epilepsy, multiple sclerosis, neuromuscular disorders and other neurological diseases.

Extended waiting times may result in delayed diagnosis, delayed treatment initiation, worsening symptoms, avoidable disability, increased hospitalisation and reduced quality of life. Delays may also affect employment, education, independence and family functioning.

The impacts can be particularly significant where access to specialist nursing support, multidisciplinary services and diagnostic investigations is limited.

Sexual Health Medicine

Timely access to specialist sexual health medicine services is important for both individual patient outcomes and public health.

Delayed access can contribute to increased transmission of communicable diseases, delayed diagnosis, avoidable hospitalisations and missed opportunities for prevention and treatment.

Examples include delayed treatment of tuberculosis, HIV and viral hepatitis, as well as delayed identification and management of latent infections that may later progress to more serious disease.

Nuclear Medicine

For many cancer patients, delays in specialist assessment and diagnostic imaging can alter treatment pathways and affect survival outcomes.

Delayed or inaccessible molecular imaging may result in:

- delayed diagnosis
- less accurate staging
- inappropriate treatment selection
- progression from potentially curative to non-curative treatment pathways.

Patients living outside major metropolitan centres may face additional barriers where specialised imaging and therapeutic services are unavailable locally.

Delays may also increase healthcare expenditure through duplicated investigations, unnecessary treatments and avoidable hospital admissions.

Key Insight

Across populations and specialties, delayed access to specialist care can result in poorer health outcomes, greater disability, avoidable hospitalisation and increased healthcare costs. The impacts are often greatest for people with complex, chronic and progressive conditions, and for communities already experiencing significant barriers to healthcare access. Improving timely access to specialist care should therefore be viewed as both a health outcome imperative and a health system sustainability strategy.

Appendix 6: Specialty-Specific Innovative Models of Care

While many innovative models of care have broad applicability across the health system, some specialties and population groups require tailored approaches that reflect their unique clinical, workforce and service-delivery needs. The examples below illustrate models with significant potential to improve access, equity and health outcomes.

Nuclear Medicine: Hub-and-Spoke Theranostic Networks

Technology-dependent specialties such as nuclear medicine require specialised infrastructure, workforce expertise and supply chains that may not be feasible to replicate in every location. Hub-and-spoke networks provide an opportunity to improve access while maintaining quality and safety.

Under these models, highly specialised functions such as radiopharmaceutical manufacture, complex dosimetry and specialist oversight can be coordinated through metropolitan or tertiary hubs. Patient assessment, treatment administration, follow-up monitoring and surveillance imaging can then be delivered through accredited regional services supported by remote specialist governance and advice.

This approach has the potential to:

- Improve access to highly specialised therapies closer to home.
- Reduce patient travel and associated costs.
- Strengthen regional service capacity.
- Improve equity of access for regional and rural patients.
- Make more efficient use of specialist expertise and infrastructure.

Paediatrics: Strengthening Care for Children Model

Collaborative paediatric models that embed specialist expertise within primary care settings have demonstrated the potential to improve access and reduce pressure on hospital outpatient services.

The Strengthening Care for Children model integrated paediatricians within general practice through case discussions, co-consultations and ongoing specialist advice. These approaches demonstrated how specialist expertise can be extended beyond traditional referral pathways while supporting primary care capability and reducing unnecessary hospital utilisation.

Potential benefits include:

- Earlier access to specialist expertise.
- Reduced referrals to hospital outpatient services.
- Improved care coordination.
- Greater support for families and community-based care.
- Reduced pressure on hospital services.

Paediatrics: RACP National ADHD Care Model

Access to assessment and management of Attention Deficit Hyperactivity Disorder (ADHD) remains a significant challenge in many parts of Australia.

Innovative shared-care approaches can improve access while maintaining specialist oversight of complex cases. These models support greater involvement of appropriately trained general practitioners working in partnership with paediatricians and other specialists through:

- Shared-care arrangements.
- Clear referral pathways.
- Specialist consultation support.
- Multidisciplinary care planning.
- Consistent prescribing and management frameworks.

Such approaches may improve affordability, reduce waiting times and increase access for children and families living in regional, rural and remote communities.

Paediatrics: Thriving Kids Model

The Thriving Kids model demonstrates the value of integrated, community-based approaches to developmental care. The model brings together health, disability, education and family support services through multidisciplinary community hubs, supported by specialist oversight.

Potential benefits include:

- Earlier identification of developmental concerns.
- Improved care coordination.
- Reduced fragmentation between systems.
- More accessible services for families.
- Better long-term developmental, educational and health outcomes.

Addiction Medicine: Virtual Addiction Medicine Services

People living with substance use disorders frequently face substantial barriers to accessing specialist care, particularly in regional, rural and remote communities.

Virtual addiction medicine services provide opportunities to improve access through:

- Remote specialist assessment.
- Ongoing treatment and review.
- Shared-care arrangements with local providers.
- Reduced travel and geographic barriers.
- Greater continuity of care.

International experience has demonstrated the feasibility of online assessment and treatment models for addiction medicine. Expanding specialist telehealth clinics, virtual case review services and specialist support for local healthcare providers could significantly improve access for underserved communities.

These models are particularly valuable when integrated with:

- General practice.
- Mental health services.
- Community health services.
- Aboriginal Community Controlled Health Organisations (ACCHOs).
- Local hospital and primary care networks.

Key Insight

Innovative models of care should be tailored to the clinical realities of specific specialties and populations. Whether through hub-and-spoke networks, virtual specialist services, integrated paediatric care pathways or multidisciplinary community hubs, successful models share common characteristics:

- They extend specialist expertise beyond traditional hospital settings.
- They improve access to care closer to home.
- They strengthen collaboration across providers and sectors.
- They make more efficient use of limited specialist workforce capacity.
- They improve equity for populations facing the greatest barriers to care.

These targeted innovations complement the broader reforms outlined in Terms of Reference E and demonstrate practical pathways for improving access to specialist care across Australia.

Additional non-specialty-specific models include:

Remote Reporting, Supervision and Specialist Support

Digital technologies can enable specialist reporting, clinical supervision and multidisciplinary consultation to occur remotely. For specialties with highly subspecialised expertise, remote reporting and tele-supported service models may allow regional services to access expertise that would otherwise be unavailable locally.

Such models require:

- Reliable digital infrastructure and image-sharing capability.
- Appropriate funding arrangements.
- Nationally consistent governance and accreditation standards.
- Workforce development and training support.