

Inquiry into access and affordability of medical specialists in Australia

House of Representatives Standing Committee on Health, Aged Care and Disability

16 October 2026

Australian College of Nursing

australian college of nurse practitioners

apna Supporting nurses in primary health care

Australian College of Mental Health Nurses

CRANA plus improving remote health

CATSINaM Congress of Aboriginal and Torres Strait Islander Nurses and Midwives Unity and Strength through Caring

Australian College of Midwives

Cancer Nurses Society of Australia



Acknowledgement of Country

We acknowledge the Traditional Custodians of Country throughout Australia and their enduring connections to land, waters, culture and community. We pay our respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples on the lands on which we live, work and provide care.

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Submission Terminology and Professional Acronyms:

Unless otherwise specified within this submission, the term *'nursing and midwifery professionals'* is used as an inclusive term encompassing the breadth and depth of the nursing and midwifery workforce, across all roles, scope of practice, career stages and professional contexts.

RN – Registered Nurse

NP – Nurse Practitioner

GP – General Practitioner

CMHN – Credentialed Mental Health Nurse

EXECUTIVE SUMMARY

This joint submission welcomes the opportunity to contribute to the House of Representatives Standing Committee on Health, Aged Care and Disability inquiry into Access to and Affordability of Medical Specialists. It reflects the collective perspective of participating nursing and midwifery organisations committed to improving equitable, affordable, and timely access to specialist Healthcare for all Australians.

The submission contends that Australia's challenges in specialist access and affordability stem, not only from specialist workforce shortages and rising costs, but also broader structural issues in the way Healthcare services are organised, funded and delivered, including workforce utilisation, service integration, referral systems and models of care. Increasing specialist numbers will form part of the solution, but sustainable reform requires a comprehensive whole-of-workforce and whole-of-system response.

Across Australia, people experience significant barriers to accessing specialist care, including long waiting times, workforce maldistribution, rising out-of-pocket costs, geographic isolation, fragmented referral pathways and limited-service coordination. Many patients and carers navigate multiple appointments, repeated assessments, duplicated investigations and complex administrative processes before accessing specialist care, increasing costs to individuals and governments while placing additional pressure on primary care, hospitals and specialist services. These challenges disproportionately affect people living in regional, rural and remote communities, Aboriginal and Torres Strait Islander peoples, older Australians, people living with disability, and those experiencing socioeconomic disadvantage.

Nursing and midwifery professionals working in advanced practice, within their defined roles and scopes are qualified to assess, diagnose, treat, prescribe and coordinate care, often providing comprehensive care without requiring specialist referral. Medicare policy and funding arrangements that better use the nursing and midwifery workforces would improve access, reduce unnecessary referrals, and support timely, high-quality, safe, person-centred care.

Rising out-of-pocket costs for specialist consultations, diagnostics, treatment, travel and follow-up care are creating significant barriers to access, contributing to poorer health outcomes and increased pressure on hospitals. The Cormack Scope of Practice Review 2024[1] highlighted significant opportunities to improve access and system efficiency through better utilisation of the health workforce, including Medicare-funded services based on practitioner capability rather than professional type. Nurses and midwives are highly qualified to deliver, coordinate, lead and support care across a wide range of settings, yet funding, regulatory and administrative barriers continue to limit their contribution.

Rising out-of-pocket costs for specialist consultations, diagnostics, treatment, travel and follow-up care are creating significant barriers to access, contributing to poorer health outcomes and increased pressure on hospitals.



The central issue is not solely workforce supply, but how available workforce capability is used within the health system. Future reforms should focus on ensuring people receive care from the most appropriate provider, at the appropriate time, in the most appropriate setting. This requires a shift towards capability-based care, modernised referral systems, integrated multidisciplinary models and funding arrangements that support collaboration rather than fragmentation. Greater adoption of capability-based models of care; including multidisciplinary teams, shared care, telehealth, specialist outreach and community-based services, would improve access, reduce system bottlenecks, enhance continuity of care and better meet the needs of underserved communities.

Reforms must also prioritise Cultural Safety, equity and the removal of barriers to Healthcare access, particularly for Aboriginal and Torres Strait Islander peoples, people living with disability and communities experiencing the greatest challenges in accessing specialist care. Improving access and affordability will require policies and funding arrangements that support the full utilisation of workforce capability and enable more integrated, accessible and responsive models of care.

INTRODUCTION

Australia's health system is under increasing pressure from rising demand for Healthcare services, population ageing, the growing prevalence of chronic and complex conditions, workforce constraints, and persistent inequities in access to care.[2] These challenges are particularly evident in access to medical specialist services, where people across metropolitan, regional, rural and remote Australia experience significant barriers relating to availability, affordability, waiting times and geography.[3]

Access to timely, affordable specialist care is a critical component of a high-performing health system. While workforce shortages in some specialist disciplines contribute to access challenges, these issues are also driven by system design, including funding, regulatory and administrative arrangements that have not kept pace with contemporary models of care. As a result, many people experience unnecessary delays, duplication and fragmented care, while appropriately qualified health professionals are prevented from working to their full scope of practice. This includes the nursing and midwifery workforces, whose knowledgeable and skilled members provide highly specialised care across a range of settings.

Nursing and midwifery workforces are diverse and encompass a wide range of practitioner levels and scopes of practice. This includes Nurse Practitioners (NPs) and endorsed midwives who are advanced clinicians with expertise to assess, diagnose, treat, prescribe and manage care within their areas of practice. By providing comprehensive, autonomous care, they can often reduce the need for referral to medical specialists and improve timely access to healthcare services. Midwives are a distinct profession providing maternity care and services across public, private and community settings. They identify clinical need, coordinate care and initiate consultation, referral or transfer when medical specialist expertise is required. As primary maternity care providers, midwives have a central role in coordinating care and ensuring women and families can access specialist services when required.[4,5] Better use of the full capability of the nursing and midwifery workforces would improve access, reduce inefficiencies, strengthen care integration and support more equitable, person-centred Healthcare.

Access to specialist services must be considered within the broader context of health system reform, recognising that specialist workforce growth alone will not address barriers to access, affordability and equitable outcomes. Sustainable reform requires a coordinated approach that strengthens care coordination, modernises referral pathways, supports multidisciplinary and team-based care, expands virtual and outreach services, and enables the nursing and midwifery workforces to work to full scope of practice. This reform must also embed Cultural Safety and equitable, person-centred care, particularly for Aboriginal and Torres Strait Islander peoples and other underserved populations. This is especially critical in regional, rural and remote communities, where workforce shortages, geographic barriers and service gaps require flexible models that maximise the capabilities of the available health workforce and deliver timely, high-quality care closer to home.

This joint submission examines specialist access through a whole-of-system and whole-of-workforce lens. It focuses on opportunities to improve the equity, affordability and timeliness of specialist care through better workforce use, integrated models of care, capability-based approaches and person-centred system design. The recommendations that follow, identify practical opportunities to improve access, affordability and equity through workforce reform, care integration, modernised funding arrangements and capability-based models of care.

Together, these reforms have the potential to improve health outcomes, reduce unnecessary demand on hospitals and emergency departments, strengthen health system sustainability, and ensure all Australians can access timely specialist care regardless of postcode or socioeconomic circumstances.

RECOMMENDATIONS

Recommendation 1: Enable full scope of practice

Remove restrictive commonwealth, state and territory legislative, funding and administrative barriers that prevent nurses and midwives from working to their full scope of practice.

Recommendation 2: Reduce the total cost of care

Address affordability across the entire patient journey by reducing out-of-pocket costs associated with specialist care, diagnostics, medicines, travel and other Healthcare expenses.

Recommendation 3: Strengthen national reporting on Nurse Practitioner contributions

Implement routine reporting of Nurse Practitioner-initiated specialist referrals within Medicare and national health datasets to improve visibility of the NP workforce's contribution to specialist care, inform workforce planning, and support reforms that enhance equitable access to health services across all care settings.

Recommendation 4: Modernise Medicare funding

Reform Medicare Benefits Schedule (MBS) and related funding arrangements to support sustainable nurse and midwife led models of care across preventive health, chronic disease management, mental health, aged care, palliative care and maternity services.

Recommendation 5: Streamline referrals and diagnostics

Enable nationally consistent referral, requesting and diagnostic pathways for appropriately qualified nurses and midwives to reduce duplication, delays and unnecessary costs.

Recommendation 6: Strengthen multidisciplinary and continuity-of-care models

Invest in integrated team-based care, including nursing and midwifery continuity of care models to improve coordination, continuity, Cultural Safety, and timely access to specialist services across primary, community, residential and hospital settings.

Recommendation 7: Improve access equity

Assess all specialist care reforms through an equity and Cultural Safety lens. Expand telehealth, virtual care and outreach services to improve access to specialist care for people living in rural, regional and remote communities.

Recommendation 8: Improve transparency and accountability

Strengthen fee transparency and informed financial consent, and measure reforms against their impact on access, affordability, workforce use, equity and health outcomes.

Terms of Reference – Inquiry into access and affordability of medical specialists Australia

a) Examine current access to medical specialists in cities, regional and rural communities, with consideration of workforce distribution, shortages, waiting times and barriers to recruitment, retention and training.

Current access to medical specialists in cities, regional and rural communities

Access to medical specialists is not equitable across Australia and is strongly influenced by geographic location.[6,7,8] Specialist services are generally more accessible in metropolitan areas, where larger workforces and greater service availability support shorter travel distances and continuity of care. In contrast, people living in regional, rural and remote communities often face workforce shortages, longer waiting times and substantial travel requirements to access specialist services.

While the proportion of people accessing specialist consultations is similar in major cities and inner regional areas, use declines substantially with increasing remoteness.[9] This suggests that limited local availability of specialist services continues to affect access for people living in remote and very remote Australia, who frequently rely on a range of primary Healthcare providers, including General Practitioners (GPs) and NPs, to address health needs locally that might otherwise be managed by specialist services.

These geographic disparities contribute to inequitable access to timely care and poorer health outcomes. Compared with people living in metropolitan centres, the more than 7.3 million Australians residing in rural and remote areas experience shorter life expectancy, higher rates of preventable illness, and more frequent avoidable hospitalisations.[10] These challenges, compounded by workforce shortages and barriers to timely specialist and diagnostic services, highlight the need for funding and service delivery models that improve access to care regardless of geographic location or provider type.[11]

Case Study: Improving access to cancer care through NP-led pathways

Geographic inequities in cancer care result in delayed diagnosis and treatment, particularly for Aboriginal and Torres Strait Islander peoples in regional, rural and remote communities, who often require access to multiple specialist services. These delays increase travel burdens, worsen health outcomes and compound existing inequities.

NPs can safely initiate and coordinate many aspects of the cancer care pathway within their scope of practice, including referral to medical specialists where clinically appropriate. However, patients referred by NPs may receive lower Medicare rebates than those referred by medical practitioners, and NPs remain unable to directly access some Medicare-supported diagnostic and imaging services that are critical to cancer care. For example, Positron Emission Tomography (PET) imaging is an essential component of many cancer pathways for diagnosis, staging and treatment monitoring, yet Medicare-funded access often requires referral through a specialist or other eligible medical practitioner. This creates additional steps, delays access to investigations, and may necessitate further travel and appointments, particularly for patients in rural and remote areas.

Expanding NP access to Medicare-supported diagnostic, imaging and referral pathways within their endorsed scope of practice would support earlier diagnosis and treatment, reduce unnecessary delays where specialist services are limited, and improve equitable access to cancer care. This reform would complement specialist-led services by enabling NPs to practise more effectively as part of multidisciplinary cancer care teams, while ensuring patients receive timely, coordinated care closer to home.

Understanding access requires recognising the contribution of the full Healthcare workforce

It is important to acknowledge that commonly reported Medicare specialist attendance data does not fully reflect all referral pathways operating within the Australian health system.[12]

While NPs can provide valid referrals to medical specialists and consultant physicians under Medicare arrangements, national reporting on Medicare-subsidised specialist attendances does not routinely publish data on referral source.[13] As a result, workforce data may underestimate the extent to which NPs facilitate access to specialist care, as well as the advanced clinical services that nursing and midwifery professionals independently provide within their scope of practice.

This is particularly significant in communities where access to GPs and medical specialists is constrained. Improving recognition and reporting of NP-generated referrals together with the advanced clinical services delivered by nursing and midwifery professionals, would provide a more accurate picture of patient pathways and workforce use across the health system.

> *These findings demonstrate that access to specialist care is not experienced equally across the Australian population.*

Equity of access

Barriers to specialist care extend beyond geographic location and continue to disproportionately affect Aboriginal and Torres Strait Islander peoples and other underserved populations.

According to AIHW reporting, around 18.3% of Australians delayed or did not see a medical specialist when they needed to. Barriers were more commonly reported by females, people aged 25-34 years, those aged 85 years and over, and people living with long-term health conditions.[14,15]

These access challenges are particularly important for Aboriginal and Torres Strait Islander peoples. In the National Aboriginal and Torres Strait Islander Health Survey, 30% of First Nations people reported needing to see a Healthcare provider but not doing so on at least one occasion during the previous 12 months.[16] Among those unable to access care, one-third identified barriers related to service availability, transport or distance. Waiting times, lack of local services and limited transport options were reported significantly by people living in remote areas than in non-remote areas.[17]

The inequity is also evident in specialist use. Medicare specialist claim rates among First Nations people were substantially lower in remote and very remote areas (161 per 1,000) than in major cities (860 per 1,000 population); and across remoteness areas, specialist Medicare claim rates for First Nations people were 24% to 70% lower than for non-Indigenous Australians.[18]

These findings demonstrate that access to specialist care is not experienced equally across the Australian population. Reform must address workforce distribution, waiting times, local service availability, referral systems, transport barriers and culturally safe models of care.

Case Study: Keeping women connected to care, community and Country

Sarah is a 26-year-old Aboriginal and Torres Strait Islander female living in a remote Australian community and expecting her first child. While routine antenatal care is available locally, ultrasound appointments, specialist obstetric care and birthing services require travel more than 400 kilometres to a regional centre.

As her pregnancy progresses, Sarah must travel frequently for appointments and is required to relocate before birth, spending several weeks away from her family, community and Country. This creates significant emotional, social and financial burdens and perpetuates intergenerational trauma.

Throughout her pregnancy, Sarah receives care through a continuity of care model led by a known midwife, who coordinates her care, arranges specialist consultations and provides culturally safe support. Without access to this model, Sarah would need to navigate multiple providers across different locations, increasing the risk of fragmented care, missed appointments and delays in accessing services, all contributing to worsened health outcomes.

The maternity scenario above demonstrates that access to specialist maternity care in rural and remote Australia depends, not only on the availability of obstetricians, but also on a sustainable midwifery workforce capable of coordinating and delivering care across the pregnancy continuum.

The closure of rural maternity services can require women to travel or relocate to access antenatal care, diagnostic services, specialist appointments and birth. In 2025, 7.9% of maternity models routinely required women to relocate before labour, increasing to 28% in the Northern Territory, 14% in Western Australia and 13% in Queensland. These arrangements impose substantial clinical, financial and social burdens, creating barriers to specialist maternity care and often resulting in separation from family, community and support networks, particularly for First Nations women.[19,20,21]

> *Privately practising endorsed midwives are also an important component of the rural maternity workforce.*

A sustainable midwifery workforce is fundamental to maintaining access to specialist maternity care. Midwives are often the primary providers coordinating care, facilitating referrals, supporting telehealth consultation with specialists and identifying when escalation is required. Continuity of care models strengthen this coordination while improving both workforce retention and women's experiences and outcomes of care. Approximately one-third of midwives surveyed through the Midwifery Futures project reported considering leaving the profession due to negative workplace experiences. Improving retention requires safe staffing levels, opportunities to practise to full scope, access to continuity of care models, strong professional support and reliable pathways to specialist consultation and retrieval services when required. [22]

Privately practising endorsed midwives are also an important component of the rural maternity workforce. In several regional, rural and remote locations, the number of privately practising midwives equals or exceeds the number of locally available obstetricians.[23] Through the provision of continuity of care and homebirth services, these midwives have a critical role in maintaining local maternity access where service options are otherwise limited.

Workforce distribution, shortages and waiting times

A major contributor to specialist access challenges is the maldistribution of the health workforce.

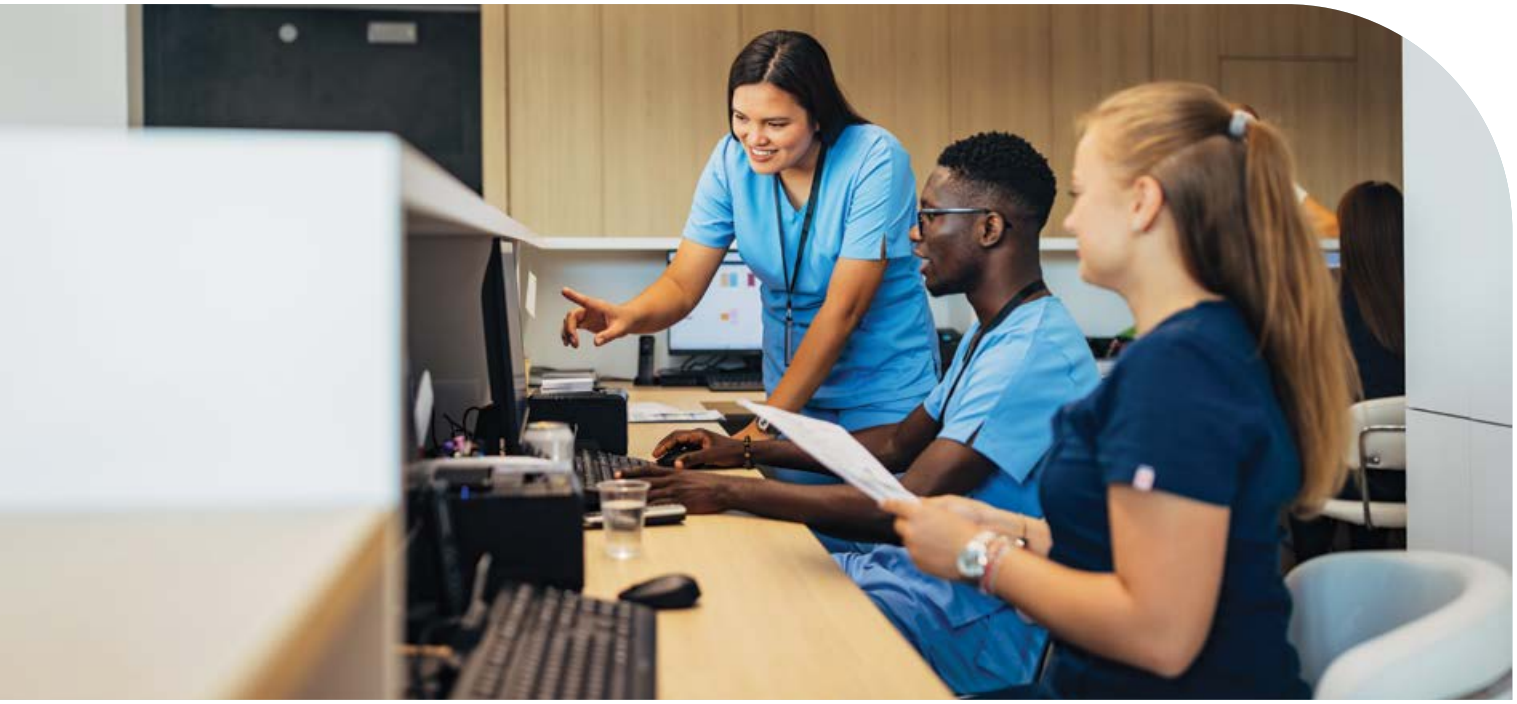
In 2023, specialist workforce varied substantially across Australia, ranging from 169 FTE per 100,000 population in metropolitan areas (MM1) to significantly lower levels in rural and remote areas, with 16 in MM5 areas, 77 in MM6 areas and 31 in MM7 areas.[24] In 2024-25, approximately one-third of people living in major cities and inner regional areas received at least one specialist consultation, compared with only 12% of people living in very remote Australia.[25]

People living in rural and remote Australia are significantly less likely to access specialist medical care than those living in metropolitan areas. Lower utilisation rates are often associated with the limited availability of local specialist services and greater reliance on general practitioners, nurses, midwives and other local providers to meet healthcare needs.[26]

However, access to specialist care is influenced by more than workforce distribution alone. System-level factors, including referral pathways, funding arrangements, travel requirements, service coordination, access to diagnostic services, and restrictions on the scope and utilisation of other health professionals, can also affect the timeliness and accessibility of specialist care.

Workforce shortages in specialist disciplines contribute to longer waiting times for consultations, diagnostics and elective procedures, placing additional pressure on primary care, hospitals and community health services. However, increasing specialist numbers alone will not address inequities in access where patients continue to experience fragmented care pathways, financial barriers and challenges navigating the health system.

Importantly, these challenges are not confined to rural and remote settings. Patients in some regional areas and cross-jurisdictional catchments, including the ACT and surrounding NSW regions, may also experience significant delays, travel burdens and service gaps when specialist services are limited or poorly coordinated. These examples demonstrate that improving access to specialist care requires both specialist workforce solutions and broader system-level reforms that strengthen care coordination, streamline access pathways and support the full utilisation of all health professionals working to their scope of practice.



Investing in Advanced Practice to Strengthen Access and Capacity

A sustainable health system requires investment not only in workforce development, but in funded and supported roles that enable advanced practice clinicians to contribute their full value. Ensuring the availability of funded, supported and enduring NP positions would improve recruitment and retention, reduce workforce attrition, and better utilise a highly skilled workforce whose expertise remains underused. This would strengthen service capacity, improve access to care, and support more responsive and efficient models of care by enabling patients to receive care from the most appropriate clinician, which includes highly qualified nursing and midwifery professionals.

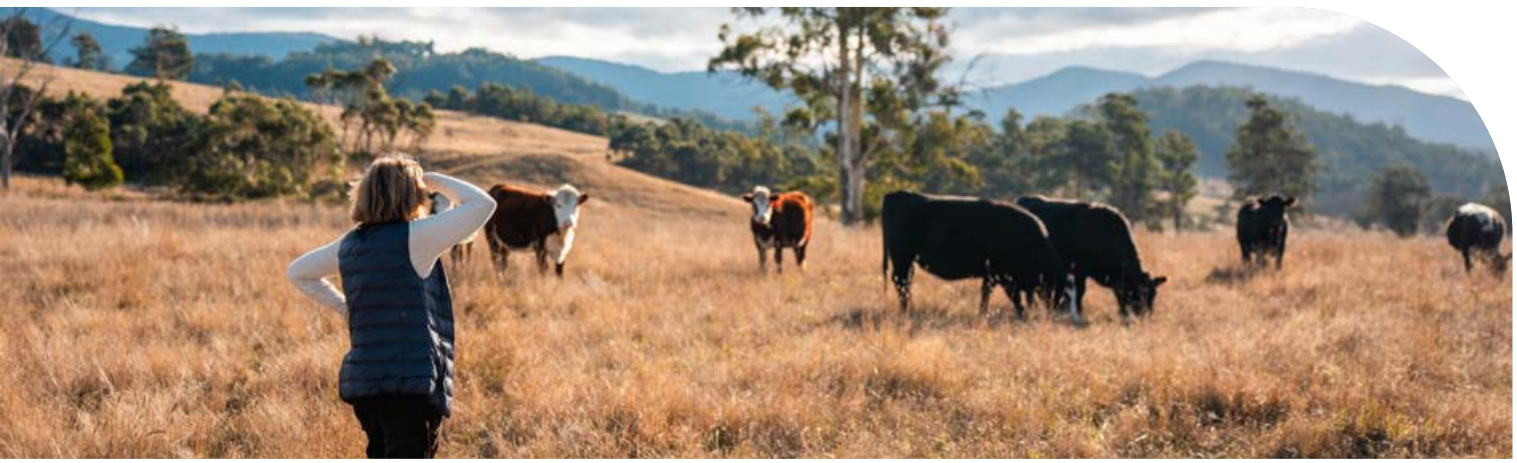
Telehealth and local workforce capability

Telehealth provides an important opportunity to improve access to specialist care, particularly in rural and remote communities and unlocking the 12-month face-to-face rule for regional and remote telehealth would ensure people have timely access to the care they need. Although evidence indicates telehealth is most effective when integrated within locally based models of care rather than used as a standalone substitute for face-to-face services, this should not create barriers to access where geographic isolation or service availability may otherwise prevent a person from accessing affordable care.[27] Research conducted across remote Australian communities also found that many people require support from local Healthcare workers to facilitate consultations, coordinate care and manage associated administrative processes.

The study concluded that for this cohort telehealth works best as a complementary component of broader care models.[28]

These findings reinforce the importance of a strong local Healthcare workforce. Nursing, midwifery and Aboriginal and Torres Strait Islander Health Practitioners and workers have a critical role in preparing patients for consultations, coordinating referrals, supporting ongoing management and ensuring Culturally Safe care close to home. Improving access to specialist care through telehealth therefore requires investment not only in technology, but also in locally based health workforces enabled to work to full scope and multidisciplinary models of care that support continuity, Cultural Safety and community connections.[29]

Australia's specialist access challenges are driven not only by shortages in specialist medical workforces but also by longstanding maldistribution of services, workforce utilisation barriers and limitations within current models of care. These challenges are most pronounced in regional, rural and remote communities, where waiting times, travel requirements and local service availability continue to affect timely access to specialist expertise. Improving access will require coordinated action to strengthen recruitment and retention, support and maximise the capability of all locally based Healthcare workforces, expand multidisciplinary models of care, improve workforce reporting and enable appropriately qualified health professionals to work to their full scope of practice. Such reforms would improve timely access to specialist expertise while ensuring care is delivered as close to home as possible.



b) Examine the effectiveness, transparency and equity of referral pathways from the perspective of patients, primary Healthcare practitioners and medical specialists across the public and private health sectors, with consideration of factors affecting referral patterns and any systemic, regulatory or administrative barriers to the appropriate utilisation of these pathways.

Referral pathways should reflect the contemporary health workforce

Australia's health system has evolved considerably; however, elements of the MBS and associated referral pathways have not kept pace with contemporary models of care. Current arrangements do not consistently reflect the capability, scope of practice and contribution of the modern health workforce.

Referral requirements can create unnecessary complexity for people, primary healthcare practitioners and specialists. The Commonwealth's recent consultation on modernising referral pathways recognised concerns about whether existing Medicare arrangements effectively support timely and equitable access to specialist care. Proposed reforms, including providing people with a copy of their referral, introducing indefinite referral validity by default, and enabling continuity of treatment with a different practitioner under the same referral, have the potential to improve transparency, reduce administrative burden and provide people with greater flexibility and choice in accessing specialist services. Importantly, these measures may also reduce avoidable consultations and associated costs.

However, broader reform is needed to address practitioner-specific barriers within referral pathways and Medicare entitlements. While NP referrals are recognised for Medicare-subsidised specialist services, acceptance remains inconsistent, with some specialists requiring people to obtain an additional GP referral before an appointment can proceed.

This variability may reflect ongoing misconceptions about the NP role and limited understanding of NPs' autonomy, advanced clinical capability and legislated scope of practice.

These barriers are compounded by practitioner-specific MBS restrictions, which can result in people receiving different Medicare rebates or entitlements depending on which appropriately qualified health professional initiates a referral, consultation or investigation. People should not incur additional costs, receive lower Medicare benefits, or be required to attend another practitioner solely because their care was appropriately initiated by an NP. Such arrangements duplicate care, create unnecessary costs and delays, reduce system efficiency, and place additional pressure on an already stretched health system, particularly where an NP or endorsed midwife is the person's primary healthcare provider. They also introduce an unnecessary step into an otherwise appropriate and clinically established care pathway.

Unlocking and strengthening the local workforce to improve access

Modern referral pathways should support the full utilisation of the health workforce, enabling appropriately qualified clinicians to provide care to the full extent of their education, training and competence. Addressing access challenges requires a whole-of-workforce approach that recognises and enables the contribution of all health professionals. Many health conditions can be safely and effectively assessed, diagnosed, treated and managed by appropriately qualified clinicians without specialist intervention, while ensuring timely referral when specialist expertise is required. All regulated health professionals are educated, trained and accountable for practising within their scope of practice and escalating care when necessary. Removing unnecessary legislative, regulatory and operational barriers would improve access, strengthen care coordination, and ensure specialist services remain available for people whose needs genuinely require specialist care.

National workforce data demonstrates the critical role of nurses, midwives and Aboriginal Health Workers in delivering care outside metropolitan areas, where they are often among the most accessible healthcare professionals. Enabling these clinicians to work to their full scope of practice would maximise workforce capacity, improve timely and culturally safe access to care, and reduce unnecessary reliance on specialist services by ensuring care is delivered by the most appropriate provider when safe, effective and clinically appropriate.

While NPs and endorsed midwives can refer people to medical specialists, significant limitations remain within broader Medicare-funded referral pathways. For example, NPs are unable to initiate Mental Health Treatment Plans or Chronic Disease Management plans, limiting their ability to directly refer people to allied health services under these programs. Similar restrictions apply to other Medicare-funded initiatives, including menopause and perimenopause health assessment items and aspects of the Better Access initiative. These limitations require unnecessary duplication through GP appointments to access services that an NP has already determined are clinically appropriate. Addressing these barriers would strengthen multidisciplinary care, improve system efficiency, and help ensure people receive the right care from the right provider at the right time. [30]

Mental Healthcare provides a clear example of the need for a contemporary whole-of-workforce approach. In many regional, rural and remote communities, access to psychiatrists and other specialist mental health services is limited, with lengthy waiting times common. Credentialed Mental Health Nurses and Mental Health NPs play a critical role in providing assessment, therapeutic interventions, care coordination, risk monitoring and ongoing management while people await specialist services.

Current Medicare referral arrangements can nevertheless create avoidable barriers to timely specialist mental Healthcare. Enabling NPs to refer directly to psychiatrists would streamline access to specialist assessment and treatment, reduce unnecessary delays, and improve care pathways, particularly in communities experiencing medical workforce shortages. Strengthening utilisation of the mental health nursing workforce and aligning referral pathways with NP capability and scope of practice, would improve continuity of care, reduce deterioration during waiting periods, and enhance access to specialist-informed mental health services closer to home.

Case Study: Mental health nursing bridging gaps in access to specialist care

Michael, a 42-year-old man with severe depression, anxiety and alcohol dependence, faces a six-month wait for psychiatric care in his regional community. During this period, a CMHN provides assessment, therapeutic interventions, risk monitoring, care coordination and support for social and alcohol-related issues. As his needs increase, a Mental Health NP undertakes further assessment, adjusts treatment within scope, and coordinates specialist medical referral.

As a result, Michael remains engaged in care, avoids deterioration and potential hospital admission, and reaches specialist psychiatric services in a more stable condition. This highlights the critical role of CMHNs in improving access, continuity of care and patient outcomes.

Nursing referral pathways

Referral pathways can create significant barriers for nurses practising at advanced levels and for the people they support.

Despite regularly coordinating care and facilitating access to health services, RNs are unable to directly refer people to specialist services or consultant physicians for Medicare-funded care under current *Health Insurance Regulations 2018* (clause 95-96). RNs who are not endorsed as NPs or midwives cannot make these referrals, even if it is within their scope of practice. As a result, referrals are frequently 'double handled' requiring a person to attend an additional appointment with a GP (with an out-of-pocket expense) or NP before accessing the required service. For example, an appropriately qualified RN managing a known mental health patient may be unable to refer directly to a mental health service and instead must direct the patient to obtain a GP or NP referral. This again creates additional appointments and the unnecessary involvement of other practitioners; delays access to care and increases system inefficiency.

Australian Primary Healthcare Nurses Association's (APNA) 2025 workforce survey data indicate more than half of primary Healthcare nurses regularly refer to external practitioners and services, highlighting the extent of this burden.[31]

Modern referral pathways should enable appropriately qualified clinicians to work to their full capability while making it easier for people to understand and access the care options available to them. This would improve access, reduce duplication and support more efficient, person-centred care.

> *Referral pathways can create significant barriers for nurses practising at advanced levels and for the people they support.*

Endorsed midwife referral pathways

Expanding endorsed midwife referral pathways would improve transparency, reduce duplication, and support equitable access to multidisciplinary maternity care, regardless of location.[32]

Existing referral arrangements do not adequately reflect the role of endorsed midwives as primary maternity care providers and create barriers to effective care coordination.[33] Although endorsed midwives can assess, diagnose and manage care across the maternity continuum, referral rights remain restricted to obstetricians and paediatricians.[34,35] For example, if a midwife detects a thrombophilia during pregnancy, they are unable to directly refer the woman to a haematologist. Instead, the woman is referred to a GP or obstetrician, who can then facilitate a referral to the specialist.

Midwives not being able to refer directly to specialists results in additional appointments, increased costs and delays in accessing clinically indicated services for women.[36] These barriers are particularly significant in regional, rural and remote communities where workforce shortages and geographic distance already limit access to specialist care.

Diagnostic and imaging pathways

Current arrangements for imaging and diagnostic investigations do not consistently align with practitioner scope of practice, with MBS restrictions resulting in different Medicare entitlements depending on which clinician initiates a clinically appropriate investigation. Requiring specialist involvement solely to meet Medicare requirements, where a qualified health professional can safely order the investigation, creates unnecessary costs, delays and complexity. These arrangements can impede timely diagnosis and treatment, particularly in communities with limited access to specialist care, while also increasing costs to health services through the duplication of consultations and clinical assessments.

Telehealth-enabled referral pathways

Telehealth provides an important opportunity to improve access to specialist care, particularly in rural and remote communities. Removing the 12-month face-to-face requirement for regional and remote telehealth would help ensure people can access the care they need. While telehealth is most effective when integrated within locally based models of care, rather than used as a standalone substitute for face-to-face services, requirements should not create additional barriers where geographic isolation, workforce shortages or limited-service availability already restrict access.

Further reform should support access to specialist mental Healthcare via telehealth without requiring a prior face-to-face assessment, recognising the significant barriers people may experience in accessing psychiatric and other specialist mental health services. NPs have long provided expert mental Healthcare via telehealth in rural, regional and underserved communities, and their expertise should be fully utilised within contemporary models of care to support timely and equitable access.

More broadly, referral pathways remain fragmented, practitioner-dependent and not always aligned with contemporary multidisciplinary models of care. Regulatory and administrative barriers limit the effective utilisation of appropriately qualified health professionals, including NPs, CMHNs endorsed midwives and other advanced practice nurses. A modern referral system should be capability-based rather than practitioner-dependent, support multidisciplinary care, and enable timely access to diagnostics and specialist services. Consumers should be able to access the most appropriate pathway based on their clinical needs and choice, regardless of their location, provider type or service setting.



c) Examine the affordability of specialist services, including out of pocket costs for consultations, diagnostics, procedures, and patient access to specialists through public health services, as well as factors influencing fee setting by specialists in the public and private health sectors.

Rural and regional access: the hidden costs created by specialist-dependent Medicare pathways

The affordability of specialist care cannot be considered in isolation from broader issues related to workforce distribution, referral pathways, geographic accessibility and the organisation of Medicare-funded care. While consultation fees are a significant component of Healthcare costs, affordability is also influenced by the number of appointments required, travel distances, waiting times, eligibility for Medicare rebates, access to diagnostics, and the need to navigate multiple Healthcare providers.[37,38]

For many Australians, particularly those living in rural, regional and remote Australia, these factors create substantial indirect and cumulative costs, delaying or preventing access to clinically appropriate care. For Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, people with disability and other priority populations, access is further influenced by the Cultural Safety and appropriateness of services. Affordability and accessibility are therefore intrinsically linked.

> *People should not face higher out-of-pocket costs for the same clinically appropriate service solely because it is delivered by a different qualified health professional.*

Specialist-dependent Medicare pathways

Medicare funding arrangements do not adequately reflect contemporary models of care and continue to rely on practitioner-specific eligibility rather than clinical need, practitioner capability and service delivery. [39] Current funding settings also affect the viability of NP-led models of care. Lower Medicare rebates for NP services, combined with the exclusion of NP-led practices from key primary care funding initiatives such as MyMedicare, limit service sustainability and reduce opportunities for people to access affordable care through alternative models.

As a result, NP-led practices may be required to rely more heavily on private patient fees to remain financially viable, creating inequitable access to care. People should not face higher out-of-pocket costs for the same clinically appropriate service solely because it is delivered by a different qualified health professional.

Numerous MBS items for assessments, diagnostics and procedures remain linked to practitioner type rather than health need and practitioner capability. This can require people to obtain an additional specialist consultation solely to access a Medicare-funded diagnostic or treatment pathway, creating unnecessary costs, duplication and delays for both patients and health services. For example, a person with a clinically indicated musculoskeletal condition who has already been assessed by a GP or NP may still be required to see a specialist where access to an MBS-rebated MRI depends on the type of practitioner making the request.

Funding and access arrangements should recognise the service provided and the competency of the practitioner delivering it, rather than professional title alone. Where an appropriately educated, trained and authorised health professional can safely provide a service, consumers should have access to the same Medicare-supported care regardless of practitioner type. For example, the removal of a long-acting reversible contraceptive (LARC) is the same clinical procedure irrespective of whether it is performed by a NP, endorsed midwife or medical practitioner.

A more equitable approach would better utilise the available workforce, improve service sustainability, and enhance consumer access to timely and affordable care.

Where a Medicare rebate for MRI is dependent on a specialist request, that patient may be required to:

1. obtain a referral to the specialist;
2. wait for and potentially travel considerable distance to attend the specialist consultation;
3. obtain the MRI request;
4. travel to access the MRI if it unavailable locally; and
5. return to the specialist for review and ongoing management.

The resulting costs extend beyond consultation fees and may include additional medical fees, imaging costs, transport, accommodation, meals, parking, childcare, time away from work and, in some cases, travel for carers and support persons. The burden is even greater for people living with disability, frailty, chronic disease, limited mobility or socioeconomic disadvantage.

Alternatively, the person may obtain appropriate imaging locally following assessment by a GP or NP but face higher out-of-pocket costs because the request does not satisfy practitioner-specific MBS requirements. Where referrals expire before services can be accessed, people may incur additional consultations and associated costs simply to recommence the pathway.

Case study: Referral barriers and increased patient costs

A RN working in an advanced practice role within an Urgent Care Clinic assesses a patient who presents following a fall with a suspected fractured wrist. Using advanced assessment skills and working within scope of practice, the nurse determines that imaging is required. However, due to restrictions on diagnostic imaging requests, the patient must be referred to a NP who repeats the assessment and orders the X-ray.

The X-ray confirms a fracture requiring immobilisation and orthopaedic follow-up. The RN reviews the imaging results, reassesses the patient and applies an appropriate plaster product. However, despite managing the patient's care to this point, the nurse is unable to refer directly to the public orthopaedic fracture clinic. The local hospital also does not accept referrals from NPs. Consequently, the patient must attend an additional appointment with their GP solely to obtain a referral for specialist follow-up.

This pathway requires multiple assessments by different clinicians despite no change in the clinical outcome. The administrative restrictions create unnecessary duplication of care, delay access to specialist review and generate additional costs for the patient, including consultation fees, travel costs and time away from work or other responsibilities. These impacts are particularly significant in rural and remote communities where access to Healthcare providers may already be limited.

Geographic inequity and priority populations

Medicare arrangements that link access to practitioner types can create significant geographic inequities in access to care. A consumer's ability to access a Medicare rebate may depend not only on their clinical need and the capability of their treating health professional, but also on whether they can access the specific category of practitioner authorised to initiate the service. This particularly disadvantages people in rural, regional and remote communities, where access to some health professionals and specialist services may already be limited.

This inequity disproportionately affects Aboriginal and Torres Strait Islander peoples, who are more likely to live in regional, remote and very remote areas where access to medical specialists is limited. The impact is significant. Approximately 24.8% of Aboriginal and Torres Strait Islander peoples live in Inner Regional Australia, 19.0% in Outer Regional Australia, and a further 15.4% live in Remote or Very Remote Australia.[40]

In many of these communities, NPs are among the most accessible advanced clinical providers. However, Medicare restrictions continue to limit people's ability to access fully funded diagnostic and treatment pathways based on practitioner type rather than clinical need.[41] Addressing these barriers would support the objectives of the National Agreement on Closing the Gap, improving timely access to diagnosis, treatment and culturally responsive care.

Out-of-pocket costs

Out-of-pocket expenditure remains a significant barrier to Healthcare access, accounting for approximately 18% of Australia's total health expenditure.[42]

Costs continue to increase across both public and private Healthcare settings. Privately insured Australians face growing out-of-pocket expenses for specialist consultations and hospital-based care, while maternity consumers experience some of the highest personal Healthcare costs. For those with private health insurance, the average out of pocket cost per episode of care for medical services has risen to $260.74 and risen to $513 for hospital episodes.[43] Women giving birth in private hospitals incur average out-of-pocket charges of approximately $4,915 compared with $572 in public hospitals, with obstetric services representing the largest contributor.[44]

The increasing cost of living means these expenses are having a growing impact on access to care for those experiencing socioeconomic disadvantage.[45] Consistent with this trend, the Australian Bureau of Statistics reported the 8.6% of Australians who delayed or did not see a medical specialist in 2024–25, did so because of cost.[46]

Australia's medical imaging market is largely comprised of for-profit corporations and with no regulation on fees, these corporations have the freedom to set their own fees and choose whether they bulk-bill patients. Government have set levels of Medicare fees and rebates; however, this model has resulted in unclear out-of-pockets costs to people who may not be aware of the variability of pricing depending on service provider.[47] This lack of transparency, regulation and standardisation can impact ability to access diagnostic testing resulting in delays in specialist care.

Case study: Hidden imaging costs within public specialist care

A woman with a high-risk pregnancy receives specialist maternity care through a public hospital, incurring no out-of-pocket costs for obstetric or midwifery appointments. However, specialist management requires serial fetal ultrasounds every four to six weeks. Despite receiving public specialist care, she incurs more than $700 in out-of-pocket imaging costs alone, excluding medicines, equipment and other Healthcare expenses associated with her pregnancy.

This example illustrates how affordability barriers can remain significant, even when specialist consultations themselves are publicly funded.

Those living in rural, regional and remote communities are further disadvantaged with additional transport and accommodation costs required on top of gap fees or medical service fees. People are often required to travel considerable distances to attend specialist appointments, only to discover consultation fees and gap payments are substantially higher than anticipated and beyond their financial means. This can result in delayed care, cancelled appointments, additional travel costs and worsening health outcomes.[48,49]

High out-of-pocket costs can increase financial strain and can also restrict access to appropriate Healthcare for people with limited financial resources, especially for those with cancer.[50] Improving the affordability of cancer care requires practical solutions to reduce out-of-pocket costs, improve access to timely care, and make better use of the existing health workforce. NPs are well positioned to contribute to these objectives, yet current MBS arrangements continue to limit the full potential of NP-led models of care.

While recent reforms have removed the legislative requirement for collaborative arrangements between NPs and medical practitioners, improving professional autonomy and access to Medicare-funded care and Government incentives as well as further MBS reform is also needed to address ongoing barriers to affordable cancer care.

Expanding and modernising MBS support for nurse-led cancer services could improve affordability across the cancer journey.[51] Dedicated MBS items for cancer survivorship care, treatment monitoring, symptom management, supportive care and care coordination would enable patients to access timely, high-quality services closer to home. Such models could reduce unnecessary specialist appointments and associated costs for rural and regional patients, and support earlier intervention when complications arise.

Further reform is needed to ensure NP referrals provide equitable access to Medicare-funded allied health and supportive care services. Removing remaining funding and referral barriers would reduce duplication, streamline access to multidisciplinary care, and enable consumers to receive timely, affordable and coordinated care from the most appropriate health professional.

Fee transparency

Greater transparency of specialist fees is essential to support informed consumer choice and improve access to care. Consumers should receive clear information regarding expected out-of-pocket costs before appointments wherever practicable.

For people travelling long distances, advance provision of fee estimates, and financial consent information is particularly important. This allows consumers to make informed decisions before incurring travel and accommodation costs and reduces the risk of financial hardship associated with accessing specialist services.

The Australian Government's proposed reforms through the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026* are welcomed and represent a positive step towards improving price transparency.[52] However, transparency should extend beyond specialist consultation fees to include diagnostic imaging, pathology, procedures, follow-up consultations and other likely costs associated with an episode of care.

The *Medical Costs Finder* [53] has the potential to assist consumers in understanding likely out-of-pocket expenses before treatment. Greater awareness and promotion of this resource through general practice, specialist referral pathways, hospitals and consumer health organisations could support informed decision-making and reduce the risk of unexpected Healthcare costs, as well as encourage greater use of the service by medical specialists.

Consumer information should be presented in accessible language and clearly distinguish between a clinician's fee and the Medicare rebate, recognising that many patients incorrectly assume that Medicare rebates fully cover the cost of care. Information should also provide meaningful insight into variations in costs between providers.

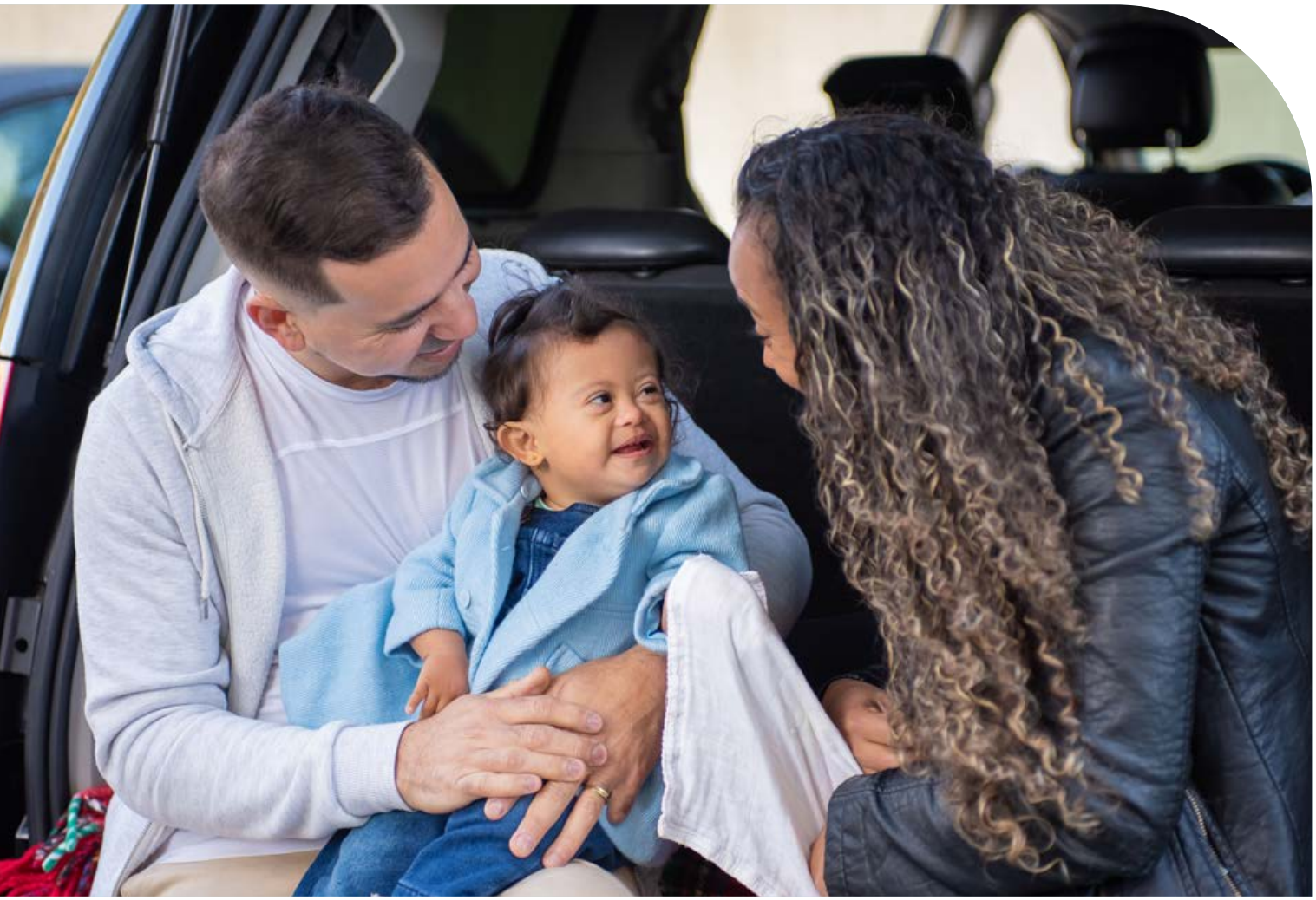
Cost transparency initiatives should support informed decision-making rather than simple price comparison. Where feasible, consideration should be given to incorporating appropriate quality indicators alongside cost information to help consumers assess affordability in the context of quality, outcomes and suitability of care.

Social impacts and indirect costs

Patients and carers may be required to take leave from work, arrange childcare, travel significant distances, temporarily relocate, or be separated from family, community and cultural obligations. These impacts are particularly pronounced in regional, rural and remote communities.

The cumulative financial burden associated with repeated appointments can contribute to significant financial stress, which is itself associated with poorer mental health outcomes, including increased psychological distress, anxiety and depression.[54]

For Aboriginal and Torres Strait Islander peoples, travelling away from Country to access Healthcare can also have substantial social, cultural and emotional impacts, further influencing whether people are able to access, continue and benefit from specialist care. These indirect costs and burdens are exacerbated when health system requirements create unnecessary barriers to accessing specialist care. Nurse-led and midwifery-led advanced practice services are often unable to directly refer patients into specialist pathways despite possessing the expertise to identify the need for specialist assessment. Patients are instead redirected to a GP or NP solely to facilitate referral requirements, increasing costs, delaying care and fragmenting service delivery.



d) Examine the impact on patient outcomes by delays due to cost, distance and waiting times, and broader system impacts on primary care, emergency departments, public hospitals, chronic disease management, as well as impacts on people due to deferred or missed care

The impact of specialist access barriers is not measured solely by waiting times. It is reflected in what occurs while people wait. Delayed access to specialist assessment, diagnosis and treatment can contribute to disease progression, preventable complications, deterioration in physical and mental health, increased pressure on carers and families, and growing demand across primary care, emergency departments and public hospitals.

For many Australians, delays arise from the combined effects of cost, workforce shortages, travel requirements, limited-service availability and fragmented referral pathways. These barriers can result in specialist care being delayed, deferred or forgone altogether, creating consequences for individuals, communities and the broader health system.

The Impact of Financial Uncertainty on Access to Care

Access to healthcare must be considered through both geographic and financial lenses. While rural and remote communities often experience provider shortages, people in metropolitan areas may also face significant barriers where the cost of care limits access despite local service availability.

Private specialist consultations and assessment processes, particularly for paediatric, developmental and behavioural conditions, can involve substantial out-of-pocket expenses. Specialist gap fees frequently exceed Medicare rebates by hundreds of dollars, resulting in significant upfront costs for individuals and families before they reach the Medicare Safety Net threshold. When multiple consultations and diagnostic assessments are required, out-of-pocket expenses can readily exceed $1,000 and may surpass $2,000, creating a significant barrier to timely access to care.[55]

The impact of financial barriers can delay assessment, diagnosis and treatment, resulting in unmet Healthcare needs and poorer outcomes. For children requiring developmental, behavioural or neurodevelopmental assessment, delayed access may affect educational participation, access to funded early intervention services, disability supports, family wellbeing and long-term health outcomes.

Despite their advanced education, endorsement and capability to assess, diagnose and manage complex conditions, NPs are not consistently recognised within key funding mechanisms. For example, NP assessments and diagnoses are not routinely recognised within National Disability Insurance Scheme (NDIS) processes and cannot establish Mental Health Treatment Plans (MHTPS) that provide access to Medicare-subsidised allied mental health services. Enabling appropriately qualified Nurse Practitioners to undertake these functions would improve timely access to disability and mental health supports, particularly in underserved communities.

These affordability challenges affect many Australians across a wide range of health conditions and care settings. They are often compounded in rural, regional and remote communities, where workforce shortages and limited provider availability contribute to longer waiting times, reduced choice of specialists, and additional travel and accommodation costs. Delays in accessing specialist care may allow conditions to progress before treatment can commence, reducing opportunities for prevention, timely diagnosis, government-funded early intervention, and optimal health outcomes.

Impact of Out-of-Pocket Costs

Patients often tell nurses they need to "save up" before attending a specialist appointment, despite the service attracting a Medicare rebate. This commonly occurs before patients have reached the Medicare Safety Net threshold and can result in delays to specialist consultations, diagnostic investigations and treatment. In regional, rural and remote areas, these costs are often compounded by travel and accommodation expenses, creating additional barriers to timely care.

Patients should have access to clear information about specialist fees, expected out-of-pocket costs and Medicare rebates before deciding whether to proceed with care. The actual cost of specialist assessment and treatment, and uncertainty about what patients will ultimately be required to pay, can contribute to delayed, deferred or forgone care. Improving fee transparency across all specialist services would support informed decision-making, reduce financial uncertainty and improve timely access to assessment, diagnosis and treatment. Efforts to improve access should also support the full utilisation of the skills, capabilities and scope of practice of all relevant health professionals, ensuring patients can access the right care from the right practitioner at the right time.

Patients should have access to clear information about specialist fees, expected out-of-pocket costs and Medicare rebates before deciding whether to proceed with care.

Impact on people, families and carers

The impacts of specialist access barriers extend beyond the patient.

For many Australians, particularly those living in rural, regional and remote communities, people with disability, Aboriginal and Torres Strait Islander peoples and older Australians, specialist care, as previously highlighted, often involves significant additional costs associated with travel, accommodation, meals, childcare, parking and also time away from community, cultural obligations and employment.[56,57]

For people with disability, complex health conditions or mental ill health, a carer or support person may be essential to enable access to Healthcare. These costs are frequently unavoidable and can significantly increase the overall burden of accessing specialist services.

The combined impact of specialist fees, Medicare gaps, waiting times, distance and support needs can result in people delaying or abandoning specialist referrals, postponing treatment or accessing care only after their condition has deteriorated. Consequences may include worsening physical or psychological health, increased stress and anxiety, avoidable emergency department presentations and greater reliance on family and informal support networks.

Case study: Telehealth referral – out of pocket cost

The mother of a child with ASD and additional complex medical concerns required a referral to a paediatric endocrinologist from the child's usual paediatrician due to the complexity of the child's medical needs.

A telehealth consultation was arranged solely to facilitate the referral and lasted approximately 15 minutes (MBS Item 91825). The mother was charged $750, with a Medicare rebate of $77.95, leaving a substantial out-of-pocket cost. No fee information was provided prior to the consultation, leaving the family without an informed understanding of the financial commitment before proceeding.

For a family already managing the financial and practical demands associated with caring for a child with disability and complex medical needs, this represented a substantial financial burden for what was effectively an administrative referral process. Costs of this nature may discourage ongoing engagement with specialist care and contribute to delayed or forgone treatment.

Impacts on chronic disease management

Delayed access to specialist care can significantly affect chronic disease management and long-term health outcomes.

Aboriginal and Torres Strait Islander peoples experience a disproportionately high burden of disease, with more than 317,000 years of healthy life lost in 2022 due to illness, injury and premature death.[58] While premature mortality has improved over time, the burden associated with living with chronic illness remained substantial.[59]

Access to specialist care is strongly influenced by geography. Approximately 33% of people living in major cities and 34% of those in inner regional areas received at least one specialist consultation, compared with only 12% of people living in very remote Australia. This disparity reflects the ongoing shortage of specialist medical services in rural and remote communities and contributes to poorer access to diagnosis, treatment and ongoing management of chronic conditions.[60]

Delayed specialist access can interrupt treatment plans, delay intervention and contribute to preventable deterioration in chronic disease. Without timely specialist access, opportunities for prevention, early intervention and treatment optimisation may be lost, increasing the likelihood of avoidable complications and more complex Healthcare needs over time.

Delayed specialist access can interrupt treatment plans, delay intervention and contribute to preventable deterioration in chronic disease.

Broader system impacts on primary care

When specialist services are delayed, inaccessible or unaffordable, responsibility for ongoing management frequently shifts to primary care clinicians.

Nursing and midwifery professionals have a critical role in managing acute and chronic conditions while patients await specialist review. This includes assessment, symptom management, chronic disease management, care coordination, health system navigation, referral management and monitoring for deterioration. These functions are essential to maintaining continuity of care and preventing avoidable complications while specialist services remain inaccessible.

Nurses and midwives are often among the most trusted Healthcare professionals within Aboriginal and Torres Strait Islander communities and are well positioned to provide Culturally Safe, accessible and relationship-based care. Nurse - and midwife-led models can support self-determination by providing greater choice in how, where and by whom Healthcare is delivered, while helping to address structural barriers such as workforce shortages, geographic isolation, transport difficulties and limited access to specialist services.

These models are particularly relevant to Australia's Closing the Gap commitments. Improving access to affordable, Culturally Safe and community-responsive Healthcare is essential to reducing inequities in health outcomes and supporting Aboriginal and Torres Strait Islander peoples to access care without facing disproportionate financial, geographic or systemic barriers.

However, significant funding and administrative barriers continue to limit the contribution of this workforce. Unlike general practitioners, NPs do not have access to a Medicare-funded health assessment item equivalent to MBS Item 715 (Aboriginal and Torres Strait Islander Health Assessment).[61] As a result, people receiving comprehensive assessment and care from a NP may be required to attend an additional GP appointment solely to access Medicare funding. This creates unnecessary duplication, increases system burden, may generate additional out-of-pocket costs, and can disrupt continuity of care where the NP is the person's established and trusted provider.

Administrative barriers also affect access to ongoing specialist care. While NPs can make valid specialist referrals, referral validity is generally limited to 12 months.[62] People receiving long-term specialist care under NP-led management may therefore require repeat referrals solely to maintain access to existing specialist services, creating additional administrative burden and potential delays in care.

Addressing these barriers would strengthen chronic disease management, improve access to culturally safe care, support earlier identification of health risks and enable more effective use of the health workforce. Creating a NP health assessment item equivalent to MBS Item 715 and facilitating full scope of practice would be consistent with contemporary models of care, the recommendations of the *Scope of Practice Review*,[63] *National Nursing Workforce Strategy*,[64] *Nurse Practitioner Workforce Plan*,[65] *and Closing the Gap.*[66]

Delayed access to specialist care also places pressure on the nursing and midwifery workforce itself. Nurses and midwives are frequently required to manage increasingly complex health needs while navigating barriers to timely specialist intervention. Repeated exposure to situations where the appropriate pathway of care is known but inaccessible can contribute to increased workload pressures, professional frustration and moral injury.

Broader system impacts on emergency departments and public hospitals

Delayed or forgone specialist care can have significant consequences for both individuals and the broader health system.

When people are unable to access timely specialist assessment and treatment due to cost, distance, waiting times or referral barriers, their condition may deteriorate, increasing the likelihood of acute episodes of illness, emergency department presentations and hospital admission. Conditions that may have been managed through earlier specialist intervention can progress to a point where more intensive, complex and costly treatment is required.

As specialist access barriers increase, demand is redistributed across the health system. People frequently seek support from primary care services, urgent care services and emergency departments while awaiting specialist review, increasing pressure on already stretched services. Delays in specialist care can also prolong hospital stays, contribute to avoidable admissions and increase demand for outpatient and community services.

The impacts of specialist access barriers are therefore not confined to specialist services alone. They create system-wide consequences that affect primary care, emergency departments, public hospitals, community-based services and overall health system sustainability.



Rural maternity care and specialist delays

Delays in specialist maternity care can have immediate consequences because pregnancy is time limited and clinical needs can change rapidly. Women require both timely specialist services as well as a midwife who can identify emerging concerns, coordinate referrals and provide ongoing monitoring while specialist input is pending.

Cost, distance, waiting times and fragmented referral pathways can delay diagnosis and treatment, reduce opportunities for early intervention, interrupt management of pre-existing or pregnancy-related conditions and result in urgent presentations or transfers. First Nations mothers who attended fewer than five antenatal visits, or none, had a preterm birth rate of 20.7%, compared with 7.8% among those attending five or more visits. Delayed or absent care was also associated with lower birthweight.[67]

When timely primary maternity or specialist care is inaccessible, women may present later in pregnancy, experience avoidable complications, or require urgent hospital care, increasing pressure on maternity services, emergency departments and retrieval systems. Midwives reduce these risks by maintaining clinical oversight, coordinating specialist input and escalating care when required. Reduced access to community-based maternity care and continuity models may further increase pressure on hospital-based services, particularly in rural and remote communities.[68]

Continuity of midwifery care supports coordinated and timely access to specialist services when consultation or referral is required. A 2024 Cochrane review of 17 studies involving 18,533 women found that continuity models were associated with fewer caesarean and instrumental births, more spontaneous vaginal births and more positive experiences of care, while maintaining collaboration with specialist teams when required.[69]

Improving maternity outcomes therefore requires more than access to obstetric care alone. It requires timely access to a midwife, and midwifery continuity of care while specialist input is pending, and clear pathways for consultation, diagnostics and escalation. Strengthening these pathways supports earlier intervention, reduces the risk of fragmented, deferred or missed care, and improves outcomes for women and babies, particularly in rural, remote and First Nations communities.

> *Midwives reduce these risks by maintaining clinical oversight, coordinating specialist input and escalating care when required.*



e) Assess innovative and emerging models of care that may improve access to medical specialists

Australia's specialist access challenges cannot be addressed through specialist workforce growth alone. Sustainable solutions will require innovation in how care is organised, funded and delivered, with greater emphasis on fully utilising the health workforce already embedded within communities. Contemporary, fit-for-purpose models of care should be designed around patient need and workforce capability rather than traditional professional boundaries.

Across aged care, disability, cancer and palliative care, Nurse Practitioners have demonstrated the value of innovative, capability-based models of care that improve access, address service gaps and respond to changing community needs. These models highlight the contribution of advanced practice roles in strengthening health system capacity, supporting more integrated care, and delivering high-quality services across a range of settings.

Effective models improve access by enabling timely assessment, diagnosis, referral, treatment and care coordination, while ensuring specialist expertise is available for people requiring highly specialised intervention.

People living in rural and remote Australia experience higher rates of disease and hospitalisation, poorer health outcomes, and reduced access to primary and specialist Healthcare.[70,71] These inequities are compounded by workforce maldistribution, geographic barriers, service fragmentation and increasing demand for care.[72]

By supporting care to be delivered at the most appropriate level of the health system, innovative workforce models can improve access, strengthen care coordination and increase system capacity, while ensuring specialist expertise is directed to patients with the greatest complexity and need. This approach is consistent with the recommendations of the Scope of Practice Review and offers a practical pathway to improving equity, sustainability and health system performance.

Case Study - Nurse-led symptom and urgent review clinics

A symptom and urgent review clinic (SURC) is an example of an innovative nurse led model of care designed to address and identify gaps within an oncology service to support patients experiencing chemotherapy toxicities during the period of active treatment.

This model has been shown to have a significant positive impact on early symptom recognition and management in a timely manner, that reduces emergency department presentations and the need for inpatient admissions.[73]

Capability-based models of care

Many specialist access challenges arise because Healthcare systems continue to rely on profession-based rather than capability-based pathways.

Appropriately qualified nurses and midwives can safely undertake advanced assessment, diagnosis, management, referral and care coordination within their scope of practice. However, regulatory, funding and administrative barriers frequently require additional consultations or specialist review where equivalent assessment and management could be safely provided by an appropriately qualified clinician.

Expanding capability-based models would:

- improve timely access to care;
- reduce duplication of assessment and referral processes;
- lower out-of-pocket costs;
- improve continuity of care; and
- preserve specialist capacity for patients requiring highly specialised intervention.

Within NP-, RN- and midwifery-led models of care are increasingly delivering specialist-level services across primary care, emergency care, chronic disease management, cancer care, maternity services, mental health and community settings. These models improve access to timely assessment, treatment and ongoing management, particularly in communities where specialist services are limited or difficult to access.

A growing body of evidence demonstrates that nurse-led and midwifery-led services can improve access to Healthcare, reduce waiting times, enhance patient outcomes and make more effective use of specialist workforce capacity. These models allow specialist expertise to be directed towards patients with the most complex needs, while ensuring people receive timely care from the most appropriate clinician.

Midwifery group practice and continuity of care models provide a strong example of this approach. Evidence demonstrates that these models achieve improved maternal and infant outcomes at lower cost than standard models of care, while supporting better access and continuity of care, particularly for rural, remote and priority populations.[73]

Case Study – Emergency department mental health RN & NP model

Providing appropriate, timely intervention and care to people who present with mental health issues to an Emergency Department (ED) presents unique ongoing challenges, often affecting patient experiences and outcomes. To address such concerns, a mental health liaison nurse role, led by a mental health NP, was introduced to a regional ED.

This role provided integrated emergency-based mental health clinical practice with positive findings reported in a recently published multi-site translational research project. With sound quantitative and qualitative evidence detailing the benefits of this role, the experiential perspective from a clinician working on the frontline further confirms the importance of having access to such a position in leading cultural and systemic change.[74]

Case Scenario: An innovative, midwifery-led model of care in action

The Bentley Health Service Midwifery Birthing Centre in Western Australia is a midwifery-led model staffed by endorsed midwives. Women receive continuity of care from a known midwife throughout pregnancy, birth and the postnatal period, with specialist consultation and referral pathways available when required.

The model enables more women to access maternity care closer to home, improves continuity and consumer experience, and reduces reliance on specialist-led services for women with uncomplicated pregnancies. It demonstrates how endorsed midwives can safely provide autonomous care while working collaboratively with specialist teams when additional expertise is required.

Virtual care models

Access to specialist care is shaped not only by workforce availability, but also by geography, transport and the cost of travel. Telehealth can reduce these barriers by improving access to specialist expertise and supporting care closer to home. However, MBS requirements for in-person consultations before some telehealth services attract a rebate can undermine these benefits and disproportionately affect rural and remote communities, people with disability, older Australians, people receiving palliative care and those for whom in-person attendance presents additional barriers. Reform of MBS telehealth arrangements is needed to ensure funding settings support, rather than restrict, equitable access to appropriate care.

Telehealth can reduce these barriers by improving access to specialist expertise and supporting care closer to home.

Case Study: Telehealth in cancer treatments

The Queensland Remote Chemotherapy Supervision (QReCS) model enables rural nurses to administer chemotherapy in smaller communities under the remote supervision of specialist health professionals based in larger centres through telehealth.

The use of telehealth in cancer care has been shown to be safe and effective, improving access to specialist services, particularly for people living in rural and remote areas.

Components of cancer care including pre-chemotherapy assessments, routine follow-up, long-term monitoring, supportive care and palliative care consultations can be safely delivered through telehealth, reducing the need for travel while maintaining access to specialist expertise.

A telechemotherapy nurse is a specialised oncology RN who administers low-risk cancer treatments in local and rural settings while receiving real-time support from specialist oncology clinicians through videoconferencing and other digital health technologies. This model has been successfully implemented to deliver safe, high-quality cancer care closer to home, improving access and patient experience while reducing the burden of travel for treatment.

Future Directions

The most significant opportunity to improve access to specialist care lies not in specialist workforce growth alone, but in redesigning models of care around health need, workforce capability and multidisciplinary collaboration. Future reforms should focus on enabling all health professionals to practise to the full extent of their education, training, competence and scope of practice, while ensuring specialist expertise is directed towards people who require the highest level of specialist intervention. Future specialist access reforms should support:



NP-led, midwifery-led and RN-led advanced practice specialist clinics



multidisciplinary models of care



telehealth-enabled specialist services



regional specialist outreach networks



integrated shared-care arrangements between primary care, specialist services and hospitals



capability-based referral pathways[75]



funding arrangements that support full utilisation of the health workforce

These approaches align with the findings of the *Scope of Practice Review* [74] and represent practical, scalable and evidence-informed strategies to improve specialist access, affordability and health system sustainability. By enabling Healthcare professionals to practise to their full scope, Australia can reduce unnecessary duplication, improve continuity of care, strengthen service capacity and ensure patients receive timely care from the most appropriate clinician.

Key Reform Opportunities

The evidence and examples presented throughout this joint submission demonstrate that improving access to specialist care requires more than increasing workforce numbers. Funding arrangements, referral pathways, regulatory settings and the effective utilisation of workforce capability all play a critical role in determining access, affordability and system performance.

Addressing these challenges requires a contemporary, whole-of-system approach that better aligns models of care, Medicare funding and workforce utilisation with patient need. The following reform opportunities provide practical and evidence-informed actions to improve access to specialist care, reduce unnecessary costs and duplication, and support a more equitable, sustainable and responsive health system.

Key reform opportunities include:

- **Enable full scope of practice** by removing legislative, funding and administrative barriers that restrict nurses and midwives from practising to their education, competence and capability.
- **Modernise Medicare funding** to support sustainable nurse and midwife-led models of care and improve access to affordable services.
- **Streamline referral and diagnostic pathways** through nationally consistent arrangements that reduce duplication, delays and unnecessary costs.
- **Remove practitioner-specific Medicare restrictions** where equivalent competence and scope of practice exist.
- **Recognise NP referrals and care pathways** across specialist outpatient, multidisciplinary, allied health and supportive care services.
- **Invest in multidisciplinary and continuity of care models** that are centred on patient need and practitioner capability.
- **Expand telehealth, virtual care and outreach services** to improve access in rural, regional and remote communities.
- **Reduce the total cost of care** by addressing out-of-pocket costs associated with specialist consultations, diagnostics, medicines and travel.
- **Improve transparency and accountability** through better fee disclosure, informed financial consent and public reporting.
- **Strengthen data collection and reporting** on NP contributions to specialist care to support workforce planning and evidence-informed reform.
- **Embed equity and Cultural Safety** in specialist care reform to improve access for priority populations and underserved communities.

Collectively, these suggested reforms would support a more equitable, affordable and sustainable specialist care system by improving access, reducing duplication, strengthening workforce utilisation and ensuring care is delivered by the most appropriate practitioner. These findings reinforce the joint recommendations outlined in this paper and highlight the importance of reform that aligns funding, referral pathways and workforce capability with contemporary models of care.

Conclusion

Australia's medical specialist access challenges cannot be addressed through increasing specialist workforce numbers alone. Sustainable improvement requires a whole-of-workforce approach that enables all health professionals, including medical specialists, NPs, RNs, midwives, endorsed midwives, pharmacists and allied health professionals, to practise to the full extent of their education, training, competence and scope of practice. The Scope of Practice Review provides a clear and timely roadmap for achieving this reform.

Improving access to specialist care requires contemporary, capability-based models of care that are designed around patient need rather than professional boundaries. Multidisciplinary, team-based approaches should draw on the strengths of the entire health workforce, with care coordinated by the practitioner/s best placed to meet a person's needs. Moving beyond traditional profession-based hierarchies will support more flexible, efficient and responsive care delivery.

This includes nursing and midwifery-led models, integrated primary and specialist care, telehealth and virtual care, regional specialist networks, and collaborative multidisciplinary teams. These approaches have demonstrated their capacity to improve access, strengthen continuity of care, reduce unnecessary costs and duplication, and ensure people receive the right care, from the right clinician, at the right time and in the right setting.



Reform must also be grounded in equity and Cultural Safety. This is particularly important for Aboriginal and Torres Strait Islander peoples and for people living in regional, rural and remote communities, where workforce shortages, geographic barriers and service gaps continue to limit access to timely specialist care.

Improving access to specialist care is a shared responsibility across governments, funders, health services and the broader health workforce.

By removing unnecessary funding, referral, regulatory and administrative barriers, and enabling health professionals to work to their full capability, Australia can improve affordability, strengthen care coordination, enhance workforce sustainability and achieve better health outcomes. These reforms align with contemporary health workforce priorities and represent a practical pathway towards a more equitable, accessible and sustainable health system, ensuring all Australians can access timely, affordable and high-quality care regardless of where they live.

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