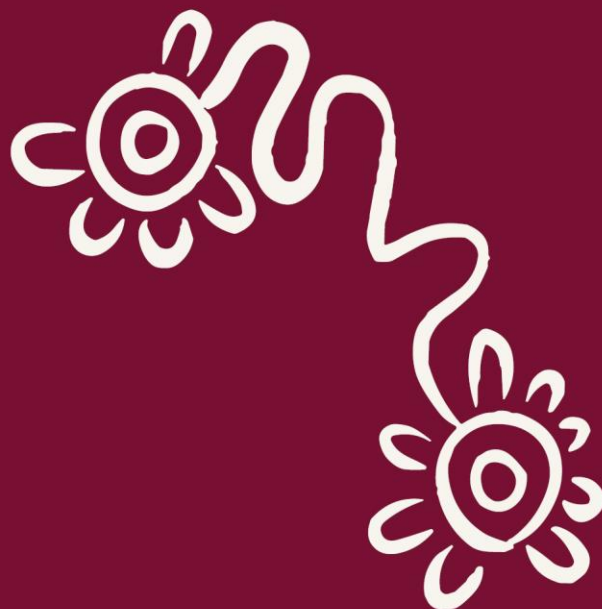




Aboriginal Health Council
of South Australia Ltd.



Inquiry into Access to and Affordability of Medical Specialists in Australia

Date: October 2026



Inquiry into Access to and Medical Affordability of Medical Specialists in Australia

[Standing Committee on Health, Aged Care and Disability](#)

AHCSA acknowledges the Traditional Custodians of the lands and waters across Australia and pays respect to Elders past and present. AHCSA also extends this respect to all Aboriginal and Torres Strait Islander people whose knowledge, culture and leadership continues to guide and strengthen Aboriginal Community-Controlled health.

Executive Summary

The Aboriginal Health Council of South Australia (AHCSA) welcomes the opportunity to present this submission to the Standing Committee on Health, Aged Care and Disability.

AHCSA is the peak body representing Aboriginal Community-Controlled Health Organisations in South Australia. Our members deliver culturally safe, holistic health services to Aboriginal people across metropolitan, regional, and remote areas of the state.

The full list of our Member Services is available [on our website](#).

The complexity of the Australian healthcare system, particularly related to governance and funding arrangements, has created a number of barriers for people trying to access medical specialists across the country. The costs associated with these services are substantial, even within the public system, and the health literacy needed to navigate complicated referral pathways is considerable. People living in regional, remote and very remote areas often face additional financial burdens when travelling outside their local area to attend appointments, and are otherwise reliant on outreach services with extensive waitlists.

These barriers are exacerbated for Aboriginal people and communities.

It is well established that Aboriginal people face significant challenges in accessing affordable, culturally safe care at all levels of the health system. The historical and ongoing inequities experienced by Aboriginal communities as a result of colonisation, dispossession and forced assimilation have contributed to much higher rates of chronic disease, co-morbidities, disabilities and poor health outcomes (Nolan-Isles et al., 2021). Aboriginal people are also more likely to live in regional and remote areas, further amplifying issues with accessing healthcare services (ABS, 2026). Traumatic experiences with government institutions and mainstream services make many Aboriginal people hesitant to access healthcare that is not culturally safe. As a result, Aboriginal people may delay seeking treatment until their conditions become more severe, increasing the need for acute, multi-disciplinary healthcare.



Whilst Aboriginal Community Controlled Health Organisations (ACCHOs) provide culturally safe services, they are limited to primary healthcare. As such, Aboriginal people are often forced to rely on mainstream services for more complex, specialised care. Given the existing inequities experienced by Aboriginal communities, it is therefore imperative that medical specialists are both affordable and accessible, ensuring existing health disparities are not intensified.

Recommendations

AHCSA recommends that the Australian Government:

- 1. Funds and supports community-controlled organisations to provide specialist outreach services** as an extension of current investment in public medical clinics.
- 2. Mandates cultural safety and anti-racism training within specialist training programs** to ensure specialist healthcare is safe and responsive to the unique needs of Aboriginal people.
- 3. Develops an online portal to track referrals to medical specialists**, including access to the portal for referring clinics (such as ACCHOs) and medical specialists, to increase transparency of wait times and manage appointments.
- 4. Invests in shared care models to decrease the need for face-to-face appointments**, improving access for patients in geographically isolated areas and reducing the financial and human costs associated with attending appointments in-person.
- 5. Fund dedicated, regular medical specialist clinics for ACCHOs**, particularly those in remote and very remote locations.
- 6. Invest in adequate infrastructure and workforce training for the delivery of telehealth medicine**, particularly within the ACCHO sector and remote healthcare services.

Response to Terms of Reference

- 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***

The Department of Health, Disability and Ageing reported that in 2024, 81% of medical specialists were practicing in locations classified as MM1 (Metropolitan) under the Modified Monash Model (Department for Health, Disability and Ageing, 2025). In contrast, MM6 (Remote) and MM7 (Very Remote) locations had a medical specialist headcount of 246 and 105 respectively. However, the number of available FTE positions in these areas was reported 263 and 125, indicating the presence of unfilled positions across

remote and very remote communities. Additionally, medical specialists operating in MM6 and MM7 locations worked an average of 7.3 hours more per week when compared to their metropolitan counterparts, the equivalent of nearly one additional working day. These data points highlight both the significant workforce shortages experienced in remote and very remote areas, as well as the strain placed on the existing specialist workforce in order to meet community demand.

People living in remote and very remote communities are reliant on fly-in fly-out (FIFO) specialist services. This model does not offer adequate or sustainable support for Aboriginal people living with chronic, complex conditions that require regular treatment and follow-up. Specialist visits are often contingent on securing a sufficient number of patients to make travel financially viable, meaning access to these services is irregular. As a result, waitlists are often extensive, and not always prioritised according to clinical need.

For urgent issues that may arise between specialist visits, responsibility for managing this often falls to the local ACCHO. However, ACCHOs may not have access to the expertise, infrastructure, or workforce capacity required to provide the level of care needed. This places additional pressure on already stretched services and contributes to delays in treatment for Aboriginal people and communities.

These barriers to specialist care are further exacerbated by poor engagement and relationships between ACCHOs and public health services. In many communities, Aboriginal people are hesitant to access specialist services within mainstream settings due to a lack of trust and previous negative experiences.

Access to specialist mental health and drug and alcohol services is particularly inadequate for Aboriginal people living in regional, remote and very remote areas. Despite high rates of psychological distress, substance addiction, and mental health conditions in some communities, treatment options remain limited. Local ACCHOs often support these clients as the mainstream services may not be available in remote and very remote communities, or are underutilised by Aboriginal communities. These ACCHOs will support their communities with the limited resources they have, further stretching the impact of inadequate access to medical specialists across individual patients, communities and healthcare providers. One ACCHO in remote South Australia has independently recruited a psychologist to support these clients, despite receiving no additional funding for this position. This lack of access to specialised psychiatric care poses a significant risk to progress against Target 14 of Closing the Gap, and has flow on effects for rates of incarceration of Aboriginal people.

A report by the Grattan Institute (2025) highlighted a critical need to increase government spending in public specialist clinics for under-served areas. An investment of \$470 million over 5-years to fund an additional 984,000 specialist appointments would be needed to shift the lowest quarter of under-served areas into the 25th centile, again demonstrating the significant shortages currently being experienced. The

report also noted that certain specialists - including dermatology, ophthalmology, psychiatry and obstetrics - are particularly undersupplied.

b) Examine the effectiveness, transparency and equity of referral pathways from the perspective of patients, primary health care 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

The complexity of referral pathways for specialist care is contributing to delayed treatment for Aboriginal people across the country. Current communication processes for referrals are heavily reliant on patients having regular access to technology to manage, track and confirm their appointments. For Aboriginal people who are transient or experiencing housing insecurity, these electronic-based processes are not practical, and often result in people missing their scheduled consultations. Additionally, ACCHOs are often disconnected from the referral process (particularly for FIFO services), leaving them unable to support their communities with navigating these complex systems and processes.

Did Not Attend (DNA) policies commonly require a new referral after three missed appointments, forcing people to attend another GP appointment and restart lengthy waiting periods. This rigid process disproportionately impacts Aboriginal people, as it does not take into consideration cultural and kinship obligations and responsibilities, and the significant distances many people in remote communities' travel to attend appointments and the costs associated with this process. Experiences of systemic racism have eroded trust in the healthcare system, creating a significant barrier to care for many Aboriginal people. Referral pathways are fragmented and impersonal, with referring agencies lacking established relationships with Aboriginal patients, families and communities. As a result, patients may be required to navigate complex systems without culturally safe support or advocacy, increasing the likelihood of disengagement from care, missed appointments and poorer health outcomes.

These barriers can contribute to delayed access to care, with Aboriginal people half as likely to be admitted for elective surgery when compared to the non-Aboriginal population. Furthermore, median wait times for elective surgery is approximately 50 days for Aboriginal people, compared to 41 days for non-Aboriginal people (O'Brien et al., 2021), whilst rates of emergency surgery for Aboriginal people are significantly higher. These statistics reflect missed opportunities for preventative care and early intervention.



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

The burden of out-of-pocket costs for specialist services, combined with additional expenses associated with travel and accommodation, contributes to poorer health outcomes and exacerbated chronic and complex conditions (Ryder et al., 2024). A report released by the Senate Standing Committee on Community Affairs noted that the majority of out-of-pocket healthcare costs are incurred through accessing specialist services, and disproportionately impact vulnerable populations, including Aboriginal people and those living in remote communities (Commonwealth of Australia, 2014). A study examining barriers to adherence to Optimal Care Pathways for lung, bowel and breast cancers among Aboriginal people in NSW found that whilst some clinicians bulk billed consultations, particularly for patients referred by ACCHOs, many surgeons did not offer bulk billing (Ivers et al., 2024). As surgical intervention is often a critical component of cancer treatment, these costs create significant barriers to accessing effective care.

Clinicians working in ACCHOs have described significant difficulties in accessing specialist services for their patients, with out-of-pocket costs forcing many Aboriginal people to forgo the care they need.

CASE STUDY: Accessing specialist gynecology services in remote South Australia

An Aboriginal patient with uterine cancer living in remote SA was unable to access specialist gynecology services in their local area as they could not afford the consultation fee. Consequently, the patient returned to their GP for a new referral to a public outpatient clinic in the nearest city. Despite the significant travel requirements, the Patient Assistance Transfer Scheme (PATS) was unable to provide financial assistance, as there was technically a service available closer to the patient's residence. However, this local service was already found to be inaccessible due to financial barriers. The resulting delay in receiving gynecological care negatively impacted the patient's health outcomes, and caused considerable emotional distress, including feelings of shame and embarrassment.

This case study demonstrates that the presence of a service does not equate to access. The significant out-of-pocket costs for these specialist services mean that many Aboriginal people are locked out of accessing the critical healthcare they need.

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

As discussed previously, for Aboriginal people living in remote and very remote communities, the inability to access specialist services means that ACCHOs are regularly required to manage complex health conditions beyond their scope of care, and beyond their funding parameters. This places a significant strain on services that are already at capacity due to workforce shortages, limited funding, and inadequate infrastructure. When specialist care is deferred or delayed, many Aboriginal people experience further health complications that result in avoidable hospitalisations. For hospitals in regional and remote areas, this transfers a significant cost and workforce burden onto smaller facilities that receive less funding when compared to metropolitan areas.

It is well established that geographic isolation, limited transport options, associated costs and lengthy waiting times create significant barriers to healthcare access for Aboriginal people, delaying timely healthcare (AIHW, 2025). When specialist medical care is delayed, existing health inequities are amplified. For example, Aboriginal people experience chronic diseases at 2.3 times the rate of non-Aboriginal people; a lack of accessible specialist services to manage and treat these conditions further contributes to the substantial gap in life expectancies for Aboriginal people. In 2023, 58% of Aboriginal deaths were attributed to avoidable causes (including chronic conditions), more than three times the rate of non-Aboriginal people (AIHW, 2023). It is therefore critical that access to specialist medical care is improved, particularly for regional, remote and very remote communities, to improve life expectancies and health outcomes for Aboriginal people.

Governments should increase investment in preventative healthcare services for Aboriginal people, particularly in remote and very remote communities. Preventative services delivered on Country by ACCHOs improve continuity of care, support early intervention and improve long-term health outcomes. ACCHOs provide culturally safe, community-led care that is based on local knowledge, trusted relationships and a holistic understanding of health. These services offer an alternative to mainstream settings where Aboriginal people may experience racism, discrimination and stereotyping.

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

Telehealth and Shared Care

Several telehealth models have been successfully utilised to support specialist appointments occurring within ACCHOs, including video conferencing for real-time consultations and store-and-forward technologies that allow clinical images and information to be transmitted for specialist review. Store-and-

forward technologies can support specialist assessment across a range of clinical areas, including ear health (digital otoscopy for ENT review), eye health (retinal imaging for diabetic retinopathy screening) and skin conditions (teledermatology). These technologies are particularly relevant to Aboriginal communities, given the disproportionate burden of hearing and vision disorders and barriers to accessing specialist services (AIHW, 2026). Related remote monitoring technologies, such as blood pressure and glucose monitoring, can also support the management of chronic conditions locally. A systematic review of telehealth services for Aboriginal people reported positive outcomes, including improved access to healthcare, reduced travel, improved screening rates and positive patient experiences (Caffery et al., 2017). Additionally, telehealth models of care allow Aboriginal patients to remain on Country and receive support from family, while maintaining their cultural obligations and responsibilities.

A shared care model supported by Aboriginal Health Practitioners (AHPs) could also be implemented alongside telehealth technologies, with suitably trained clinicians with enhanced diagnostic capabilities (e.g. spirometry, electrocardiograms and ultrasounds) facilitating virtual consultations and coordinating care. This approach would enable more comprehensive assessments to occur within ACCHOs, and support access to specialist services without requiring patients to travel. This may also reduce instances of patients not attending appointments, with care being delivered in a community-controlled environment alongside trusted clinicians.

Primary care clinicians should have access to specialist advice through flexible mechanisms such as secure telephone, email and videoconferencing platforms. This would enable primary care clinicians to access timely specialist guidance, support clinical decision-making, and manage complex conditions locally. Face-to-face consultations could then be reserved for circumstances where in-person specialist assessment or treatment is clinically required.

The implementation of these models requires adequate and sustainable funding for ACCHOs, including access to appropriate diagnostic equipment, reliable digital infrastructure, workforce training and care coordination. This would support ACCHOs to facilitate specialist care locally, reducing travel requirements and associated costs for both patients and the health system. These models would complement existing face-to-face specialist and outreach services, ensuring patients can access care appropriate to their clinical needs.

Incentivising Medical Specialists

Increasing incentives for specialists to provide regular outreach services in regional, remote and very remote communities would reduce the burden placed on Aboriginal people who are often required to travel long distances to access care. Travelling away from home, family and Country can cause considerable stress and anxiety, particularly when appointments are brief and do not result in improved health

outcomes. Whilst specialist outreach services are currently funded by the Rural Doctors Workforce Agency (RDWA), there is limited community-controlled involvement in the planning, governance and oversight of these services. Regional and remote ACCHOs report frustration at the lack of influence they have regarding which specialists visit their communities, the frequency of visits, the services provided and the required cultural capabilities of specialists. The design and delivery of specialist outreach services for Aboriginal communities should be Aboriginal-led and community controlled, and should prioritise healthcare that recognises and aligns with cultural, community and familial obligations.

Cultural Safety

Specialists should receive training regarding the ACCHO model of care, culturally safe practices, and the impact of social determinants of health on Aboriginal peoples. Strengthening specialist understanding of Aboriginal communities, and the reality of Aboriginal life within these communities, would support more culturally responsive, person-centred care, improving engagement and health outcomes for Aboriginal patients. The medical workforce has a proactive role to play in changing the narrative of Aboriginal health, redirecting mainstream understanding from deficit-based discourse to strength, empowerment and resilience.

ACCHO Based Outreach

Public specialist services should be incentivised to partner with ACCHOs across metropolitan, regional, remote and very remote locations to work within Aboriginal-led models of care (inclusive of AHPs), and deliver clinics from environments where Aboriginal people feel culturally safe and connected to community. Dedicated specialist clinics could be provided from ACCHOs, allowing patients to access specialist care within trusted healthcare settings. Models of this nature already operate within some SA Health Aboriginal Medical Services, and could be expanded across the community-controlled sector to improve accessibility, cultural safety and continuity of care.

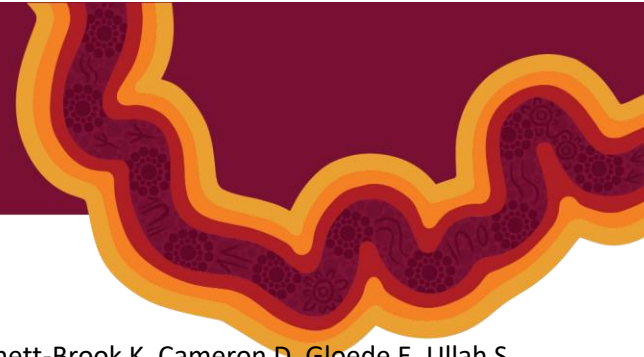
Conclusion

Ensuring specialist services are accessible, affordable, and culturally responsive is essential to reducing health inequities and improving outcomes for Aboriginal communities. Without targeted action to address the barriers outlined within this submission, existing disparities will continue to be amplified, placing Aboriginal people at greater risk of avoidable death, disease progression and poorer health outcomes.

We thank the Committee for its time and consideration, and for the opportunity to contribute to this important work.

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