



Submission: Access to and affordability of Medical Specialists in Australia

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

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Acknowledgements

The National Rural Women's Coalition (NRWC) acknowledges the Traditional Owners of the land on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and future. We value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We extend our respect to Aboriginal and Torres Strait Islander women who for thousands of years have preserved the culture and practices of their communities on Country. This land was never surrendered, and we acknowledge that it always was and always will be Aboriginal land. We acknowledge that Australian governments have been complicit in the entrenched disadvantage, intergenerational trauma and ongoing institutional racism faced by Aboriginal and Torres Strait Islander people. We recognise that Aboriginal and Torres Strait Islander people must lead the design and delivery of services that affect them for better life outcomes to be achieved.

About NRWC

The National Rural Women's Coalition (NRWC) is a grass roots organisation, established in 2002, that provides a collaborative, powerful national voice for women living in rural, regional, and remote Australia. We are a coalition of five peak rural alliances comprising the Australian Local Government Women's Association, Australian Women in Agriculture, National Rural Health Alliance, Women in Seafood Australasia and Transport Women Australia Limited. For over 20 years, we have worked to ensure better social, economic, and environmental outcomes for women in rural townships, in rural communities and in primary production throughout Australia.

Executive summary

Rural regional and remote women and their children have significantly poorer access to medical specialists than their metropolitan counterparts. While all rural patients face difficulty accessing medical specialists, it is women who pay more, face barriers to having their pain and conditions taken seriously and who are more likely to delay their care.

Existing urban centric models of care have failed rural women and their families when it comes to medical care. High out of pocket costs to see specialists across the board, are compounded by the significant cost of travelling long distances for treatment. Existing patient transport schemes are vastly inadequate and should be nationalised and overhauled.

To include the voices of rural, regional and remote women in this submission, the National Rural Women's Coalition (NRWC) conducted a survey of 119 women about their experiences accessing specialist treatment. The stories are striking in their consistency and highlight the brutal reality faced by rural women seeking medical care.

The survey overwhelmingly showed long delays accessing appointments, significant travel times (even for initial appointments) and the significant cost of travelling and often staying overnight to access treatment. Many noted the severe limitations of the patient transport schemes in their state, either through only covering a small portion of costs, not being eligible or delays in reimbursement.

Lack of choice of specialist was rated as the most difficult factor in accessing treatment, followed by cost of appointment and cost of travel to the appointment. Other factors including time off work, cost of meals and accommodation and negotiating childcare were mentioned. Many respondents noted it was a combination of all factors.

When asked what they would change about their most recent experience of seeking specialist care, most said being able to access appointments closer to home, Medicare rebates for telehealth appointments, ability to choose specialist, shorter wait times and better reimbursement.

This submission outlines in more detail the barriers to accessing treatment and sets out a range of recommendations to improve access for rural, regional and remote women, including:

1. Nationalising and overhauling patient transport schemes to increase subsidy rates, include more treatments and ability to choose specialist
2. Incentivising specialists to operate in regional, rural and remote areas, building on and expanding the Specialist Training Program beyond training into service delivery
3. Increase Medicare rebates for specialists to address out of pocket costs and include more telehealth appointments where appropriate

4. Investment in multidisciplinary public health clinics (with a focus on specialised women's healthcare) in underserved regional, rural and remote areas.

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.

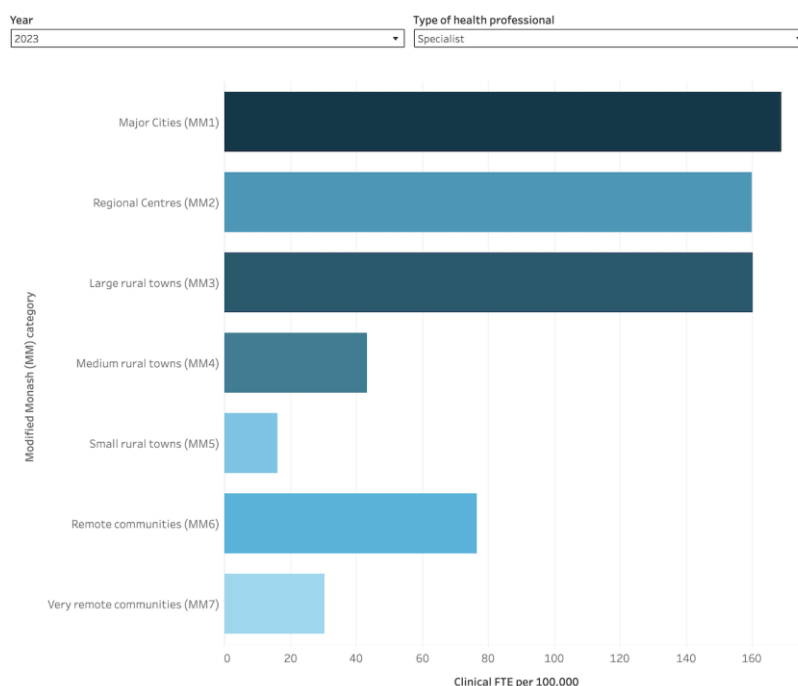
People living in regional rural and remote Australia have poorer access to medical specialists close to where they live. Because of this service gap, rural, regional and remote people must travel, pay more, wait for appointment or even forego the care they need. For rural women, this disadvantage is compounded by their gender, and the additional barriers women face accessing high-quality health care (including sexual and reproductive healthcare) including having their pain dismissed, paying more and delaying appointments.

Access to non-GP specialist care falls after MMM 3, with more remote regions having to travel for care.ⁱ

A 2025 study that looked at supply of medical practitioners (specialists, interns, registrars, non-specialist and hospital medical staff) currently and into the future found that the Specialist workforce is expected to be in undersupply of 6,981 FTE specialists (7.3%) by 2033 with this deficit increasing further to 12,812 FTE (9.7%) by 2048.ⁱⁱ

This same report highlighted the maldistribution of medical practitioners between rural and remote areas compared with metropolitan areas. In 2023, the FTE medical practitioners per 100,000 people in metropolitan areas was 510.5, compared to only 135.5 in small rural towns (MM5).ⁱⁱ

Data from the Australian Institute of Health and Welfare shows a similar disparity in access to medical specialists, with a significant drop in access from MM4-7.ⁱⁱⁱ



Sources: ABS 2025; Department of Health, Disability and Ageing 2025; Table S8.

According to the Grattan Institute, half of remote and very remote areas receive less than one specialist service per person, per year (Figure 1.8). There are no parts of major cities where this is the case.ⁱⁱ

NRWC's survey of 119 rural, regional and remote women showed 90% had had difficulty accessing specialist medical appointments in the past 12 months. The survey overwhelming showed long delays accessing appointments and significant travel times (even for initial appointments). Some respondents shared their stories:

"I live in Toowoomba. I had to wait 12 months to see a gastroenterologist or travel to Brisbane, 6 months to see a psychiatrist."

"Permanent carer of 9 year old grandchild, cannot get into a paediatrician. Took over 2 years to access one. Have to travel 5 hours each way for each appointment. Been on a waiting list 45 minutes away for 3 years."

One survey respondent described the difficulties booking with the visiting specialist who visits monthly.

"Often I cannot get my next appointment to be in time for my script to run out so I go without medication for a period of time."

One woman described her situation (being pregnant with gestational hypertension, living on a farm an hour away from the nearest hospital) and requiring appointments 4 hours away fortnightly until she gives birth. Other examples covered everything from cancer to fertility treatment and paediatric appointments for children.

"I find it hard to travel over 400km one way to these (fertility) appointments due to work and general life commitments"

"Had to make multiple 6 hour round trips to take my father to specialist appointments and surgeries and radiotherapy in Ballarat at least weekly (sometimes twice a week) while hubby had to take time off work the same days to care for our preschool aged children"

"My son's appointment with an allergy paediatrician 300kms away as no local options in our area. Waitlist was 18months as a returning patient with referral."

"Needed to travel 10hr round trip to access chemo, PET scans and other cancer support services"

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.

In addition to long wait times and travel times, rural regional and remote women and their families - face challenges with lack of choice in which specialist they see. Some of this is down to geographic barriers but is compounded by the fact that most patient transport subsidy schemes only cover treatment at the nearest treating specialist.^{iv} Most schemes also specifically note that a second opinion is not covered. This could mean rural women may be forced to see a specialist who is not necessarily the best provider for them or choose to not seek reimbursement through these schemes so they can have a greater choice.

This issue was noted in NRWC's survey of women accessing specialist care. Though most did not know about or access these schemes, those that did, noted their severe limitations.

“What is particularly frustrating is being told that I don't get to have a choice of specialist (that's why I'm not eligible for Pats). This is complete discrimination against rural people over metro.”

Patients in metropolitan areas have greater choice by virtue of having many more treating specialists accessible and not needing to pay high costs to travel or rely on the subsidy schemes to partially cover costs.

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.

Across the board, Australians are facing increasing out of pocket costs to see a specialist (fees have risen 73 per cent since 2010), which are causing many to delay or skip care.^v

The high cost of seeing medical specialists was confirmed by NRWC's survey of rural women. However, for women living in rural, regional and remote areas, the cost of travel significantly increases the overall cost of consultations and treatment. These additional expenses can include fuel or airfares, accommodation and meals, as well as lost income or business costs when women or their support person need to take time off work to attend appointments. More than 30% of respondents said they spent more than \$1000 on their most recent appointment. More than 75% said they did not claim their expenses against their state or territory travel scheme for reasons including lack of awareness, incomplete paperwork or choosing not to bother with the process. For those that had private health insurance, 55% said it did not materially impact their costs.

One survey respondent travelled to Brisbane to see a gynaecological oncologist for uterine cancer treatment. The initial consultation required an overnight stay, while treatment involved three nights in hospital and additional accommodation in Brisbane before travelling home. The total cost exceeded \$11,000.

One survey respondent described needing to see a gastroenterologist for a colonoscopy.

“I had to wait 5 weeks for an appt - I had to drive 620km for a 30min appt because there's no Medicare rebate for TH consult for the appointment. I waited another 4 weeks for the procedure (620km). I had to stay in a hotel for 3 nights to enable me to do the required bowel prep prior to the procedure and then stay 24hrs after the procedure before I could drive home. This was a cost of over \$1,000, and is not eligible for PTSS as I was a private patient, and my private health only offers a very small reimbursement for overnight admissions, with no reimbursement for day procedures.”

Travel costs compound the existing growing costs of seeking specialist treatment that exist across Australia. The Royal Australian College of Obstetricians and Gynaecologists has drawn attention to the ongoing sustainability of private obstetrics and gynaecology services. They point to rising operational costs and inadequate remuneration via private health insurers and the MBS placing considerable strain on private practitioners.^v They argue that without policy reform, there is a risk that further contraction in private O&G services will increase pressure on already overstretched public hospitals and reduce choice and access for women.^{iv} The impact is further exacerbated in regional, rural and remote areas.

RANZCOG point out that women continue to experience disproportionately high out-of-pocket costs associated with sexual reproductive health, fertility treatment, maternity care, consultations, procedures, medications, and the ongoing management of chronic conditions such as endometriosis, PCOS and menopause.^{iv} RANZCOG acknowledges that women living in rural, regional and remote Australia continue to face significant barriers to accessing obstetric and gynaecological care, including long travel distances, higher out-of-pocket costs associated with travel and accommodation, and reduced service availability.

Compounding this problem is the lower rates of private health coverage for rural regional and remote people. According to the National Rural Health Alliance the proportion of people who have private health insurance is lower in Outer Regional, Remote or Very Remote areas.^{viii}

The high costs of seeing a medical specialist are also highlighted in the Grattan Institute's report *Special Treatment*. This report recommends a review of Medicare Benefits Schedule rebates to ensure they reflect the cost of care.^{vi}

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.

Roughly 7 million people – or 28 per cent of the Australian population – live in rural and remote areas. People living in rural and remote areas have higher rates of hospitalisation, death and injury and also have poorer access to, and use of, primary health care services, than people living in major cities.^{vii} According to the National Rural Health Alliance, each person in rural Australia is missing out on nearly \$1218 a year of healthcare access, which equates to a total annual rural health spending deficit of \$9.23 billion.^{viii} Specifically, there is a clear trend showing that as remoteness increases, the disease burden also increases for conditions like coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, lung cancer, stroke, suicide and self-inflicted injuries and type 2 diabetes^{ix}

For women, these poorer health outcomes are exacerbated by their gender. Women's experiences of having their pain dismissed, being disrespected and receiving inadequate treatment of their pain are well established.^x Women pay more and are more likely to delay their treatment.^{xi}

For rural, regional and remote women, this is likely to be exacerbated by lack of access to care providers, higher costs associated with travel, delays getting treatment and fewer choices of providers.

The Victorian Government's recent Inquiry into Women's Pain demonstrated this double disadvantage. Women living in rural Victoria reported additional challenges when accessing pain care including extensive travel for care and limited provider choices.^{xii} Respondents highlighted a lack of GPs, specialists and allied health practitioners in regional and rural areas, with 65% of rural and regional respondents reporting long wait times as a challenge to seeking care for pain.^{xxiv} When access to GPs, specialists and allied health services is limited, women's pain goes untreated, their conditions worsen, and their quality of life declines.

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

Access to medical specialists is another example of the urban centric services failing rural, regional and remote patients (just like the provision of maternity care, early childhood education and care, and access to primary and allied health). Where the population is dispersed, there is simply not enough paying clients for providers to operate in these areas. Workforce shortages in rural and remote areas and the problems this causes are widely documented. Rural health services struggle to fill vacancies. They're often left employing temporary locum staff to fill gaps, increasing costs and reducing continuity of care for patients.^y New approaches are needed to incentivise specialist providers to extend their services into rural, and remote areas to reduce the burden and cost of travel for rural, region and remote patients.

When it comes to specialist care, the issue is not just access but also affordability of the specialist themselves, which is a barrier to access both in metropolitan and non-urban areas. Grattan Institute's report identified the key driver of this cost gap, as the fact that most specialist training funding comes from public hospital budgets.^v This funding is mostly dictated by how many services hospitals deliver and how much training they deliver. Neither of these funding sources is linked to workforce planning, and both lock in the current distribution of training places, disadvantaging rural areas. This contributes to too much training in some areas, such as in emergency medicine, and too little in others, such as dermatology.^{vi}

The federal government's Specialist Training Program (STP) aims to address these imbalances by funding new positions in under-supplied specialties and in rural, remote, and private hospitals. However, this program has been criticised as too small and inflexible to enable the training system to respond to workforce needs.ⁱⁱ

The Grattan Institute recommends greater investment in public health clinics and setting a national target to bring the bottom quarter of communities up to the 25th percentile for services per person, across each medical specialty, within five years. Its analysis identifies 81 communities requiring additional investment in at least one specialty. The communities requiring the largest increases in services are predominantly in regional and remote areas, including outback communities across the Northern Territory, South Australia, Western Australia and Queensland. This highlights the need for targeted investment to address geographic inequities in healthcare access and ensure rural women can access the specialist services they need closer to home.^{vi}

Rural workforce challenges must also be addressed, with a particular focus on women's healthcare. RANZCOG's Rural Regional and Remote Strategy points to ongoing challenges accessing training and upskilling opportunities, resulting in a lack of training and reduced confidence levels when delivering certain services, professional isolation and a lack of support networks. Additionally, the relocation to rural and remote areas is not seen to be a viable option by some members, in part due to inadequate rural and remote infrastructure systems and limited support for partners and families.^{xiv}

This strategy highlights the development of the FRANCOG rural O&G specialist advanced training pathway, GP upskilling and expansion of the multi-disciplinary Obstetrics and Gynaecology Education and Training (OGET) program as priorities to address health care gaps in rural and remote areas. Additionally, the strategy calls for increased telehealth use and adequate MBS reimbursement, keeping rural and remote maternity services open and recognising rural general practitioner obstetricians to be recognised for the critical role they have in the delivery of women's health services in rural and remote communities.^{xiii}

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- ⁱ https://www.ruralhealth.org.au/wp-content/uploads/2025/08/The_Forgotten_Health_Spend_Report_08_2025.pdf
- ⁱⁱ <https://apo.org.au/node/330492>
- ⁱⁱⁱ <https://www.aihw.gov.au/reports/rural-and-remote-health>
- ^{iv} The state-based patient transport schemes subsidise travel the closest available and approved service <https://wacountry.health.wa.gov.au/~media/WACHS/Documents/PATS/PATS-Handbook.pdf>
<https://www.health.vic.gov.au/rural-health/victorian-patient-transport-assistance-scheme-vptas>
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- ^{vii} Rural and Remote Health. Australian Institute of Health and Welfare. Retrieved December 7, 2025, from <https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health>
- ^{viii} <https://www.ruralhealth.org.au/the-forgotten-health-spend-report/>
- ^{ix} <https://www.ruralhealth.org.au/wp-content/uploads/2025/02/NRHA-Rural-Health-in-Australia-Snapshot-2025.pdf>
- ^x <https://www.abc.net.au/news/2025-11-09/womens-pain-inquiry-victoria-released/105988930>
- ^{xi} May, N., (2024a). How much does the gender health gap cost? For Alyse, it's \$400,000. The Guardian. <https://www.theguardian.com/australia-news/2024/nov/12/alyse-chronic-health-conditions-have-cost-her-400000-doctors-say-the-system-unfairly-penalises-women>
- ^{xii} <https://www.health.vic.gov.au/sites/default/files/2025-11/bridging-the-gender-pain-gap-pain-inquiry-report.pdf>
- ^{xiii} <https://ranzcog.edu.au/wp-content/uploads/Rural-Regional-Remote-Strategy-Summary.pdf>