Submission by the Australian Nursing and Midwifery Federation

House of Representatives Standing Committee on Health, Aged Care and Disability: Inquiry into Access to and Affordability of Medical Specialists in Australia

14 October 2026

Australian Nursing & Midwifery Federation

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Key Points and Recommendations

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country. The ANMF thanks the House of Representatives Standing Committee on Health, Aged Care and Disability (the Committee) for the opportunity to contribute to the Inquiry into access to and affordability of medical specialists in Australia.

2. Access to affordable and timely specialist care is fundamental to an equitable, person-centred health system, yet many Australians are currently forced to choose between high out-of-pocket costs and lengthy waits for public specialist care. Almost two million people delay or skip specialist care each year because of cost. The impact falls hardest on people in rural, regional and remote RRR areas, Aboriginal and Torres Strait Islander People, older people, people with disability, culturally and linguistically diverse communities and people on low incomes. Nurses and midwives see the consequences every day when people present later, sicker, and with more complex conditions.

3. Timely specialist care is delivered by multidisciplinary teams, not by medical specialists alone. Workforce planning, funding, and reform must include the nurses, nurse practitioners (NPs), and midwives who assess, triage, coordinate and deliver much of this care.

4. Referral pathways should be designed around the person, not legacy administrative rules. The ANMF recommends indefinite referral validity for specified chronic conditions, a copy of the referral and fee information for every patient, parity for NP referrals and implementation of the direct referral pathways recommended by the Scope of Practice Review.

5. Excessive fees and opaque billing must be addressed through a legislated obligation that fees for Medicare-subsidised services are not unreasonable, service-level maximum fees benchmarked to the MBS Schedule Fee, and mandatory, legally enforceable informed

financial consent. The consequences must fall on the billing provider, not the patient.

6. The Australian Government, in partnership with states and territories, should invest in public specialist outpatient capacity where access is poorest, including in nurse- and midwife-led services, expand affordable alternatives such as midwifery continuity of care and NP-led care, and help rural patients meet the full cost of reaching care, including travel and accommodation.

7. The costs of delayed and missed specialist care are borne by emergency departments, public hospitals, primary care, and aged care, and by the workforces in each, many of whom are our members. People on waiting lists should be actively reviewed and supported through nurse-led waiting list management and care navigation.

8. NP-led and specialist nurse-led clinics have reduced waiting times without compromising safety. These models should be scaled up, sustainably funded and properly evaluated, rather than left reliant on short-term pilots.

9. The ANMF offers 19 recommendations to the Committee:

- **Recommendation 1:** Establish and embed national health workforce planning and data collection and analysis covering the medical, nursing and midwifery workforces, including a National Nursing and Midwifery Workforce Planning and Data Unit, with legislated reporting obligations, and tie specialist training places, including rural training, to identified community need.

- **Recommendation 2:** Introduce nationally consistent, publicly reported measures of public specialist outpatient waiting times in all jurisdictions, including the time from referral to first appointment.

- **Recommendation 3:** Fund designated NP, endorsed midwife and specialist nurse positions in specialist outpatient and outreach services in under-served areas, expand the Primary Care Nursing and Midwifery Scholarship Program with ring-fenced rural and First Nations places, recommence implementation of the Nurse Practitioner

Workforce Plan, and formalise specialist or dual registration categories for NPs.

- **Recommendation 4:** Fund ACCHO-led specialist outreach and partnerships, designated nurse practitioner education places for Aboriginal and Torres Strait Islander nurses, and cultural safety training, delivered by CATSINaM, for staff in specialist outpatient and outreach services.

- **Recommendation 5:** Expand midwifery continuity of care and midwifery-led birthing services in regional, rural and remote areas, including reinstating services that have closed and increase the role and autonomy of endorsed midwives as primary maternity care providers.

- **Recommendation 6:** Make referrals indefinite for specified chronic and lifelong conditions, replace time-based billing rules with a condition-based framework, allow second opinions under the same referral with mandatory reporting back to the referrer, and require that every patient receives a plain-language copy of their referral, including their right to choose a specialist and where to find fee information.

- **Recommendation 7:** Implement in full the recommendations of the Scope of Practice Review and the findings of the Nurse Practitioner Reference Group, including the recommended direct referral pathways, giving NP referrals parity with GP referrals, including validity periods, indefinite referrals and Medicare recognition, and, as the Review recommended, expanding the referral authority of endorsed midwives and remote area nurses within their scope of practice.

- **Recommendation 8:** Establish funded secondary consultation systems accessible to both GPs and NPs to enable primary healthcare providers to obtain rapid, expert advice from specialists.

- **Recommendation 9:** Legislate an obligation that fees for Medicare-subsidised services must not be unreasonable, supported by service-level maximum fees benchmarked to the MBS Schedule Fee, a designated regulator, patient refunds and escalating consequences; prohibit differential fees based on insurance status; and review MBS Schedule Fees.

- **Recommendation 10:** Make informed financial consent mandatory and legally enforceable, prohibit split billing practices, establish an accessible complaints pathway with reimbursement where charges substantially exceed estimates or informed financial consent was not obtained, and add indicative waiting times to the Medical Costs Finder and integrate it into referral software for all referrers.

- **Recommendation 11:** Commit new Commonwealth and state funding through the National Health Reform Agreement to expand public specialist outpatient capacity in under-served areas, allocated according to need and at least at per capita parity with metropolitan areas, including nurse- and midwife-led services.

- **Recommendation 12:** Expand affordable alternatives to high-fee specialist care through midwifery continuity of care, expanded funding pathways, including MBS access, for NP and mental health nurse-led care, broader Medicare-rebated diagnostic and prescribing rights for NPs and endorsed midwives, and their inclusion in the Bulk Billing Incentive Program.

- **Recommendation 13:** Harmonise Patient Assisted Travel Schemes across jurisdictions so that assistance is adequate, provided upfront where needed and includes support persons, and assess specialist affordability on the total cost of care, including travel, accommodation and lost income.

- **Recommendation 14:** Fund nurse-led waiting list review, clinical prioritisation and care navigation in public specialist outpatient services so that people waiting for care are actively monitored and escalated when needed, and fund nurse-led triage and care navigation in general practice and Primary Health Networks to improve the quality of referrals.

- **Recommendation 15:** Collect and publicly report data on deferred and missed specialist care and its downstream impacts, including emergency department presentations and avoidable hospital admissions, and stress test future reforms for their impact on RRR communities.

- **Recommendation 16:** Scale up NP- and specialist nurse-led outpatient, outreach and virtual clinics, and nurse-led specialty roles in cancer and chronic disease care, including lung cancer specialist nurses and national scale-up of nurse-led skin cancer screening in regional Australia, through the National Health Reform Agreement, with national pricing that recognises nurse- and midwife-led models of care.

- **Recommendation 17:** Include NPs in MyMedicare, consistent with arrangements for GPs, and fund nurse- and midwife-led virtual care, including nurse support for consumers at the local end of specialist telehealth consultations.

- **Recommendation 18:** Provide sustainable funding for NP- and midwife-led models of care through MBS rebate parity, a single Commonwealth funding stream (single-payer scheme) for nurse- and midwife-led clinics, and block funding where fee-for-service arrangements are not fit for purpose.

- **Recommendation 19:** Establish a dedicated nurse- and midwife-led health services research and evaluation fund to evaluate innovative models of care and support the scale-up of those that work. Further, the grant scheme should be announced early and provide busy clinicians with sufficient time to develop competitive applications for funding.

Introduction

10. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives, and care-workers across the country.

11. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

12. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

13. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

14. The ANMF thanks the House of Representatives Standing Committee on Health, Aged Care and Disability for the opportunity to contribute to this Inquiry. Our submission addresses each of the terms of reference. It builds on the ANMF's recent submissions to the Department of Health, Disability and Ageing on modernising referral pathways, fee transparency and options to address excessive specialist fees, and to the Senate inquiry into rural, regional and remote (RRR) Medicare access and funding.

15. The ANMF supports a health system in which a person's ability to pay, their insurance status or their postcode does not determine whether they receive timely, clinically necessary care. While this Inquiry focuses on medical specialists, specialist care is delivered by teams.

Reforms that consider the medical workforce in isolation will miss many of the most practical and cost-effective opportunities to improve access. It is important to recognise that the issues raised in this Inquiry do not exist in isolation, and that access to and affordability of specialist care are closely interconnected with the broader pressures facing Australia's health system and its workforce.

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

16. Access to specialist care across Australia remains inequitable, with significant variation according to where people live and their socioeconomic circumstances. In 2019 there were nearly 200 specialists per 100,000 people in major cities but fewer than 70 per 100,000 in remote communities. Half of all remote and very remote areas receive less than one specialist service per person each year, while no part of a major city does. People in poorer communities receive fewer specialist services despite having greater need, and Aboriginal and Torres Strait Islander People received just over half as many specialist services as other Australians after adjusting for age.[1]

17. Closing this gap requires culturally safe services and a stronger Aboriginal and Torres Strait Islander nursing and midwifery workforce. Aboriginal Community Controlled Health Organisations (ACCHOs) already coordinate specialist outreach, multidisciplinary care and culturally safe support that help people navigate referral pathways and remain engaged in treatment. These organisations are trusted by the communities they serve, and are often best placed to understand and respond to local needs. In the Northern Territory, for example, ACCHO-coordinated outreach clinics make full use of on-site pathology and imaging and provide transport for patients.[2] The ANMF has called for designated places for Aboriginal and Torres Strait Islander nurses in nurse practitioner education, support for ACCHOs to employ nurses at advanced practice level, and nationally mandated cultural

[1] Breadon P, Geraghty J, Jones D, Baldwin E. *Special treatment: Improving Australians' access to specialist care.* Melbourne: Grattan Institute; 2025. Available from: https://grattan.edu.au/report/special-treatment-improving-australians-access-to-specialist-care/

[2] National Rural Health Alliance. Submission to the House of Representatives Standing Committee on Health, Aged Care and Disability Inquiry into access to and affordability of medical specialists in Australia. Canberra: NRHA; October 2026.

safety training for all health workers delivered by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM).[3]

18. Public outpatient clinics are the main free alternative to private care, but provide only about a third of specialist appointments and waiting times are often far longer than clinically recommended. Across Sydney, Melbourne, Brisbane, and Adelaide, there are 50 specialties in which one in ten patients waits more than a year for a first appointment, and 29 per cent of people who needed to see a specialist in 2023-24 waited longer than they felt was acceptable. Waiting time data are not nationally consistent, and several jurisdictions do not publicly report outpatient waiting times at all.[1] Without consistent measurement, the true extent of waiting cannot be known or addressed. This is particularly concerning for consumers living in RRR areas, who often have few, if any, alternatives available to them.

19. The ANMF supports national workforce planning that links specialist training places, including rural training, to community need. However, planning must cover the whole health workforce. Here, workforce planning that focuses on the medical workforce alone risks overlooking the essential role that nurses and midwives play in delivering and referring patients to specialist care in every setting. Specialist outpatient clinics, procedural and diagnostic services and outreach programs cannot expand without nurses and midwives. Retaining this workforce requires safe staffing, protection from occupational violence and fair pay and conditions. The ANMF has called for a National Nursing and Midwifery Workforce Planning and Data Unit within the Commonwealth or the Australian Institute of Health and Welfare, with legislated reporting obligations, consistent with Action 1.1 of the National Nursing Workforce Strategy.[3]

20. The NP workforce is substantially underused. Of the 2,664 nurses endorsed as NPs, only 1,871 are employed in NP roles.[4] Many NPs practise in specialty fields such as cardiology, oncology, gastroenterology, neurology, mental health and wound care, and can provide

[3] Australian Nursing and Midwifery Federation. 2026-27 Pre-Budget Submission. Melbourne: ANMF; 30 January 2026.

[4] Australian Government Department of Health, Disability and Ageing. Nursing and Midwifery Workforce Dashboard (National Health Workforce Dataset). Available from: https://hwd.health.gov.au/nrmw-dashboards/index.html

assessment, diagnosis, prescribing and ongoing management that would otherwise wait for a medical specialist appointment. Despite this, many NPs continue to face barriers that prevent them from working to their full scope of practice. Designated, funded NP and endorsed midwife positions in specialist and maternity services, and formal recognition of advanced specialty practice through specialist or dual registration categories for NPs, would make better use of this workforce, particularly in RRR areas. Further, growing this workforce requires a reliable pipeline. The Primary Care Nursing and Midwifery Scholarship Program should be expanded, with places ring-fenced for rural and First Nations applicants and paid protected study time for registered nurses studying to become NPs, and work on the Nurse Practitioner Workforce Plan, which has stalled, should recommence.[3]

21. Access to maternity and obstetric care in rural areas has been further reduced by the closure of rural birthing services leaving women to travel long distances to give birth. Midwifery continuity of care and midwifery-led birthing services, with endorsed midwives working as primary maternity care providers and streamlined escalation to obstetric care where clinically indicated, can sustain safe, affordable maternity care closer to home.[3]

Recommendations

Recommendation 1: Establish and embed national health workforce planning and data collection and analysis covering the medical, nursing and midwifery workforces, including a National Nursing and Midwifery Workforce Planning and Data Unit, with legislated reporting obligations, and tie specialist training places, including rural training, to identified community need.

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formalise specialist or dual registration categories for NPs.

Recommendation 4: Fund ACCHO-led specialist outreach and partnerships, designated nurse practitioner education places for Aboriginal and Torres Strait Islander nurses, and cultural safety training, delivered by CATSINaM, for staff in specialist outpatient and outreach services.

Recommendation 5: Expand midwifery continuity of care and midwifery-led birthing services in regional, rural and remote areas, including reinstating services that have closed and increase the role and autonomy of endorsed midwives as primary maternity care providers.

b) Effectiveness, transparency and equity of referral pathways

22. As the ANMF set out in our submission regarding modernising referral pathways, current referral rules reflect legacy administrative controls more than contemporary clinical need.[5] By default, referrals from GPs and NPs are valid for 12 months and specialist-to-specialist referrals for three months.[6] Referrals frequently expire while people are still on waiting lists, forcing additional appointments solely to renew them, adding cost for consumers and workload for clinicians. The ANMF recommends indefinite referral validity for specified chronic and lifelong conditions, supported by clear communication between treating clinicians, and replacing time-based billing rules such as the nine-month rule with a condition-based framework. Here, extending referral validity for those living with chronic and lifelong conditions is not simply an administrative adjustment, but an equity-focused reform that would help to protect continuity of care.

23. Referrals are often not transparent to the people receiving them. Many consumers never see their referral and do not know they can be involved in decision making to select where or which specialist they see. Health literacy and the ability to navigate complex health

[5] Australian Nursing and Midwifery Federation. Submission to the Department of Health, Disability and Ageing – Modernising Referral Pathways. Melbourne: ANMF; 13 March 2026.

[6] Australian Government Department of Health, Disability and Ageing. MBS Online factsheet: Referrals for specialist services. July 2026. Available from: https://www.mbsonline.gov.au

information also vary considerably between individuals and groups, particularly for culturally and linguistically diverse consumers. Every consumer should receive a copy of their referral in plain, understandable language, with information about their right to choose a specialist and links to fee information. Patients should also be able to seek a second opinion under the same referral, with the second specialist required to report back to the referrer.

24. Importantly, current restrictions upon who can make referrals also have significant implications for equity of access, particularly in RRR communities. NPs can refer to specialists under Medicare and, since November 2024, no longer require a collaborative arrangement with a medical practitioner to do so. However, the Scope of Practice Review found that restrictions on referrals by nurses and midwives arise more from the application of MBS rules than from the scope of practice of the referring professional, and recommended direct referral pathways for health professionals working within their scope.[7] Referral pathways for endorsed midwives remain limited, and in communities without a resident GP, remote area nurses have no Medicare-recognised referral pathway. People must then travel long distances, or wait for a visiting doctor, simply to obtain a referral to a specialist who may also have an unfeasibly long waiting list. This delays access to care and worsens health outcomes and costs. The ANMF has called for all of the Review's recommendations to be implemented in full, together with the findings of the Nurse Practitioner Reference Group.[3]

25. Many referrals could be avoided if primary care clinicians had timely access to specialist advice. Secondary consultation systems, in which a specialist provides written advice on a specific patient, could avoid an estimated 68,000 referrals a year.[1] Importantly, these systems should be available to NPs as well as GPs. Nurse-led triage and care navigation roles in general practice, Primary Health Networks and outpatient clinics can also improve the quality of referrals and reduce rejected or incomplete referrals. Any national digital referral system must be interoperable, work reliably in RRR areas, and include NPs and midwives as both referrers and recipients. With careful planning, co-design with clinicians and

[7] Australian Government Department of Health and Aged Care. *Unleashing the potential of our health workforce: Scope of practice review – final report.* Canberra: Commonwealth of Australia; 2024. Available from: https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report

consumers, and appropriate implementation support, these reforms could be introduced in a way that minimises additional administrative burden on already busy clinicians.

Recommendations

Recommendation 6: Make referrals indefinite for specified chronic and lifelong conditions, replace time-based billing rules with a condition-based framework, allow second opinions under the same referral with mandatory reporting back to the referrer, and require that every patient receives a plain-language copy of their referral, including their right to choose a specialist and where to find fee information.

Recommendation 7: Implement in full the recommendations of the Scope of Practice Review and the findings of the Nurse Practitioner Reference Group, including the recommended direct referral pathways, giving NP referrals parity with GP referrals, including validity periods, indefinite referrals and Medicare recognition, and, as the Review recommended, expanding the referral authority of endorsed midwives and remote area nurses within their scope of practice.

Recommendation 8: Establish funded secondary consultation systems accessible to both GPs and NPs to enable primary healthcare providers to obtain rapid, expert advice from specialists.

c) Affordability of specialist services

26. In Australia, specialist care is becoming less affordable. This is a growing concern for many households already facing significant cost-of-living pressures. The average out-of-pocket cost for a non-bulk-billed specialist consultation increased from $46 in 2009-10 to $126 in 2024-25.[8] Patients pay a fee for around two thirds of specialist appointments, and average out-of-pocket costs for specialist attendances have risen by 73 per cent in real terms since 2010, faster than for other Medicare services.[1] Costs for diagnostics and procedures add to this burden, and accumulate quickly for people with chronic or complex conditions who

[8] Scott A. Specialist doctors are charging too much. 4 options to rein in excessive fees. The Conversation; 2026. Available from: https://theconversation.com/specialist-doctors-are-charging-too-much-4-options-to-rein-in-excessive-fees-281986

need to see several specialists or the same specialist repeatedly.

27. Specialists are free to set their own fees, and increased competition has not constrained fee growth.[8] Patients have limited capacity to shop around because of urgency, distance, waiting lists and the need for continuity of care. While most specialists do not charge excessive fees, regulation is needed to protect patients from the minority who do. Consistent with our forthcoming submission around options to address excessive fees, the ANMF supports a benchmark against the MBS Schedule Fee, transparent service-level maximum fees, a legislated obligation that fees for Medicare services must not be unreasonable, a clear remit for a regulator, refunds to affected patients and escalating consequences for repeated breaches.[9] Excessive fees should not be made ineligible for Medicare benefits, as this would leave patients further out of pocket. Charging higher fees based upon a patient's private health insurance status should be prohibited, and a review of whether MBS Schedule Fees reflect the cost of contemporary care should follow without delaying action. It is important to recognise that even with greater access to information and transparency regarding fees, many patients will continue to have limited freedom to choose their specialist provider.

28. Patients also need to know what they will pay before care begins. The ANMF supports mandatory, legally enforceable informed financial consent, including a single written, itemised estimate of all expected fees, including those of anaesthetists and surgical assistants whom patients rarely choose, and reforms to prevent split billing.[10] These obligations must rest with the billing provider and not shift to nurses and midwives who often communicate with patients but do not set fees. Nurses and midwives should not be unduly placed in the position of having to explain or justify fees that they have had no role in setting. Without clear standards and enforcement, voluntary transparency measures have proven largely ineffective. By the end of 2022, just six of around 6,300 eligible specialists had chosen to publish their fees on the Medical Costs Finder.[10] The ANMF welcomes legislation

[9] Australian Nursing and Midwifery Federation. Submission to the Department of Health, Disability and Ageing on Specialist Affordability: Options to Address Excessive Fees. Melbourne: ANMF; October 2026.

[10] Australian Nursing and Midwifery Federation. Submission to the Department of Health, Disability and Ageing – Fee Transparency in Health Care on Informed Financial Consent and Split Billing Practices. Melbourne: ANMF; 5 August 2026.

enabling the publication of individual specialists' fees. The Medical Costs Finder should be integrated into clinical and referral software so that all referrers, including NPs, can discuss likely costs at the point of referral. It should also show indicative waiting times so that patients and referrers can weigh cost against timeliness.[2]

29. Public outpatient services are the only affordable option for many people, but do not fill the gaps left by private care. People in the worst-served areas receive about a third fewer specialist services than those in the best-served areas.[1] The Australian Government, in partnership with states and territories, should prioritise health funding to expand public specialist outpatient capacity in under-served areas, including through nurse- and midwife-led services. The National Rural Health Alliance estimates an annual gap in health spending of $9.23 billion between urban and non-urban Australia.[2] Investment in public specialist services in rural areas should be allocated according to need and at least match metropolitan levels per capita.

30. For people in RRR areas, the fee is only part of the cost of specialist care and is greater than that borne by metropolitan residents. Travel, accommodation, meals, support persons, childcare and lost income can exceed the consultation fee itself, particularly when repeated trips are needed for investigations, treatment and follow-up. Patient Assisted Travel Schemes help, but eligibility and subsidy rates vary between jurisdictions, assistance is generally reimbursed after travel rather than provided upfront, and it does not cover the full cost. Per person spending on these schemes reaches about $198 in MM 6 and $332 in MM 7 communities, showing how heavily rural patients rely on travel to reach specialist care.[2] Further, many patients are unaware of the support available, and care navigation roles, including nurse-led roles, can help people understand and claim it. These costs are often cumulative, and for many people living with chronic or complex conditions they can quickly become a significant barrier to accessing the care they need.

31. Affordable alternatives to high-fee specialist care should also be expanded. Midwifery continuity of care models, delivered through public services and by privately practising

midwives, provide safe, high-quality and more affordable maternity care for women who may otherwise face high private obstetric fees. Nurse Practitioner and mental health nurse-led care can improve access to ongoing mental health care, where cumulative specialist fees are particularly burdensome. Here, these models remain constrained by lower MBS rebates for NPs than for comparable medical services, limited Medicare-rebated diagnostic and prescribing rights, and the exclusion of NPs and endorsed midwives from the Bulk Billing Incentive Program.[11] Ensuing that MBS fees for NPs are at a suitable level would further reduce the occurrence of NPs needing to charge patients additional fees simply to cover the cost of providing usual services.

Recommendations

Recommendation 9: Legislate an obligation that fees for Medicare-subsidised services must not be unreasonable, supported by service-level maximum fees benchmarked to the MBS Schedule Fee, a designated regulator, patient refunds and escalating consequences; prohibit differential fees based on insurance status; and review MBS Schedule Fees.

Recommendation 10: Make informed financial consent mandatory and legally enforceable, prohibit split billing practices, establish an accessible complaints pathway with reimbursement where charges substantially exceed estimates or informed financial consent was not obtained, and add indicative waiting times to the Medical Costs Finder and integrate it into referral software for all referrers.

Recommendation 11: Commit new Commonwealth and state funding through the National Health Reform Agreement to expand public specialist outpatient capacity in under-served areas, allocated according to need and at least at per capita parity with metropolitan areas, including nurse- and midwife-led services.

Recommendation 12: Expand affordable alternatives to high-fee specialist care through midwifery continuity of care, expanded funding pathways, including MBS access, for NP and mental health nurse-led care, broader Medicare-rebated diagnostic and prescribing rights

[11] Australian Nursing and Midwifery Federation. Submission to the Senate Standing Committee on Rural and Regional Affairs and Transport: Rural, regional and remote Medicare access and funding. Melbourne: ANMF; 27 March 2026.

for NPs and endorsed midwives, and their inclusion in the Bulk Billing Incentive Program.

Recommendation 13: Harmonise Patient Assisted Travel Schemes across jurisdictions so that assistance is adequate, provided upfront where needed and includes support persons, and assess specialist affordability on the total cost of care, including travel, accommodation and lost income.

d) Impacts of delays on patients and the health system

32. Delayed access to specialist care can have significant consequences for consumers' health and wellbeing. When timely care is not available, conditions may deteriorate, diagnoses can be missed or made late, and people may live with avoidable pain and distress. Delays to cancer treatment, for example, increase mortality.[1] Our members working across emergency departments, general practice, community health, chronic disease management and aged care advise us that they regularly care for consumers who have delayed or gone without specialist consultations, investigations or treatment because of cost, limited health literacy, distance, or waiting times.

33. The costs of these delays are shifted across the health system. Where specialist and primary care is not accessible, the emergency department becomes the default point of care. People in remote and very remote areas have the highest emergency department presentation rates, at 664 and 686 presentations per 1,000 people respectively.[12] Sicker patients need more intensive hospital care, adding to emergency department crowding, ramping and bed block. This increases nursing workload and burnout and undermines the very workforce needed to reduce waits. Our members tell us that these pressures are felt particularly acutely in emergency departments, where they contribute to fatigue, moral distress and, ultimately, nurses leaving the profession. In primary care, GPs, NPs and practice nurses manage deteriorating patients while they wait, and chronic disease management stalls without specialist input. In residential aged care, residents who need specialist review often face transport and escort barriers, and delays can lead to avoidable transfers to hospital.

[12] Australian Institute of Health and Welfare. Emergency department presentations. Canberra: AIHW; 2025. Available from: https://www.aihw.gov.au/hospitals/topics/emergency-departments/presentations

Residential In-Reach programs within public health services, including nurses with dementia and psychogeriatric expertise, can bring timely assessment to residents and avoid many of these transfers.[3] Such pressures cannot be addressed by a singular reform, and will require coordinated action across Commonwealth, state and territory health systems.

34. People on specialist waiting lists are often largely invisible to the system. For many consumers, this can mean months or even years of uncertainty about when, or whether, they will receive the care they need. Lists are rarely reviewed clinically and administrative processes to confirm referrals and contact details add cost.[1] Evidence demonstrates that active waiting list management can be highly effective. In Queensland, an audit and confirmation model at Children's Health Queensland reduced long waits from around 5,500 patients to fewer than 300.[13] Nurse-led waiting list review, clinical prioritisation and care navigation can identify people whose condition is deteriorating, escalate their care and connect them with interim support in primary care.

Recommendations

Recommendation 14: Fund nurse-led waiting list review, clinical prioritisation and care navigation in public specialist outpatient services so that people waiting for care are actively monitored and escalated when needed, and fund nurse-led triage and care navigation in general practice and Primary Health Networks to improve the quality of referrals.

Recommendation 15: Collect and publicly report data on deferred and missed specialist care and its downstream impacts, including emergency department presentations and avoidable hospital admissions, and stress test future reforms for their impact on RRR communities.

e) Innovative and emerging models of care

35. There is strong evidence that changing who delivers care can improve access to specialist services. The Grattan Institute's review of Australian and international studies found that

[13] Queensland Audit Office. *Improving access to specialist outpatient services* (Report 8: 2021–22). Brisbane: QAO; 2021. Available from: https://www.qao.qld.gov.au/sites/default/files/2021-12/Improving%20access%20to%20specialist%20outpatient%20services%20(Report%208%E2%80%942021%E2%80%9322).pdf

every study of changed workforce roles in specialist clinics reported reduced waiting times, none found that quality and safety of care was worse, and four of the five studies that assessed costs found that they fell.[1] In Queensland, an ophthalmology alternate pathways project using nurse- and allied health-led clinics reduced long waits from 1,031 patients in January 2018 to five by December 2018, and a neurology service that included NP-led clinics for multiple sclerosis, epilepsy and movement disorders achieved a 61 per cent reduction in its waiting list.[13] Importantly, these models do not replace existing medical specialist care, but rather build upon it, allowing specialists to focus their time on those consumers with the most complex needs.

36. Specialist nursing roles have demonstrated their value in improving equitable access to care and health outcomes. Government funding for breast and prostate cancer specialist nurses has improved equitable access and outcomes, yet there are only around 12 full-time equivalent lung cancer nurse specialists in Australia for more than 12,700 people diagnosed with lung cancer each year.[3] Nurse-led models can also extend access to under-supplied specialties. This is especially important in RRR areas, where access to some specialties is extremely limited. Fewer than 8 per cent of dermatologists work outside major cities.[1] Building on a successful pilot in regional South Australia, the Spot Study, led by Adelaide University's Rosemary Bryant AO Research Centre in collaboration with the ANMF, proposes a national nurse-led, multidisciplinary model of skin cancer screening to improve early detection in high-risk regional communities.[3]

37. These models should be scaled up across specialties and settings, including NP-led outpatient and outreach clinics, nurse-led specialty roles in cancer and chronic disease such as lung cancer specialist nurses, Residential In-Reach programs and NP roles in residential aged care, and midwifery continuity of care with streamlined escalation to obstetric services where clinically indicated. Nurse- and midwife-led virtual care can also reduce the travel, time and cost of specialist care for people in RRR areas. However, Medicare-rebated NP telehealth does not include a MyMedicare pathway equivalent to that available to GPs.[11] This creates an unnecessary barrier for the people who would benefit most. Telehealth also

works best when patients are supported locally. Models in which a nurse or Aboriginal Health Practitioner supports the consumer at a local health service during a specialist telehealth consultation can address connectivity and digital literacy barriers and strengthen continuity of care.[2]

38. Despite this evidence, the absence of sustainable, long-term funding remains the most significant barrier to scaling up nurse- and midwife-led models of care. Nurse-led models are too often established as short-term pilots and not sustained. This creates uncertainty for both the nurses and midwives delivering these services and the communities that come to rely on them. Public outpatient funding prices reflect current practice rather than best practice, and Medicare billing arrangements in public clinics that require referral to a named medical specialist make it harder to use different workforce mixes.[1] Lower MBS rebates for NPs and the fee-for-service structure of Medicare also limit the viability of NP- and midwife-led services, particularly in RRR areas.[11] Proven models need sustainable funding through the National Health Reform Agreement, national pricing that recognises nurse- and midwife-led care, and block funding where fee-for-service is not fit for purpose. The ANMF has proposed a single Commonwealth funding stream (a single-payer scheme) to provide sustainable, ring-fenced funding for nurse- and midwife-led clinics and models of care, including in-reach to residential aged care.[3] Many nurse-led models also remain under-evaluated because nurses and midwives are under-represented in health services research funding, leaving effective models vulnerable to disinvestment.[3]

Recommendations

Recommendation 16: Scale up NP- and specialist nurse-led outpatient, outreach and virtual clinics, and nurse-led specialty roles in cancer and chronic disease care, including lung cancer specialist nurses and national scale-up of nurse-led skin cancer screening in regional Australia, through the National Health Reform Agreement, with national pricing that recognises nurse- and midwife-led models of care.

Recommendation 17: Include NPs in MyMedicare, consistent with arrangements for GPs, and fund nurse- and midwife-led virtual care, including nurse support for consumers at the local end of specialist telehealth consultations.

Recommendation 18: Provide sustainable funding for NP- and midwife-led models of care through MBS rebate parity, a single Commonwealth funding stream (single-payer scheme) for nurse- and midwife-led clinics, and block funding where fee-for-service arrangements are not fit for purpose.

Recommendation 19: Establish a dedicated nurse- and midwife-led health services research and evaluation fund to evaluate innovative models of care and support the scale-up of those that work. Further, the grant scheme should be announced early and provide busy clinicians with sufficient time to develop competitive applications for funding.

Conclusion

39. Access to timely, affordable specialist care should not depend on a person's ability to pay or their postcode. Addressing excessive fees and opaque billing is necessary, but it will not be enough on its own. Improving access to specialist care also requires modern, person-centred referral pathways, investment in public specialist services where they are most needed, help with the full cost of reaching care, and better use of the whole health workforce. Our members see the consequences of these barriers every day, and the ANMF welcomes the Committee's attention to these important issues.

40. Nurses, NPs, and midwives already deliver much of the care that people need before, during and after they see a medical specialist. With the right referral rights, funding and recognition, they can do much more to reduce waiting times and costs, particularly for people in RRR areas and those who are currently missing out. The ANMF calls on the Committee to recommend reforms that support nurses and midwives to work to their full scope of practice and ensure all Australians can access safe, quality specialist care regardless of their postcode.