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By doctors for doctors

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Avant submission to the inquiry into access to and affordability of medical specialists in Australia

Thank you for the opportunity to make a submission to the inquiry into access to and affordability of medical specialists in Australia, being conducted by the House of Representatives Standing Committee on Health, Aged Care and Disability.

Our submission is attached.

Please contact me or Chris Newlan on the details below if you require any further information or clarification of the matters raised in the submission.

Yours sincerely

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Avant submission

Inquiry into access to and affordability of medical specialists in Australia

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About Avant

Avant is a member-owned doctors' organisation and Australia's largest medical indemnity insurer, representing more than 100,000 medical practitioners. Our members work across all medical specialities, career stages and states and territories. We are committed to supporting a sustainable health system that provides high quality and safe care to patients.

Through our advocacy, research and medico-legal education activities, we work to promote quality, safety and professionalism in medical practice, Avant sees how health system settings impact doctors and their patients. We assist members with matters directly related to fee disputes, informed financial consent (IFC) and patient complaints, providing valuable insight into affordability and fee transparency issues.

This submission draws on those insights, Avant's research with General Practitioners (GPs) and patients, our claims experience, and our work on private health system sustainability and emerging models of care.

Summary of our position

Avant supports the intent of the inquiry. There are significant and persistent barriers to specialist care that affect many Australians and affordability is one of them. However, treating affordability alone as the problem, rather than as one aspect of a set of broader access issues, risks introducing reforms that have little prospect of improving access to care and with the potential to create unintended consequences elsewhere in the health system. Change should not undermine patient safety or create medico-legal risk.

Avant's 2026 Parliamentary Roundtable on access and quality in healthcare, which brought together patients and community representatives, clinicians, policymakers and health system leaders, identified four closely connected drivers of access: affordability, availability, navigability and viability. These drivers are causes of acute pressure particularly in rural and regional Australia. They also interact with each other. A service cannot be affordable if it is not available. A novel pathway does not improve access if patients cannot navigate it. A service that is not financially viable will not remain available.

The Committee should, therefore, take a whole-of-system approach. Any reforms should aim to improve access while protecting safety and quality, preserve a viable, balanced public and private system, and minimise risk to patients if new models of care are introduced.

KEY RECOMMENDATIONS

1. **Simplify specialist referral pathways and remove unnecessary return visits to GPs.**
   Provide clearer national guidance on referral duration and the use of named, unnamed and indefinite referrals. Introduce a grace period allowing a patient's usual GP to renew an inadvertently expired referral so a planned specialist consultation can proceed. Consider defined direct referral pathways from other health practitioners where they provide a clear access benefit and appropriate clinical, communication, liability and indemnity safeguards are in place.

2. **Expand public specialist capacity where access gaps are greatest and reduce clinically harmful delays.**
   Use data on the full patient journey, including hidden waiting lists, to identify specialties and communities where patients are waiting beyond clinically recommended timeframes and target additional specialist capacity to those areas. Prioritise investment in specialist workforce and service

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capacity in these areas. Reforms should recognise that prolonged delays can adversely affect patient outcomes, increase demand on general practice and emergency departments, and create uncertainty regarding clinical follow-up responsibilities.

3. **Maintain viable private system to complement public specialist care.**
Establish a national viability framework to identify and support essential regional private hospital and specialist services at risk of failure. Review and reform specialist MBS rebates to better reflect the contemporary cost and complexity of care and reduce patient out-of-pocket costs. At a minimum, freeze the current Private Health Insurance Rebate by suspending further reductions under the rebate adjustment mechanism to support private health insurance participation and private hospital viability.

4. **Mandate that safety, clinical responsibility and indemnity requirements are built into new models of care from the outset.**
Build in mandatory requirements for new and expanded models of care to establish specific clear arrangements for clinical responsibility, supervision, communication, follow-up, escalation, documentation, regulatory oversight and indemnity before implementation. Responsibility for clinical decisions should remain aligned with the practitioner or organisation exercising clinical control so that access reforms do not inadvertently transfer risk without corresponding authority.

5. **Make better use of private sector capacity and the available specialist workforce.**
Increase funding for specialist training in private settings, particularly in regional areas, enable more integrated public-private workforce models, support a broader role for appropriately qualified overseas-trained psychiatrists in private hospitals and private practice, and provide targeted practical support to attract and retain specialists in areas of greatest need.

6. **Coordinate Commonwealth specialist access reforms through a single reform framework.**
Bring together reforms to referrals, fee transparency, Medicare, private health, workforce, emerging models of care and scope of practice so their cumulative effects can be assessed, any conflicting requirements identified and implementation appropriately sequenced.

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1. Access is broader than affordability

Cost matters. According to the Australian Bureau of Statistics (ABS) in 2024-25,[1] 18.3 per cent of Australians aged 15 years and over who needed to see a medical specialist delayed or did not see one when needed. Cost was reported as a reason in 8.6 per cent of cases with the same ABS data showing that 26.4 per cent waited longer than they considered acceptable for a specialist appointment.

These figures should not be interpreted as a simple split between cost and non-cost barriers because patients may experience more than one barrier. They do, however, reinforce the broader point that access is affected not only by cost but also by whether a service exists, how long a patient must wait, whether they can find and navigate the right service or suite of services and whether those services remain viable as well as what it costs.

Geography makes this particularly evident. People living in regional, rural and remote areas are more likely than people in urban areas to use emergency departments and are substantially less likely to hold private health insurance.[1] In many communities the choice does not relate to the cost of seeing a specialist but to whether a local specialist service exists at all. Accessing care also often requires significant out-of-pocket costs associated with travel, accommodation, childcare, carer support and time away from work or education. Specialists practising in areas of workforce shortage also face unique challenges, including long working hours, on-call demands, professional isolation, limited opportunities for peer support and difficulties accessing specialist advice. These pressures can contribute to workforce burnout and retention challenges, further reducing local service availability, as well as introducing patient safety risks.

The four drivers of specialist access
Affordability means whether the patients can meet the cost of care. Availability means whether the required service or workforce exist and where they are needed. Navigability means whether patients and referrers can understand and move through the system. Viability means whether services can continue to operate sustainably.

Avant GP referral research

Avant recently conducted a national survey of GP referral drivers[2] and patient experiences of specialist referrals, the first research of its kind in Australia. It included:

- 16 in-depth interviews with GPs from diverse practice settings to identify factors influencing referral decisions.
- A survey of 357 GPs, capturing details of 694 referral decisions and quantifying the relative importance of factors such as clinical suitability, access and cost.
- A survey of 503 patients who received a specialist referral in the previous 12 months to better understand their experience of accessing specialist care.

The research found clinical suitability and access to specialists were the primary drivers of GP referral decisions. Cost ranked fourth of five key considerations. Where cost did influence a referral, it was more likely to determine whether a patient was referred through the public or private system than the choice of individual specialist.

Waiting times emerged as the dominant system concern. 68 per cent of GPs surveyed were dissatisfied with referrals into the public system, while 62 per cent of patients identified better access to specialists as the single most important improvement needed.

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[1] Australian Bureau of Statistics. *Patient experiences, Australia, 2024-25* [Internet]. 2025. Available from: https://www.abs.gov.au/statistics/health/health-services/patient-experiences-australia/latest-release

[2] The Navigators, *GP Referral Drivers Survey: Understanding factors influencing the referral of patients to non-GP specialists.* Prepared for Avant; June 2026. Available from: 0697 Avant - GP Referral Driver Survey June 2026

These findings reinforce the principle that reforming referral pathways alone will not resolve the barriers patients face in accessing specialist care. The more fundamental constraint is whether appropriate specialist services are available when and where patients need them. This is particularly evident in parts of the public system where demand exceeds available capacity, resulting in long waiting times and greater pressure on GPs to manage patients while they wait for specialist care.

Improving referral pathways can make the system easier to navigate, but it cannot be a substitute for sufficient specialist capacity. Reform must also address the underlying availability and viability of services alongside affordability and navigability.

Availability and viability are closely linked

When a service closes, access to care can be lost rapidly. The withdrawal of private maternity services at Darwin Private Hospital provides an illustrative example which we detail further below. The closure removed the only private maternity pathway in the Northern Territory, increasing reliance on Royal Darwin Hospital and alternative postnatal arrangements. The ABC reported one of these options was a "luxury postnatal maternity retreat … at one of Darwin's boutique hotels"[3].

Speaking at Avant's Parliamentary Roundtable in June 2026, the last doctor in the Northern Territory providing private obstetric care in a private hospital setting, Dr Alia Vemuri, highlighted the risks of this approach. Dr Vemuri said "…but hotel rooms are not hospital wards, and if a mother suffers from an eclamptic seizure, they are cut off from immediate clinical recognition, as there is no 24-hour onsite midwife, and they rely solely on an overstretched ambulance service to transport them back to the public emergency department."

This lesson extends well beyond maternity care. Specialist services depend on viable hospitals, clinics, workforces and supporting infrastructure. Policy settings that weaken one part of that system can move demand elsewhere rather than remove it and also increase patient safety risks.

Navigability matters for patients

Patients and carers are often expected to coordinate care across multiple clinicians, services and funding systems. GPs may also spend considerable time helping patients find a service that is clinically appropriate, available and affordable. This becomes more difficult when waiting time, availability and fee information is incomplete or difficult to compare.

Improving navigability should therefore be treated as an access reform theme in its own right. Better information can reduce unnecessary return visits, repeated referrals and delays, but it must be paired with actual service capacity.

2. Referral reform can remove unnecessary access barriers

Avant supports making referral arrangements easier for patients and practitioners to understand and navigate. We also support reforms that remove unnecessary steps in the patient journey where there is evidence they can improve access without compromising safety, continuity or quality of care.

Our submission to the Australian Government's Modernising Referral Pathways consultation highlighted recurring confusion about referral duration, indefinite referrals and named and unnamed referrals. In some cases, patients return to their GP for a new referral when an existing or longer referral may have been clinically appropriate.

[3] Chaseling O. New postnatal care options announced for families affected by Darwin Private Hospital maternity services closure. ABC News [Internet]. 2025 Feb 21. Available from: New postnatal care options announced for families affected by Darwin Private Hospital maternity services closure - ABC News

The first step should be clearer guidance and education for patients and practitioners. Patients also should have easier access to reliable information about specialist availability, likely waiting times and fees so that, where clinically appropriate, they do not feel they need to return to their GP simply because the first service they contact is unavailable.

There also may be certain defined circumstances where direct referral from another health practitioner to a medical specialist might remove an unnecessary step and allow patients to access appropriate care sooner. Previous Federal Government reviews have given consideration to defined direct referral pathways, including from physiotherapists to orthopaedic surgeons where conservative management has not been successful or a patient presents with an acute or serious injury. However, increasing referral sources may also increase demand for specialist services, particularly when referrals are made by practitioners who may not be as skilled as GPs in determining referrals are not clinically necessary. Rejected referrals are already an emerging access problem, where GPs frequently face repeated referral attempts before a patient secures specialist care.

Avant recommends these pathways be assessed individually rather than through a broad expansion of referral rights. Access benefits should not be diminished by increased demand. The test should be whether the pathway provides a clear access benefit, is within the referring practitioner's scope and competency, and maintains appropriate clinical oversight and continuity of care.

Any new pathway also must establish clearly who is responsible for the referral and subsequent care, the information that must accompany it, communication with the patient's GP and treating team, documentation, follow-up and escalation. As stated in our submissions to those reviews[4] and later in this submission, liability and indemnity arrangements should be considered as part of the design of the pathway, not after it has been implemented.

3. Affordability is shaped by system pressures as well as fees

Avant acknowledges community concerns about affordability of specialist fees. A small number of outlier fees may cause financial distress, damage trust and undermine confidence in the private system. Outlier fees should not, however, be used to tarnish the profession as a whole or to obscure the structural pressures that affect the cost of delivering care.

The policy debate also risks focusing on the most visible component of affordability, being specialist fees, while underestimating contributing factors such as declining Medicare support, workforce shortages, public system constraints and increasing practice costs.

The erosion in the real value of Medicare rebates has also been a significant contributor to rising out-of-pocket costs. Over time, rebates have not kept pace with inflation and the increasing costs of delivering specialist care, widening the gap between the Medicare benefit and the cost of providing a consultation. This means a greater share of the cost is increasingly borne by patients, even where specialists have sought only to maintain the real value of their fees.

Medical indemnity is one practice cost, but the evidence does not support treating it as a general explanation for rapid fee growth. Focusing on medical indemnity premiums alone overlooks the broader cost pressures facing practices, including rising employment costs for nurses and administrative staff and other practice costs for example medical equipment, software and cybersecurity, and compliance costs. Avant has kept average premium increases for most members below CPI over recent years. The median premium to private billings ratio for Avant members is less than 3 per cent and has remained at a similar level over the past five

[4] Avant Mutual. *Submission to Scope of Practice Review – Issues Paper 1* [Internet]. 2024 Mar 8.

years. Further information on Avant's medical indemnity premiums can be accessed here: Demystifying medical indemnity insurance premiums - Avant[5]

RECOMMENDATION

Simplify specialist referral pathways and remove unnecessary return visits to GPs.

The Federal Government should simplify the specialist referral journey so patients are not returning to their GP unnecessarily where an existing referral remains clinically appropriate. This should include clearer national guidance for patients and practitioners on referral duration and the use of named, unnamed and indefinite referrals, supported by practical education.

The Government also should introduce a grace period that allows a patient's usual GP to renew an inadvertently expired referral so that a planned specialist consultation can proceed and the patient remains eligible for the relevant MBS rebate.

As referral pathways are modernised, the Government should also identify circumstances where unnecessary steps can be safely removed, including defined direct referral pathways from other health practitioners where there is a clear access benefit and appropriate clinical, communication, liability and indemnity safeguards are in place.

Public referral pathways must be supported

For patients who have difficulty affording private specialist care, a timely pathway to public care is essential. Analysis conducted by the Grattan Institute (Grattan) found public outpatient clinics provide approximately one third of specialist appointments and waiting times in some specialties and locations extend well beyond clinical guidance.[6]

Across Sydney, Melbourne, Brisbane and Adelaide, Grattan identified 50 specialties where waits can exceed a year. For some patients waiting times are considerably longer. Grattan found 10 per cent of patients in Sydney seeking a respiratory cystic fibrosis appointment waited more than three years. Similar waits were reported for neurosurgery in outer regional Victoria, immunology in inner regional South Australia and haematology in outer regional NSW. Even patients assessed as requiring urgent care can wait well beyond clinically recommended timeframes.

There may also be significant geographic differences in the amount of specialist care people receive. After adjusting for differences in population characteristics, Grattan found people in the worst served areas receive around one third fewer specialist services than those in the best served communities. Public services currently do not compensate for areas with low levels of private specialist care.

Published waiting times can also understate how long patients wait for care. So-called "hidden waiting lists" - delays before the reported waiting period even begins – further lengthen the patient journey. A patient may first wait for a GP assessment, then for a public specialist consultation and, where treatment is required, wait again on an elective surgery waiting list. Measuring only the final stage does not capture the full period between a patient first seeking care and receiving treatment.

[5] Avant. *Demystifying medical indemnity insurance premiums* [Internet]. 2025 August. Available from: Demystifying medical indemnity insurance premiums - Avant
[6] Grattan Institute. *Special treatment: Improving Australians' access to specialist care* [Internet]. 2025 Jun 15. Available from: Special treatment: Improving Australians' access to specialist care - Grattan Institute

Research commissioned by Avant from DeltaPearl Partners[7] found that hidden waiting lists in the public hospital system can result in patients waiting up to 7.9 years in South Australia for Category 3 surgery, despite a clinically recommended timeframe of within 12 months. Significant waits beyond recommended clinical timeframes were also identified across other states and territories, including for patients requiring the most urgent Category 1 surgery.

Long waits do not remove cost from the health system. Indeed, delayed specialist care has the potential to result in delayed diagnosis and treatment, deterioration in a patient's condition and the need for higher levels of care later. It also places additional pressure on GPs who continue to manage patients while they wait, as well as emergency departments and other parts of the health system. Grattan estimates that around 1.9 million Australians delay or miss specialist care each year because of high costs or long waits.

A worthwhile affordability strategy therefore cannot focus solely on the costs of private specialist care. For patients who cannot afford private care, the public system must provide a genuine and timely alternative. Improving access requires investment in public specialist capacity, particularly in communities and specialties where the gap between demand and available services is greatest.

RECOMMENDATION

Expand public specialist capacity where patients face the greatest access gaps.

Use data on the full patient journey, including hidden waiting lists, geographic variation and service availability, to identify specialties and communities where patients are waiting beyond clinically recommended timeframes. Target additional specialist and service capacity to those areas, with priority given to communities where patients have limited or no viable alternative pathway to care.

Delays create medico-legal pressures

The ACT Court of Appeal case of *Ziaee v Rubino*[8] provides an example of the potential consequences when a patient waits for an extended period after referral. The patient was referred by a GP to a Canberra Hospital outpatient clinic in 2014. They were not seen until two years later, when they required acute treatment and this was before the first available outpatient appointment. The patient sued their GP but the defence of the claim succeeded on appeal, with the Court rejecting the original finding that the GP had breached the required standard by failing to pursue the public hospital referral. The case nevertheless demonstrates how long waits can create uncertainty for patients and referrers about follow-up responsibility.

Prolonged waits can create uncertainty about responsibility for ongoing management of complex conditions, surveillance testing, identification and escalation of deteriorating symptoms. These are recurrent sources of medico-legal complaints and claims. When specialist services are unavailable or delayed, responsibility for ongoing patient management frequently shifts back to GPs and other treating practitioners without corresponding access to specialist support. We have experience assisting doctors where patients have complained as a result of rejected referrals, unavailable specialists, extreme waiting times or unclear responsibilities for patient management.

[7] DeltaPearl Partners, *The Value of the Australian Government Rebate on Private Health Insurance* [Internet]. Report commissioned by Avant; 2025 August 20. Available from Delta Pearl Full Report.pdf
[8] *Ziaee v Rubino* [2023] ACTCA 7. Australian Capital Territory Court of Appeal. 2023 Feb 15. Available from: https://www.courts.act.gov.au/__data/assets/pdf_file/0005/2179166/Ziaee.pdf

Avant's claims data also shows why reliable follow-up systems matter. In diagnostic error claims closed between July 2019 and July 2024, 14 per cent had a system error as the main error. Common system issues included failure or delay in following up tests and investigations, failure to action referral recommendations, and failure to follow up a patient or referral.

4. Australia needs both a strong public specialist pathway and a viable private system

Australia's health system relies on complementary public and private capacity. While public hospital specialist services provide an essential no-cost pathway for patients who cannot afford private care, the private system delivers a substantial proportion of Australia's specialist and hospital care.

Research commissioned by Avant from DeltaPearl Partners, drawing on Australian Institute of Health and Welfare data[9], found private hospitals perform approximately 67 per cent of elective surgery in Australia, accounting for around 1.8 million procedures annually. This capacity reduces demand that would otherwise fall on public hospitals and allows the public system to focus more of its resources on emergency care, complex cases and other services for which it has primary responsibility.

This matters for equitable access. ABS data for 2024–25 show people living in the most disadvantaged areas were less likely to see a medical specialist compared to those living in the least disadvantaged areas, 38.1 per cent compared with 43.9 per cent respectively[10]. Private health insurance coverage also differed significantly, at 38.1 per cent in the most disadvantaged areas compared with 79.3 per cent in the least disadvantaged areas.

Any policy response should, therefore, not be framed as a choice between supporting private care and investing in public care. Both are required. A strong public pathway is essential for people who cannot access private care. A viable private system provides additional capacity and absorbs demand that would otherwise fall on public hospitals and clinics.

There are signs that this balance is under increasing pressure. The DeltaPearl analysis[7] found that the real value of the private health insurance rebate has declined by approximately 19 per cent since 2013 because of the rebate adjustment mechanism, which reduces the rebate when private health insurance premiums rise faster than inflation. DeltaPearl estimates that, if current settings continue, a further 1.066 million people could downgrade or leave private health insurance over the decade from 2026-27 to 2035-36.

Consumers also have moved increasingly towards lower levels of cover, and Gold coverage has declined overall. This matters because services such as maternity and psychiatric care require higher levels of cover. At least 18 private maternity units have closed since 2018 according to the DeltaPearl analysis.

The potential consequences of a larger reduction in private participation are significant. DeltaPearl modelled a series of scenarios rather than forecasts. Under a scenario involving the complete removal of the private health insurance rebate, more than eight million people were projected to downgrade or leave private health insurance over 10 years. This would result in approximately 14.3 million fewer episodes being treated privately and $74.3 billion in reduced private medical expenditure. Although government would save $43.6 billion in rebate expenditure, DeltaPearl estimated replacing the lost private expenditure would leave governments with an overall net fiscal cost of $30.7 billion over the decade.

Projections such as these demonstrate the degree of interdependence between the public and private systems. Policy decisions that reduce private participation shift patients, activity and costs into the public

[9] Australian Institute of Health and Welfare. *Referred medical specialist attendances* [Internet]. 2026. Available from: https://www.aihw.gov.au/reports/medical-specialists/referred-medical-specialist-attendances
[10] Australian Bureau of Statistics. *Patient experiences, Australia* [Internet]. Canberra: Australian Bureau of Statistics; 2025. Available from: Patient experiences, Australia

system. Conversely, maintaining viable private capacity relieves pressure on public services and preserves access across the system.

The same principle applies to Medicare rebates for specialist consultations. Affordability is determined not only by the fee charged by a specialist, but by the difference between that fee and the Medicare rebate received by the patient. The Committee must consider whether specialist rebates remain aligned with the contemporary cost and complexity of providing care and the extent to which the lack of rebate indexation over time has contributed to the growth in patient out-of-pocket costs.

Measures designed to improve specialist affordability ultimately should be assessed against their impact on the whole health system. Any reform intended to improve affordability should be accompanied by modelling of its effects on private specialist participation, public waiting times, workforce behaviour and patient safety. Reducing the cost of one part of the system will not improve access if it contributes to the loss of capacity elsewhere, as the following case study demonstrates.

RECOMMENDATION

The Federal Government should recognise the complementary role of public and private healthcare in providing access to specialist care and:

- **Establish a national viability framework and recognise essential regional private hospital services as critical national health infrastructure.** The viability framework should identify private hospitals and specialist services at risk where the loss of capacity would materially reduce access to care or place significant additional pressure on the public system. Where the framework identifies a service that is critical to a community but cannot be commercially sustained, government should be able to provide targeted funding to the private operator to maintain that service. This would apply a similar principle to regional telecommunications, where government supports the continued provision of essential services that would not otherwise be commercially viable. Funding should be targeted to the identified viability gap and conditional on the operator maintaining agreed services and capacity.
- **Review and reform MBS rebates for specialist consultations** to ensure they better reflect the contemporary cost and complexity of providing specialist care. This should include the adequacy of indexation and other factors including the presence of co-morbidities in patients, with the objective of reducing patient out-of-pocket costs while supporting sustainable access to specialist care.
- **At a minimum, freeze the current Private Health Insurance Rebate to prevent its continued erosion.** As an immediate measure, the Government should suspend further reductions arising from the rebate adjustment mechanism, recognising the critical role the rebate plays in supporting private health insurance participation and, in turn, the viability of private hospital capacity. These are interdependent and essential to maintaining a sustainable private health system that complements the public system.

5. Innovation can improve access, but clinical responsibility must be clear

Innovative models of care require careful consideration and must never abrogate responsibility for ensuring adequate and appropriate access to specialist care. Any new models must be developed in partnership with relevant specialist craft groups and designed to ensure that improving access does not come at the cost of safety, quality and appropriate standards of care.

Clinical responsibility, liability and indemnity must also be considered as part of the design of any new model of care, whether that is telehealth, Hospital in the Home (HITH), expanded scope of practice from allied health professionals or AI-enabled care. There must be clarity regarding responsibility for clinical decisions

and follow-up, what information is available to each practitioner, how care is documented and communicated, and when responsibility transfers or a patient must be escalated to another practitioner or service.

Avant's own medico-legal experience demonstrates why continuity of care and clear responsibility matter. Research published in the Medical Journal of Australia[11], drawing on Avant's medico-legal case files, examined adverse outcomes associated with fragmented general practice care. The review identified three recurring areas associated with adverse outcomes or increase risk of patient harm: delayed or missed diagnosis, inappropriate prescribing and failures in preventative care.

These cases included failures to follow up investigations, multiple practitioners prescribing high risk medicines to the same patient and circumstances where no single practitioner appeared to assume responsibility for reconsidering a diagnosis or co-ordinating ongoing care. While such a case review cannot establish causation, it highlights the significant risks that can arise when care is distributed across multiple practitioners without effective communication and clear responsibility.

These issues should mandate government consultation and pre-implementation processes for any new models of care. Table 1 below sets out a practical assessment framework to support the introduction of new models of care, identifying their potential to improve specialist access alongside the key clinical, regulatory and medico-legal safeguards that should be considered before implementation.

Table 1: Assessment framework for new models of care

Model	Description	Potential access benefit	Key safety and medico-legal considerations	Requirements for safe implementation
Hospital in the Home (also "home hospitalisation" and "virtual ward")	Provides acute and sub-acute hospital-level care[12] in a patient's home as an alternative to in-patient care	Frees inpatient capacity for patients requiring hospital-based care. Reduces hospital bed days and allows appropriate patients to receive care at home.	Clinical deterioration may not be identified as quickly where monitoring and supervision are less intensive. Patients and families may not understand who to contact or when to escalate concerns. The decision to transfer care to the home must be clinically appropriate. Responsibility for care, monitoring and escalation must be clear.	Evidence-based clinical eligibility criteria for HITH. Defined clinical responsibility and monitoring arrangements. Documented escalation pathways and safety-netting advice. Clear information for patients and families. Patient choice and shared decision-making. HITH-specific accreditation, clinical governance and service quality standards.
GP-to-specialist secondary consultation	Enables GPs to seek advice from a specialist, often through a digital platform, without initially making a formal patient referral. The specialist may provide diagnostic or management advice or recommend formal specialist assessment[6].	Provides faster access to specialist expertise. May reduce unnecessary referrals, waiting times and patient costs and support earlier diagnosis and treatment.	The specialist may provide advice without examining or speaking to the patient and based only on information selected by the GP. Important clinical issues may not be identified. Responsibility between the GP and specialist for advice, follow-up and subsequent care may be unclear. Asynchronous communication can also limit the ability to clarify information dynamically.	A nationally consistent framework defining appropriate uses and limits of secondary consultation. Clear allocation of clinical responsibility and follow-up. Minimum information requirements and secure information exchange. Advice incorporated into the patient record. Clear thresholds for formal specialist assessment. Appropriate indemnity arrangements.

[11] Marjot J, Haysom G and Brown P. *Medico-legal risks associated with fragmented care in general practice.* Med J Aust 2021; 215(5): 2030205.e.1 doi: 10.5694/mja2.51205
[12] Agency for Clinical Innovation. *Evidence brief: Hospital in the home* [Internet]. 2024 Jun 18. Available from: Evidence Brief: Hospital in the Home

Model	Description	Potential access benefit	Key safety and medico-legal considerations	Requirements for safe implementation
Autonomous pharmacist prescribing	Enables pharmacists to prescribe within an authorised scope without approval or supervision by another health practitioner[13]	May provide faster access to treatment, particularly where access to general practice is limited.	Prescribing without adequate diagnostic assessment may result in inappropriate treatment or delayed diagnosis. Expansion creates additional training, scope and indemnity considerations and may fragment care. Where the same business prescribes and dispenses a medicine, there is also a potential conflict between clinical decision and the financial benefit from dispensing.	Implement the National Decision-Making Framework agreed by Health Ministers with nationally consistent safety requirements for clinical assessment, scope, training, information sharing, continuity, escalation and indemnity. Prescribing models should support clinically appropriate decisions both to prescribe and not to prescribe.
Nurse prescribing	Enables appropriately endorsed registered nurses to prescribe within an approved prescribing arrangement in partnership with an authorised health practitioner[14]	Can provide more timely access to treatment and make better use of the existing health workforce.	Roles and responsibilities between the nurse prescriber and other treating practitioners may be unclear. Inconsistent arrangements may create uncertainty about clinical responsibility, follow-up and indemnity.	Maintain appropriate Nursing and Midwifery Board endorsement, prescribing agreements and clinical mentorship requirements. Establish clear responsibilities for supervision, follow-up and escalation and clarify insurance and indemnity requirements.
Synchronous telehealth	Provides real-time consultation between a patient and a medical practitioner using video, telephone or other technology as an alternative to in-person consultation[15]	Improves timely access and reduces travel, with particular benefits for rural and remote patients and people with mobility or other access barriers.	Some conditions cannot be adequately assessed without physical examination. Inappropriate reliance on virtual consultation can contribute to missed or delayed diagnosis and treatment[16]	Apply professional standards and guidelines for telehealth. Practitioners must determine whether telehealth is clinically appropriate and arrange in-person assessment where required. Appropriate continuity, documentation and follow-up should be maintained.
Newer telehealth business models	Provides care with limited or no real-time interaction between patient and clinician, often using online questionnaires or messaging. Models include medical certificates, single-issue prescribing and other episodic services[17]	Offers rapid and convenient access for patients and may improve access where conventional services are difficult to obtain.	Presents greater risk than synchronous care because of limited clinical interaction and reliance on information provided through forms or messages. Lack of regulatory oversight. Risks include inadequate assessment, fragmentation of care and inappropriate prescribing. Some models may fall outside indemnity coverage. Commercial models can also create conflicts of interest, including closed-loop prescribing where prescribing and supply of medicines are not sufficiently independent.	Apply professional telehealth standards regardless of the business model. Establish minimum requirements for clinical assessment and escalation to synchronous or in-person care. Clarify regulatory responsibility for businesses providing healthcare through digital platforms, not only individual practitioners. Address commercial conflicts and ensure appropriate indemnity coverage.

[13] Pharmacy Board of Australia. *Pharmacist prescribing - FAQ* [Internet]. 2019 Oct 15. Available from: Pharmacist prescribing - FAQ
[14] Australian Government Department of Health, Disability and Ageing. *Designated Registered Nurse Prescribing* [Internet]. 2026 Sep 22. Available from: Designated Registered Nurse Prescribing
[15] Medical Board of Australia. *Telehealth consultations with patients* [Internet]. 2023 Sep 1. Available from: Telehealth consultations with patients
[16] See, for example, *Inquest into the deaths of Virginia Anne Weekes and Craig Malcolm Files* (Coroners Court of South Australia). Available from: Judgment
[17] Australian Health Practitioner Regulation Agency. *Joint statement on professional responsibilities for prescribing and dispensing medicines* [Internet]. 2024 Jun 3. Available from: Joint statement on professional responsibilities for prescribing and dispensing medicines [ahpra.gov.au]

Model	Description	Potential access benefit	Key safety and medico-legal considerations	Requirements for safe implementation
Urgent care centres	Provide treatment for urgent but non-life-threatening illnesses and injuries outside hospital emergency departments[18]	Provides access when general practice is unavailable and may reduce pressure on emergency departments, allowing them to focus on higher-acuity care.	Different Commonwealth, state and private models may result in inconsistent standards and responsibilities. Episodic care can fragment care where providers lack access to patient history or where responsibility for results and follow-up is unclear.	Consistent clinical and governance standards across models. Effective sharing of relevant patient information with the patient's usual care team. Clear responsibility for investigations and follow-up. Defined escalation pathways to emergency and specialist care.
Public outpatient clinics	Provide specialist and allied health care through public hospitals without requiring formal hospital admission[19]	Provides access to specialist care at no cost to the patient and can reduce demand elsewhere in the health system.	Workforce and resourcing constraints can result in long waiting times. Commonwealth-state funding arrangements can create uncertainty around appropriate Medicare billing.	Adequate workforce and service capacity. Clear and nationally consistent guidance on Commonwealth and state funding responsibilities and appropriate Medicare billing.
Artificial intelligence	Includes AI used for administrative and triage functions as well as clinical applications such as diagnosis, decision support and treatment recommendations.	Can improve productivity, reduce administrative burden and support more efficient use of clinical workforce and resources.	Technology is developing faster than regulation. Clinical responsibility and liability for AI-supported decisions remain uncertain and may fall disproportionately on the practitioner even where harm arises from an algorithmic or product failure outside their control.	A fit-for-purpose regulatory framework for safe and ethical use of AI in healthcare. Clear requirements for validation, clinical oversight and governance. Responsibility and liability should reflect the respective roles of practitioners, healthcare organisations and technology developers, including appropriate developer accountability for product and algorithmic failures

Case study – Hospital in the Home (HITH) care

The Inquest into the death of Andrew Gilmore (2013) in Victoria examined the death of a patient cared for through a Hospital in the Home (HITH) program. The coroner found that the patient's referral to the HITH program was appropriate at the time of discharge. However, the coroner also found that when the patient's condition deteriorated, review at the original treating hospital should have been instituted. Given that HITH doesn't provide the same level of in-person care and observation as occurs when a patient is physically in the hospital, there should be earlier and lower thresholds for escalation in clinical protocols. In the coronial case, the risk of an adverse outcome was exacerbated by poor communication with the patient and their family about the steps to take if any suspected complications arose. These issues included confusion about the appropriate point of contact, which was partly caused by the fact that the patient was still an inpatient at the hospital and also a patient of the HITH program, which was not adequately explained or understood. Confusion existed amongst the hospital staff as well, which meant that when the family did make contact with either the HITH team or the hospital staff, there was no clear pathway or action recommended.

[18] Australian Government Department of Health, Disability and Ageing. *About Medicare Urgent Care Clinics* [Internet]. 2026 Feb 23. Available from: About Medicare Urgent Care Clinics
[19] NSW Health. *Outpatient services* [Internet]. 2024 Jan 15. Available from: Outpatient services

RECOMMENDATION

Require a safety and accountability assessment before new models of care are introduced or expanded.

New models of care must meet appropriate safety and accountability standards before being implemented. Before introducing or expanding a model, clear arrangements must be established for clinical responsibility, continuity of care, escalation, regulatory coverage and indemnity, alongside evidence that the model will improve access to specialist care. Avant supports innovative models of care with appropriate safeguards to reduce risk of patient harm. Responsibility should always sit with the practitioner making any clinical decision. It should not be transferred to a medical practitioner who lacks practical control over the way care is provided.

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6. Workforce reform is central to specialist access

Affordability reform cannot compensate for a specialist workforce that is too small, poorly distributed or constrained by inadequate training capacity or support in the locations and specialties where patients need care most.

Increasing the supply of specialists where there are demonstrated workforce shortages is critical to improving access over the long-term, however, expanding training pipelines takes time and workforce reform must look at a range of interventions to address persistent shortages and training capacity.

Australia's medical training systems are heavily concentrated in the public sector, despite private hospitals delivering a substantial proportion of specialist care. Expanding appropriately funded junior doctors into private hospitals, particularly in regional areas, could potentially increase training capacity and expose doctors to a broader range of clinical settings.

At Avant's June 2026 Parliamentary Roundtable, several practical opportunities to address workforce constraints were identified, including making greater use of private hospitals for medical training and supporting more integrated public-private workforce arrangements in regional communities.

RECOMMENDATION

To strengthen the specialist workforce by making better use of private sector capacity and the available medical workforce, governments at all levels should:

- Increase funding for clinical training placements in private hospitals and health services, particularly in regional areas, to increase training capacity and the regional workforce pipeline.
- Governments should support more integrated public-private workforce arrangements in regional areas, enabling clinicians to work across both settings. Such models broaden clinical experience, improve professional development opportunities, strengthen recruitment and retention, and make regional practice more attractive by exposing clinicians to a wider range of cases.
- Agree a broader role for overseas-trained psychiatrists to practise in private hospitals and private practices. We welcome the government's focus on addressing workforce constraints affecting access to private psychiatry care. As outlined in our Private Health Reforms submission, we support, in principle, measures to allow International Medical Graduates to practise in private hospitals and recommend this is extended to include private practices to support continuity of care.
- Deliver dedicated initiatives that attract and support specialists relocating to areas of need. Programs such as the NSW Government's Welcome Experience should be rolled out nationally and made available to medical specialists who sit outside the public sector. Practical support with housing, childcare, education, partner employment and professional networks, will help encourage specialists to move to rural and regional areas. It will also help support long-term connections in these communities, improving retention in areas of greatest need.

7. Specialist reform must be coordinated

The inquiry is taking place alongside several Commonwealth reform processes that touch the patient journey, including modernising referral pathways, fee transparency and informed financial consent, options for addressing high specialist fees, private health reform and broader scope of practice changes.

These proposed reforms are closely connected. Referral rules affect how patients enter specialist care and who can refer them. Fee transparency affects the information available when patients choose a specialist. Medicare and private health settings affect the cost faced by patients and the viability of services. Scope of practice and new models of care affect who provides care, how responsibility is shared and how patients move between practitioners and services.

Considered individually, each reform may have a clear policy objective. Their effects when combined, however, are less certain. Changes intended to reduce cost or improve access in one part of the system may affect workforce participation, service viability, demand for public services, administrative burden and patient safety risk elsewhere.

The ultimate measure of success should be whether patients can access appropriate specialist care sooner, at an affordable cost, and without compromising safety or continuity of care. A coordinated approach would

help ensure that reform improves access across the health system rather than simply shifting cost, demand or risk from one part of it to another.

RECOMMENDATION

Coordinate Commonwealth specialist access reforms through a single reform framework.

Bring together reforms to referrals, fee transparency, specialist fees, private health, workforce and scope of practice so cumulative effects can be assessed, conflicting requirements identified and implementation appropriately sequenced.

Conclusion

Avant supports the intent of this inquiry and recognises the significant barriers many Australians face in accessing specialist clinical care. While affordability is an important consideration, it is only one of several interconnected drivers of access. Reforms that focus on affordability alone risk overlooking broader challenges relating to availability, navigability and viability, limiting their effectiveness and creating unintended consequences elsewhere in the health system. Improving access to care requires a whole-of-system approach.

We appreciate the opportunity to contribute to this inquiry and would be pleased to provide further information or discuss any aspect of this submission.

Avant
21 October 2026