INQUIRY INTO ACCESS TO AND AFFORDABILITY OF MEDICAL SPECIALISTS IN AUSTRALIA



Submission

October 2026

NATSIAACC
National Aboriginal and Torres Strait Islander Ageing and Aged Care Council

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Acknowledgment of Country

NATSIAACC acknowledges the Traditional Owners of the lands and waters on which we work, live and gather, as well as Country throughout Australia, and their enduring connections to land, sea and community. NATSIAACC acknowledges that these lands and waters were never ceded, and we acknowledge the sovereignty and self-determination of the Traditional Owners.

NATSIAACC pays its deepest respects to Elders past and present and recognise the continued cultural and spiritual connection to Country and/or Island Home, community, culture and knowledge.

NATSIAACC thanks them for their wisdom and courage, and for sharing their ways of knowing, being and doing – teachings that guide us to cherish and protect our Elders and Older People.

This always was, and always will be Aboriginal Land.

National Aboriginal and Torres Strait Islander Ageing and Aged Care Council

About

The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) is the national peak body for Aboriginal and Torres Strait Islander Ageing and Aged Care. NATSIAACC works to ensure that Aboriginal and Torres Strait Islander Elders and Older People can access support and care that is culturally safe, trauma aware and healing-informed, and recognises the importance of their personal connections to community, Country and/or Island Home.

NATSIAACC is building a membership base of:

- Aboriginal and Torres Strait Islander community-controlled providers of Ageing and Aged Care, and
- Entities with an interest in culturally appropriate Ageing and Aged Care services.

NATSIAACC's founding Directors are all leaders in Aboriginal and Torres Strait Islander Ageing and Aged Care provision.

Our Vision

All Aboriginal and Torres Strait Islander people are thriving, healthy, strong, with ongoing cultural connections in their older years.

Our Purpose

NATSIAACC supports Aboriginal and Torres Strait Islander older peoples, their families, and communities to identify, engage in, advocate for, and lead systemic reform to embed culturally safe practices across the Aged Care and ageing sector.

With thanks

NATSIAACC thanks its members, stakeholders, and other peak bodies for their valuable contributions to this submission and for generously giving their time to support older Aboriginal and Torres Strait Islander people.

Funding

NATSIAACC is funded by the Commonwealth Department of Health, Disability and Ageing (the Department). NATSIAACC has been in operation since 2022. In the context of the current Aged Care reforms and the need for extensive advocacy, input, and leadership in the sector, it will be necessary to provide additional funding to support NATSIAACC to provide the input and engagement required to ensure that the reforms deliver much needed support to Aboriginal and Torres Strait Islander Elders and Older People.

NATSIAACC Recommendations

1. Invest in workforce-enabling infrastructure, including safe and affordable housing for specialists in regional, rural and remote communities.
2. Establish place-based specialist training and workforce pathways in partnership with Aboriginal Community Controlled Health Organisations and community-controlled Aged Care providers.
3. Embed NATSIAACC's definition of cultural safety in specialist service standards, funding agreements and accountability arrangements. Require cultural safety, trauma-aware and healing-informed training alongside action to address racism, assessment by Elders and Older People of whether their care is culturally safe and demonstrated improvements in practice and service delivery.
4. Align specialist workforce planning with health need, not population distribution alone.
5. Co-design a national cultural communication and navigation resource with Aboriginal and Torres Strait Islander Elders and Older People, community-controlled organisations and health professionals, with scope for local adaptation.
6. Improve the use and acceptance of existing specialist referral pathways, including referrals from eligible nurse practitioners. Co-design and assess extensions of referral authority for Aboriginal and Torres Strait Islander Health Practitioners and appropriately qualified nurses, supported by clear scopes of practice, clinical governance and any necessary changes to Medicare and service eligibility rules.
7. Fund Aboriginal and Torres Strait Islander health navigation and care coordination roles within ACCHOs and community-controlled Aged Care providers, linked with existing Elder Care Support services. Require locally agreed responsibilities for arranging specialist access, tracking referrals, supporting attendance, sharing information with consent and completing follow-up for Elders and Older People receiving care in all Aged Care settings.
8. Establish enforceable limits on patient out-of-pocket charges for Medicare-subsidised specialist consultations, with no-gap access for Aboriginal and Torres Strait Islander Elders and Older People on low incomes or experiencing financial hardship. Determine limits and eligibility arrangements through First Nations shared decision-making and transparent costing, supported by adequate public funding and monitoring of service availability.
9. Establish First Nations-governed monitoring of specialist access and affordability, including unmet need, delayed or forgone care, waiting times, completed referrals and treatment, direct and indirect costs relative to income, and Elders' and Older People's experience of cultural safety. Fund community participation in deciding how information is collected, interpreted, reported and used to improve services.
10. Introduce targeted, means-tested income support for Aboriginal and Torres Strait Islander People aged 50-66 whose health and ageing-related needs limit their capacity to work and who lack adequate income. Set support at a level that enables essential living and healthcare costs to be met, using Age Pension payment rates as a benchmark, and provide associated health concessions without requiring people to wait until age 67.
11. Strengthen patient travel, accommodation and support schemes for Aboriginal and Torres Strait Islander People in rural and remote areas, including upfront assistance and adequate support for an accompanying family member or carer where required.

12. Invest in prevention and early intervention through Aboriginal community-controlled primary health and Aged Care services, with timely specialist input and follow-up to reduce avoidable deterioration and loss of independence.
13. Provide sustained, flexible investment to expand community-controlled specialist access models, drawing on approaches demonstrated by Purple House and Mala'la Health Services and adapting delivery to local community priorities.
14. Fund blended models combining regular face-to-face outreach, community-based care and clinically appropriate telehealth, with continuity between visits.
15. Require specialist pricing, funding and commissioning arrangements to identify, cost and fund relationship-building, cultural engagement, family involvement, navigation, coordination and follow-up as essential service-delivery activities. Funding must cover the work undertaken by community-controlled organisations and avoid transferring these costs to Elders, Older People, families and carers.
16. Implement specialist access reforms through formal shared decision-making with Aboriginal and Torres Strait Islander representatives, including Elders, Older People and community-controlled health and Aged Care providers. Align implementation with the National Aboriginal and Torres Strait Islander Health Plan 2021-2031, the National Agreement on Closing the Gap and the Aboriginal and Torres Strait Islander Aged Care Framework 2025-2035, with named government responsibilities, funded actions, timeframes and public reporting.

Executive Summary

Aboriginal and Torres Strait Islander Peoples experience disproportionate rates of chronic disease, mental health and social and emotional wellbeing and a lower life expectancy, yet services critical to closing the gap in health outcomes between Indigenous and non-Indigenous people, in many cases remain out of reach. Aboriginal and Torres Strait Islander Elders and Older People living on traditional lands in regional and remote locations, hold deep cultural significance, where connection to Country and Island Home, kinship and community are critical holistic elements of health and wellbeing. Yet, through the ongoing impacts of colonisation, systemic racism and underinvestment into Aboriginal and Torres Strait Islander communities, First Nations people continue to be subject to inequitable and disproportionate health outcomes compared to non-Indigenous people. This is not a reflection of individual behaviour but rather the outcome of decades of inadequate and unjust policies, fragmented service systems, and structural barriers that have undermined equitable access to care.

Access to medical specialists represents one of the most significant examples of these systemic inequities. Aboriginal and Torres Strait Islander Peoples have a greater burden of chronic and complex health conditions, yet continue to face significant barriers in accessing timely, affordable and culturally safe specialist healthcare. These challenges are particularly pronounced for Elders and Older People living in regional, rural and remote communities, where specialist shortages, long wait times, travel requirements, fragmented referral pathways and out-of-pocket costs frequently delay or prevent access to essential care. As a result, many Aboriginal and Torres Strait Islander People are unable to access specialist services at the right time or place and in a way that supports their cultural, social and emotional wellbeing.

The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 recognises that improving health outcomes requires more than addressing clinical needs alone. The Health Plan is centred on culture, self-determination and genuine partnership, and calls for a health system that is prevention-focused, culturally safe, equitable, responsive and free from racism. It also recognises the critical role of the Aboriginal Community Controlled Health Sector and the need for mainstream services to provide culturally safe and responsive care that reflects the priorities, strengths and lived experiences of Aboriginal and Torres Strait Islander Peoples.

The National Agreement on Closing the Gap provides a further foundation for reform through its four Priority Reforms: shared decision-making, strengthening the community-controlled sector, transforming government organisations, and shared access to data and information. Applied to specialist care, these reforms require Aboriginal and Torres Strait Islander authority in service design and commissioning, sustained investment in community-controlled services, accountability for mainstream service performance, and community involvement in determining how progress is measured.

The Aboriginal and Torres Strait Islander Aged Care Framework 2025-2035 also provides an important connection between specialist access and culturally safe Ageing and Aged Care. Its focus on access, assessment, service delivery, provider development and workforce reinforces the need for coordinated action across health and Aged Care. Specialist access reforms should support these outcomes through practical partnerships with both ACCHOs and community-controlled Aged Care providers.

Similarly, the National Safety and Quality Health Service Standards (NSQHS) User Guide for Aboriginal and Torres Strait Islander Health highlights the responsibility of health service organisations to work in partnership with Aboriginal and Torres Strait Islander communities, address identified health needs through targeted strategies, improve cultural competency and create welcoming healthcare environments that support safety, trust and engagement. The guide reinforces that equitable health outcomes cannot be achieved through universal approaches alone but require deliberate action to address the systemic and structural barriers that continue to affect Aboriginal and Torres Strait Islander Peoples' experiences of care.

For Aboriginal and Torres Strait Islander Elders and Older People, access to specialist healthcare must therefore be understood as more than a workforce issue but instead a matter of equity, cultural safety, self-determination and system design. Addressing current barriers requires coordinated action across governments, specialist services, hospitals, primary healthcare providers, ACCHOs and Aged Care providers, including community-controlled Aged Care organisations, to ensure specialist care is available, affordable, culturally safe and responsive to community needs.

As the national peak body for Aboriginal and Torres Strait Islander Ageing and Aged Care, NATSIAACC welcomes the opportunity to contribute to this inquiry and advocates for reforms that improve equitable access to medical specialists for Aboriginal and Torres Strait Islander People. Consistent with these foundational frameworks and the NSQHS User Guide, NATSIAACC calls for reforms that embed First Nations authority, fund the full work required to make specialist care accessible and effective, and hold services accountable for measurable improvements in Elders' and Older People's access, experiences and outcomes.

Access to medical specialists in cities, regional and rural communities

Aboriginal and Torres Strait Islander Elders and Older People live across metropolitan, regional, rural and remote Australia, while specialist services are concentrated in metropolitan centres. Population distribution and workforce shortage classifications help identify potential geographic barriers, but do not establish how many Elders and Older People have little or no local specialist access. Actual access depends on the specialty required, service capacity, outreach availability, travel distance, waiting times, affordability and cultural safety. These factors must be assessed together to understand where specialist services are failing to meet need.

This distribution of the specialist medical workforce does not align with the areas of greatest health needs for Aboriginal and Torres Strait Islander Elders and Older People. While chronic disease, complex care requirements and social and emotional wellbeing needs are often higher in regional, rural and remote communities, specialist services remain concentrated in metropolitan centres. This creates a structural mismatch between where care is most needed and where it is available, requiring Elders and Older People to travel long distances or delay care altogether. Workforce planning must therefore move beyond population-based supply alone and actively prioritise specialist availability in communities with high Aboriginal and Torres Strait Islander populations, where higher burden of disease and limited-service access currently exist.

The concentration of specialist services in metropolitan centres further compounds inequitable access for Aboriginal and Torres Strait Islander Elders and Older People living in regional, rural and remote areas. When specialist care is primarily available in major cities, Elders and Older people outside these centres are often required to navigate long-distance travel, transport costs, time away from family and community, and unfamiliar health service environments. Where travel distances are substantial, suitable public or community transport may be limited or unavailable, forcing people to rely on more expensive alternatives and causing out-of-pocket costs for fuel, flights, accommodation and support from family members or carers to escalate. Reliance on visiting or outreach specialist models can assist, but these services may be intermittent, may not provide the continuity of care needed for chronic and complex conditions and may also not be delivered through culturally safe care practices if not co-designed with First Nations people. Improving access therefore requires a stronger focus on bringing specialist services closer to community, including through regional clinics, outreach delivered in co-design and partnership with Aboriginal and Torres Strait Islander communities, and sustained investment in specialist workforce models outside metropolitan settings.

Living in a major city does not guarantee timely, affordable or culturally safe specialist care for Aboriginal and Torres Strait Islander Elders or Older People. Although the workforce of medical specialists may be present in major cities, care delivered through mainstream services can be culturally unsafe and not delivered through trauma aware and healing informed practices, which are critical components of care to make Elders and Older people feel comfortable and safe. This is particularly important for Aboriginal and Torres Strait Islander Elders and Older People who are from the Stolen Generations or who have experienced racism, institutionalisation or violence in previous interactions with the health or Aged Care systems. Access must therefore encompass culturally safe specialist care that recognises the ongoing impacts of colonisation, racism and trauma, respects Elders' and Older

Peoples cultural authority and lived experience, and is delivered in ways that support trust, dignity, choice and connection to community, Country or Island Home.

NATSIAACC's Cultural Safety in Aged Care Definition provides the foundation for this position. It places responsibility on providers and workers to critically examine how their own cultures, assumptions and actions affect others, build trusted relationships, and provide care that protects autonomy, dignity and wellbeing without racism. Whether an interaction or service is culturally safe is determined by the Aboriginal and Torres Strait Islander Person receiving it. Applied to specialist care, this requires Elders and Older People to have authority in evaluating their experiences, supported by trauma-aware and healing-informed practice. Training must be accompanied by action to prevent and address racism, accessible ways to raise concerns, and measurable changes in organisational practices and service delivery.

Recruitment, retention and training barriers are central drivers of specialist workforce shortages in regional, rural and remote communities, and they disproportionately affect Aboriginal and Torres Strait Islander Elders and Older People who already experience higher levels of chronic disease and have more complex care needs. Specialist workforce growth in underserved areas is limited by factors such as metropolitan-centred training pathways, limited exposure to rural and remote practice, inadequate clinical and physical infrastructure, workforce housing constraints, high workloads and limited multidisciplinary supports. Workforce education and training should include mandatory cultural safety units that provide foundational knowledge of Aboriginal and Torres Strait Islander histories and the principles of culturally safe practice. Dedicated funding should also support place-based training pathways delivered in partnership with Aboriginal Community Controlled Health Organisations. These pathways would enable practitioners to learn directly from the lived experiences of Aboriginal and Torres Strait Islander Elders and Older People while developing the cultural capability and confidence needed to provide safe, respectful and appropriate care. Practitioners educated in metropolitan settings, whose practical experience may be largely confined to mainstream facilities, may have minimal exposure to Aboriginal and Torres Strait Islander communities and may feel limited in their ability to practice in regional and remote locations away from their established personal and professional networks. Building a culturally capable and confident workforce is therefore essential to ensure that limited knowledge, experience or preparedness does not discourage practitioners from working in regional and remote communities and Aboriginal Community Controlled Health Organisation settings. This can perpetuate workforce shortages and limit access to specialties that are critical for Elders and Older People managing co-morbidities, mental health and social and emotional wellbeing needs, pain, disability and other complex conditions.

In many regional, rural and remote communities, the lack of suitable, affordable and secure housing to accommodate and attract permanent specialist staff is a major barrier of recruitment and retention, also affecting whether specialists are able to remain in community for longer periods of time. Although the demand for medical specialists is abundant, these barriers make it hard to attract specialists to regional and remote communities and can also contribute to turnover, burnout and reliance on short-term visiting or fly-in fly-out service models. For Aboriginal and Torres Strait Islander People, not having a stable and consistent workforce and rotating through different specialists, lacks the person-centred approach required to build relationships and trust, and is essential for Elders and Older People to feel safe and comfortable when receiving specialist care.

NATSIAACC Member Case Study: Local examples raised include clients waiting two to three weeks just to see a GP, and clients considering travel of one to two hours to access primary care before a referral can even be made. In the Binjareb/Mandurah area, the departure of one of the only two GPs at Nidjalla Waangan Mia creates a major gap for the local Aboriginal community and makes continuity of care more difficult.

NATSIAACC Recommendations

- Invest in workforce-enabling infrastructure, including safe and affordable housing for specialists in regional, rural and remote communities.
- Establish place-based specialist training and workforce pathways in partnership with Aboriginal Community Controlled Health Organisations and community-controlled Aged Care providers.
- Embed NATSIAACC's definition of cultural safety in specialist service standards, funding agreements and accountability arrangements. Require cultural safety, trauma-aware and healing-informed training alongside action to address racism, assessment by Elders and Older People of whether their care is culturally safe and demonstrated improvements in practice and service delivery.
- Align specialist workforce planning with health need, not population distribution alone.

Effectiveness, transparency and equity of referral pathways

Referral pathways to medical specialists for Aboriginal and Torres Strait Islander Elders and Older People operate across a complex health and Aged Care ecosystem. The need for specialist care may first be identified through Aboriginal Medical Services, ACCHOs, general practice, hospitals, residential Aged Care, home care, disability services, allied health professionals, community programs or family and carer networks. Identifying a need and helping someone access care is distinct from issuing a referral that meets Medicare or a particular service's requirements. This means referral effectiveness depends not only on the availability of medical specialists, but on how well each part of the system recognises need, communicates across service boundaries, supports culturally safe decision-making and enables timely movement between primary care, specialist care, hospital care and Aged Care. Where medical specialists may exist in later stages of care and equitable access to these services is important, investing in Aboriginal and Torres Strait Islander health workforce pathways in primary care settings such as Aboriginal Health Practitioners, nurses, nurse practitioners, allied health professionals and general practitioners can reinforce a preventative approach across health and Aged Care systems while strengthening the effectiveness and equity of referral pathways.

From the perspective of Elders and Older People, referral pathways can be difficult to understand and navigate. An Elder may first raise a concern with a trusted Aboriginal and Torres Strait Islander Health Practitioner, Aged Care worker, allied health professional or family member. For Medicare specialist attendance items requiring a referral, the referral must come from a practitioner authorised under the applicable rules. This is not restricted to GPs: eligible nurse practitioners can already refer to specialists and consultant physicians, and other authorised practitioners have referral rights within specified limits. Public specialist services may also apply service-specific referral and intake requirements.

Barriers arise when an authorised referring practitioner is unavailable, existing referral rights are poorly understood, or services require additional steps that delay care. Aboriginal and Torres Strait Islander Health Practitioners, Aboriginal Health Workers and Aged Care workers can play essential roles in identifying need and supporting access, but these roles should not be confused with an existing general authority to issue Medicare specialist referrals. Reform should improve the use of current pathways and assess safe extensions of referral authority, with appropriate qualifications, clinical governance and funding.

The transparency of referral pathways is also limited and patients may not know why they have been referred to one specialist rather than another, whether a public or private option is available, what out-of-pocket costs may apply, how long they are likely to wait, whether transport or accommodation support is available, or whether culturally safe care can be provided. Aboriginal and Torres Strait Islander Elders and Older People must be provided with clear, comprehensive and accessible information about all available referral and service options so they can make an informed choice about the pathway that best meets their clinical, cultural and personal needs. Health professionals should communicate this information in a culturally safe and responsive manner that supports understanding, respects individual preferences and cultural authority, and enables Elders and Older People to participate meaningfully in decisions about their care.

Referral pathways are particularly affected by barriers to GP access in regional, rural and remote communities. Where GPs or other authorised referring practitioners are unavailable, long waits, limited bulk-billing, workforce turnover and travel distances can delay access before a specialist referral is made. The AIHW report, Modelling access to GPs relative to need in Australia: Geographic variation among First Nations and non-Indigenous populations noted that 17% of Aboriginal and Torres Strait Islander People have relatively poor physical access to a GP, compared with 5% of non-Indigenous Australians, and that poor access increases with remoteness. The AIHW also builds on the relationship between need and access for Aboriginal and Torres Strait Islander Elders and Older People mentioned above, whereby it is stated “a population with a high per capita need is likely to be affected more severely by low access than a population with a low per capita need. For example, if 2 populations have the same relatively poor access but different per capita needs, the population with the higher need is likely to be affected more severely by the relatively long waiting times or infrequent GP visits than the other population.” Therefore, although GP wait times are longer in regional, rural and remote areas with distance to GPs also a compounding factor of access, Aboriginal and Torres Strait Islander People with higher prevalence of health issues that increase the need for primary health care, are disproportionately affected by these barriers. Ultimately, for Elders and Older People living on Country or Island Home in regional and remote locations, this can mean access to specialist care is delayed before the specialist referral has even been made. These barriers are compounded when transport, interpreter support, digital access, help completing forms or support to attend appointments away from their community, are needed.

NATSIAACC Member Case Study: An Older Person with swallowing difficulties in the community could not be referred directly to a speech pathologist and first needed to see a GP, creating an additional wait of around three weeks before the referral process could proceed. This type of delay can increase risk and stress for Elders, families and services supporting them.

For Elders and Older People receiving care at home or in residential settings, responsibility for coordinating specialist access must be agreed and documented. With the Elders' or Older Person's consent, the referring practitioner should retain responsibility for the clinical referral and review of specialist advice; the specialist service should communicate referral acceptance, urgency, appointment arrangements, findings and follow-up requirements; and a named coordinator should track progress and help resolve access barriers. Relevant information should reach the Elder or Older Person, their nominated supporters, primary care team and Aged Care provider in an accessible and timely form.

ACCHOs and community-controlled Aged Care providers should be funded partners in these arrangements. The coordinator may sit within either service, according to local arrangements and the Elder or Older Person's preference and should connect with existing Elder Care Support services where available. Agreements must identify who arranges transport and support, follows up missed or delayed appointments, supports implementation of treatment recommendations and escalates deterioration. Coordination funding must be additional to, and clearly allocated alongside, existing health and Aged Care responsibilities.

NATSIAACC Recommendations

- Co-design a national cultural communication and navigation resource with Aboriginal and Torres Strait Islander Elders and Older People, community-controlled organisations and health professionals, with scope for local adaptation.
- Improve the use and acceptance of existing specialist referral pathways, including referrals from eligible nurse practitioners. Co-design and assess extensions of referral authority for Aboriginal and Torres Strait Islander Health Practitioners and appropriately qualified nurses, supported by clear scopes of practice, clinical governance and any necessary changes to Medicare and service eligibility rules.
- Fund Aboriginal and Torres Strait Islander health navigation and care coordination roles within ACCHOs and community-controlled Aged Care providers, linked with existing Elder Care Support services. Require locally agreed responsibilities for arranging specialist access, tracking referrals, supporting attendance, sharing information with consent and completing follow-up for Elders and Older People receiving care in all Aged Care settings.

Affordability of specialist services

Affordability is a critical barrier to specialist care for Aboriginal and Torres Strait Islander Elders and Older People and must be understood in the context of the broader access and referral issues outlined above. Specialist care is rarely a single cost. It can involve an initial consultation, diagnostic tests, imaging, pathology, procedures, prescribed medicines, follow-up appointments, transport, accommodation, meals, time away from family, community, Country or Island Home, and the unpaid support provided by family members or carers. For Elders and Older People living on low, insecure incomes, including those on the Age Pension, these cumulative costs can make specialist care unattainable even where Medicare rebates or public hospital pathways are available.

Affordability must also be considered against the different ageing profile of Aboriginal and Torres Strait Islander Peoples. While the Age Pension is generally not available until a person reaches 67 years of age, Aboriginal and Torres Strait Islander People may be eligible for Aged Care from 50 years of age, reflecting earlier experiences of ageing, poorer health outcomes and the earlier onset of complex care needs. This policy difference recognises that Aboriginal and Torres Strait Islander Elders and Older

People often experience chronic disease, disability, frailty, pain, mental health and social and emotional wellbeing needs, and multiple co-morbidities at younger ages than non-Indigenous people. It also sits alongside substantial life expectancy differences, with life expectancy at birth for First Nations males and females recorded as 71.9 and 75.6 years, compared with 81.1 and 85.1 years for non-Indigenous males and females respectively, further exacerbated by remoteness. As a result, there is a clear affordability gap for Aboriginal and Torres Strait Islander People aged 50 to 66 who may have Aged Care needs and significant health conditions but are not yet eligible for the Age Pension. For this group in particular, specialist out-of-pocket costs, travel, medicines, diagnostics and follow-up care may need to be met through lower income support payments and limited savings or family support, making timely specialist care difficult to access. Without adequate financial support, Aboriginal and Torres Strait Islander Elders and Older People aged 50 to 66 may be unable to access the preventive care and early intervention needed to equitably manage health and ageing-related conditions, increasing the likelihood that care is deferred until those conditions become more serious and complex.

Out-of-pocket costs are particularly significant in private specialist pathways. While referring practitioners may identify a clinical need for specialist input, the ability to act on that referral can depend on whether an Elder or Older Person can afford the amount remaining after the applicable Medicare rebate. Private health insurance does not generally cover out-of-hospital specialist consultation gaps. Costs can accumulate across initial and follow-up consultations, diagnostic tests, procedures and other treatment, particularly when several specialists are involved. Where a person requires input from multiple specialists for chronic disease, disability, pain, mental health or social and emotional wellbeing needs, these costs can compound over time and create a financial barrier to diagnosis, treatment planning and continuity of care.

Moreover, upfront costs can also prevent access even when reimbursement may later be available whereby the Elder and Older Person may be required to pay the full cost of an appointment, diagnostic test or procedure before receiving a Medicare rebate. For a person managing rent, food, utilities, transport, medicines and family obligations on a limited income or pension, essential expenses will often take precedence over specialist care. This should not be framed as an individual decision to defer care, but as a structural affordability issue in a system that assumes people have the income, capacity, health literacy and digital access needed to pay first and recover costs later.

Public specialist services can reduce direct out-of-pocket costs for eligible public patients, but they do not remove all affordability barriers. Public pathways may still involve long waiting times, travel to regional hospitals or metropolitan centres, accommodation costs, meals, support person expenses and time away from community. A service that is free at the point of care may still be unaffordable if an Elder or Older Person must leave Country or Island Home, pay travel costs in advance, arrange family support, or wait until their condition deteriorates before care is available. These affordability barriers are intensified for Elders and Older People in regional, rural and remote communities, where specialist workforce shortages and referral barriers already limit access, as mentioned above. Travel expenses can include fuel, flights, accommodation, meals, parking, mobility supports and the costs of a carer or family member who provides transport, translation, advocacy, cultural support or care. Patient assisted travel schemes and subsidies can be important, but they may not recognise the full cost and as a result, the real cost of specialist care is often carried by families and communities rather than being fully measured and recognised by the health and/or Aged Care systems.

Fee setting also differs across public and private settings and across metropolitan, regional and remote locations. In the private sector, specialists set their own fees, and these fees are not regulated by the Government, meaning patients face different costs depending on the speciality, location, availability of bulk-billing or no-gap arrangements, private health insurance status, and local market conditions. The Australian Government's Medical Costs Finder reports a typical patient out-of-pocket cost of $159 for an initial specialist appointment in a private setting among patients who incurred an out-of-pocket charge. This is the patient gap, not the full consultation fee, and is not a First Nations-specific estimate. It also excludes the wider costs of travel, accommodation and supporting attendance. For Elders and Older People with limited incomes, even one such payment may compete with essential living expenses. In regional and remote areas, higher service delivery costs, travel, accommodation, low patient volumes, limited infrastructure, workforce shortages and administrative pressures can affect whether services are provided, how often specialists visit, and therefore what costs are passed on to patients.

Affordability is therefore inseparable from access, referral equity and cultural safety. Where the specialist pathway requires repeated payments, travel away from community, unfamiliar mainstream services, and reliance on family members to navigate the system, Elders and Older People may delay or forgo care. This can worsen chronic disease, increase pain and disability, reduce independence, and increase pressure on primary care, emergency departments and hospitals. Improving affordability requires reducing both direct and indirect costs, including through greater access to bulk-billed or no-gap specialist services, stronger ACCHO-led care navigation, clearer information about likely costs before referral, improved patient travel and accommodation supports, recognition of unpaid family carer costs, and sustained investment in culturally safe outreach and visiting specialist models that bring care closer to community.

Affordability cannot be assessed through average expenditure alone. Low recorded spending may indicate that an Elder or Older Person has been unable to obtain care, rather than that care is affordable. Monitoring must include people who need specialist care but do not obtain a referral, cannot secure an appointment, delay or forgo treatment, or cannot complete recommended follow-up. Direct and indirect costs should be assessed relative to income and available resources, with results showing variation by age, location and care setting, including the circumstances of people aged 50–66.

Measures of improvement should include waiting times from identified need to referral, consultation and treatment; whether referrals and treatment are completed; reasons for delay or non-completion; and Elders' and Older People's experiences of cultural safety. Aboriginal and Torres Strait Islander people must share authority over indicator design, data collection, interpretation, access and use, consistent with Indigenous data sovereignty. Community-controlled organisations must be funded to participate, and findings must lead to documented service improvements.

NATSIAACC Recommendations

- Establish enforceable limits on patient out-of-pocket charges for Medicare-subsidised specialist consultations, with no-gap access for Aboriginal and Torres Strait Islander Elders and Older People on low incomes or experiencing financial hardship. Determine limits and eligibility arrangements through First Nations shared decision-making and transparent costing, supported by adequate public funding and monitoring of service availability.
- Establish First Nations-governed monitoring of specialist access and affordability, including unmet need, delayed or forgone care, waiting times, completed referrals and treatment,

direct and indirect costs relative to income, and Elders' and Older People's experience of cultural safety. Fund community participation in deciding how information is collected, interpreted, reported and used to improve services.

- Introduce targeted, means-tested income support for Aboriginal and Torres Strait Islander People aged 50-66 whose health and ageing-related needs limit their capacity to work and who lack adequate income. Set support at a level that enables essential living and healthcare costs to be met, using Age Pension payment rates as a benchmark, and provide associated health concessions without requiring people to wait until age 67.
- Strengthen patient travel, accommodation and support schemes for Aboriginal and Torres Strait Islander People in rural and remote areas, including upfront assistance and adequate support for an accompanying family member or carer where required.

Impact on patient outcomes

Delays caused by cost, distance and waiting times can turn manageable health concerns into more serious and complex conditions. When an Elder or Older Person cannot afford a specialist appointment or associated diagnostics, must travel long distances, or waits months for a public appointment, opportunities for early diagnosis and treatment may be lost, symptoms may worsen, complications may develop and treatment options may become more intensive. Deferred or missed care can therefore contribute to avoidable pain, preventable disability, reduced mobility and function, poorer quality of life and greater reliance on family, carers and Aged Care supports.

Effective chronic disease management depends on timely specialist review, access to diagnostic information, coordinated treatment plans and communication between specialists, primary care, Aboriginal Community Controlled Health Organisations, Aged Care providers and family supports. Where specialist input is delayed or intermittent, primary care practitioners may be required to manage increasing complexity without timely advice, while medication changes, procedures, rehabilitation and follow-up may be postponed. Fragmented care can also require Elders and Older People to repeat their histories across services, increasing the risk of conflicting advice, missed follow-up and disengagement from care. These delays create broader pressures across the health system; when specialist care is unavailable or cannot be completed, people may return repeatedly to general practice, Aboriginal Medical Services or community health services with unresolved needs. If a condition deteriorates, emergency departments and public hospitals become the default point of access, resulting in potentially avoidable presentations, acute admissions, longer or more complex hospital stays and earlier entry into the Aged Care system.

For Aboriginal and Torres Strait Islander Elders and Older People, the impact of delayed care cannot be measured only through hospital use or clinical indicators. Travelling away from Country or Island Home can disrupt connection with family, kinship networks, community responsibilities and trusted supports. Unfamiliar or culturally unsafe services may also discourage attendance or follow-up, particularly where a person has experienced racism, institutionalisation or trauma in health and Aged Care systems. Conversely, timely specialist care delivered close to community and in partnership with Aboriginal community-controlled services can support trust, continuity, informed choice and sustained engagement in care. Aboriginal and Torres Strait Islander Elders and Older People living in regional, rural and remote communities experience poorer health outcomes than those living in metropolitan areas, reflecting the compounding impacts of geography, age, systemic inequity and Aboriginal and Torres Strait Islander status. For Elders and Older People living outside major cities, geographic barriers

can compound complex health needs and increase the importance of timely, culturally safe specialist access. However, specialist workforce shortages in regional and remote areas mean that need is often highest where access is most limited, reinforcing the mismatch between burden of disease and specialist availability. Equitable and timely access to medical specialists allows Aboriginal and Torres Strait Islander Elders and Older People to better manage ongoing chronic conditions by supporting earlier diagnosis, regular review, medication adjustment, coordinated treatment planning and timely escalation of care when conditions worsen. This is particularly important where Elders and Older People are managing multiple chronic conditions, such as cardiovascular disease, diabetes, kidney disease, respiratory disease, vision loss, disability, pain or mental health and social and emotional wellbeing needs, which often require input from several specialists over time. Improving specialist access therefore supports more proactive management of disease burden and is critical to preventing deterioration, maintaining independence and function, and supporting Elders and Older People to remain connected to family, community, Country or Island Home, while receiving the care they need.

Reducing out-of-pocket costs, travel burdens and waiting times; strengthening culturally safe and transparent referral pathways; ensuring regular specialist outreach; and improving coordination between primary care, specialist, hospital and Aged Care services would support earlier intervention and continuity of care. These measures can help prevent avoidable deterioration, preserve mobility and independence, reduce pressure on emergency departments and public hospitals, and contribute to closing the gap in health outcomes and life expectancy for Aboriginal and Torres Strait Islander Peoples.

NATSIAACC Member Case Study: An Elder waited around five years for a hip replacement. Once surgery was scheduled, it was delayed and cancelled because the person could not maintain pre-surgery requirements over the long waiting period. Their mobility continued to decline, leading to broader complications including skin, continence, musculoskeletal and whole-body impacts. The Elder now requires permanent Aged Care at only 63 years of age and may need multiple joint replacements.

NATSIAACC Recommendations

- Invest in prevention and early intervention through Aboriginal community-controlled primary health and Aged Care services, with timely specialist input and follow-up to reduce avoidable deterioration and loss of independence.

Innovative and emerging models of care

Innovative and emerging models of specialist care must strengthen and expand culturally safe, responsive and relationship-based service delivery rather than rely solely on telehealth as the primary solution to geographic barriers. While telehealth can improve access and support follow-up, many Aboriginal and Torres Strait Islander Elders and Older People prefer face-to-face engagement that allows time to establish trust, build an ongoing relationship with their health practitioner and feel culturally safe when discussing complex or sensitive health needs. Effective models should therefore combine appropriate digital options with regular in-person outreach, regional and community-based clinics, and care delivered in co-design and partnership with Aboriginal Community Controlled Health Organisations and local communities. This blended approach can bring specialist care closer to Country

or Island Home while preserving the personal connection, continuity and cultural responsiveness that underpin meaningful engagement and improved health outcomes.

Additionally, access encompasses not only the removal of tangible barriers such as cost, distance and waiting times, but also the development of trust and respectful relationships with Aboriginal and Torres Strait Islander Elders and Older People. For specialist care to be genuinely accessible, it must be culturally safe, trauma aware and healing informed, recognising the continuing impacts of colonisation, racism, institutionalisation and previous harmful experiences within health and Aged Care systems. Specialists entering communities need to prepare before providing care by learning about the local context, culture, history, governance and community priorities, and by seeking guidance from local Elders or Older People, Aboriginal Community Controlled Health Organisations and trusted community leaders. Effective outreach requires specialists to return regularly, invest time in building trust, demonstrate respect, listen to local knowledge and establish relationships that allow Elders and Older People to feel safe, comfortable and confident engaging with care. Services should be co-designed with communities and integrated with local primary health care so that visiting specialists work alongside Aboriginal Health Practitioners, Aboriginal Health Workers, nurses, allied health professionals, Aged Care providers, families and carers.

This approach supports continuity between visits, clearer communication, culturally appropriate follow-up and shared decision-making. Pricing, funding and commissioning arrangements must identify, cost and fund the time, workforce and resources required for relationship-building, cultural engagement, family involvement, navigation, coordination and follow-up. These are essential components of effective specialist care, including work undertaken before and after the consultation. ACCHOs and community-controlled Aged Care providers must be funded for their contribution, rather than expected to absorb this work within existing resources. Families and carers must have access to practical and financial support where their involvement is needed and chosen by the Elder or Older Person.

The Aboriginal and Torres Strait Islander Aged Care Framework 2025–2035 identifies accounting for the full costs of service delivery in Independent Health and Aged Care Pricing Authority reviews as a high-priority future aspiration outside committed measures. This includes costs in culturally thin markets beyond remote and very remote locations. The Framework therefore supports the case for full-cost funding, but this provision should not be represented as an existing funded commitment. NATSIAACC calls for the same principle to inform specialist service commissioning, with explicit funding for the work that enables culturally safe access and continuity of care.

Effectiveness should be assessed through continuity, completed referrals and treatment, Elders' and Older People's experiences of cultural safety, and demonstrated improvements in access and outcomes. Providers should report back to participating communities on findings and the changes made in response.

NATSIAACC Member Spotlight

Innovative models of care are most effective when developed in partnership with Aboriginal and Torres Strait Islander communities and organisations, whereby community-led service design strengthens cultural safety, improves service uptake and ensures care models reflect local community priorities and needs, reflecting Action 2.13 on working in partnership in the National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health.

Utilising a combination of the approaches NATSIAACC members take to deliver culturally safe services on Country or Island Home to Elders and Older People should act as successful frameworks for how care should be delivered to Aboriginal and Torres Strait Islander Elders and Older People. These models of care are innovative, co-designed, place-based, Aboriginal community-controlled that improves equitable access to health care services, addresses geographic and cultural barriers, and demonstrates how specialist healthcare can be delivered in a culturally safe and person-centred manner for Aboriginal and Torres Strait Islander communities.

Purple House demonstrates an innovative, community-controlled model of care that improves access to specialist renal services by delivering dialysis and holistic healthcare in remote communities, enabling Aboriginal and Torres Strait Islander people with kidney disease to remain connected to family, culture and Country while receiving specialist treatment. The Purple Truck is a self-contained dialysis unit on wheels, alongside 20 remote dialysis clinics across the NT, WA and SA.

Mala'la Health Services Outstation Health Program demonstrates an innovative outreach model of care that improves access to healthcare for Aboriginal people living on remote homelands by delivering mobile and fly-in health services that support people to remain connected to their Country, culture and community while receiving healthcare.

NATSIAACC Recommendations

- Provide sustained, flexible investment to expand community-controlled specialist access models, drawing on approaches demonstrated by Purple House and Mala'la Health Services and adapting delivery to local community priorities.
- Fund blended models combining regular face-to-face outreach, community-based care and clinically appropriate telehealth, with continuity between visits.
- Require specialist pricing, funding and commissioning arrangements to identify, cost and fund relationship-building, cultural engagement, family involvement, navigation, coordination and follow-up as essential service-delivery activities. Funding must cover the work undertaken by community-controlled organisations and avoid transferring these costs to Elders, Older People, families and carers.
- Implement specialist access reforms through formal shared decision-making with Aboriginal and Torres Strait Islander representatives, including Elders, Older People and community-controlled health and Aged Care providers. Align implementation with the National Aboriginal and Torres Strait Islander Health Plan 2021-2031, the National Agreement on Closing the Gap and the Aboriginal and Torres Strait Islander Aged Care Framework 2025-2035, with named government responsibilities, funded actions, timeframes and public reporting.

Conclusion

The current system creates significant inequities, with Aboriginal and Torres Strait Islander Elders and Older People, particularly those living in regional, rural and remote communities, facing the greatest burden of chronic disease while navigating the most complex and inaccessible pathways to specialist care. Despite often having higher and more complex health needs, many Elders and Older People experience delayed or forgone care due to workforce shortages, culturally unsafe services, lengthy referral processes, high out-of-pocket costs, travel requirements and fragmented health and Aged Care systems. These barriers compound one another, resulting in poorer health outcomes, avoidable deterioration, earlier loss of independence and increased pressure on primary care, emergency departments, hospitals and Aged Care services.

Access to specialist care must be understood as more than the availability of clinicians whereby equitable access requires services that are culturally safe, trauma aware and healing informed; referral pathways that are transparent, timely and responsive; and affordability measures that address both direct and indirect costs of care. It also requires workforce planning that recognises the mismatch between specialist availability and the location of Aboriginal and Torres Strait Islander populations with the greatest health need, ensuring that investment is directed towards communities where the burden of disease is highest.

Improving outcomes requires sustained investment in community-controlled health and Aged Care services, practical coordination across care settings, and specialist models that support Elders and Older People to remain connected to family, community, Country and Island Home. Governments must translate the National Health Plan, the National Agreement on Closing the Gap and the Aboriginal and Torres Strait Islander Aged Care Framework 2025–2035 into funded actions with clear responsibilities and measurable outcomes. NATSIAACC's position is that culturally safe specialist access requires appropriate funding, community authority and accountability for whether Elders and Older People receive and complete the care they need.

NATSIAACC

National Aboriginal and Torres Strait Islander
Ageing and Aged Care Council



You can find more information at:

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