COTA TASMANIA
for older Australians

COTA TAS
Level 12, 39 Murray St,
Hobart TAS 7000
PO Box 4679, Hobart TAS 7000

www.cotatas.org.au
ABN 71 718 804 307

P: (03) 6231 3265
admin@cotatas.org.au

Submission: Inquiry into access to and affordability of medical specialists in Australia

1. Overview

COTA Tasmania welcomes this inquiry and endorses the central position advanced by our colleagues at COTA Australia: access to specialist care should be determined by clinical need, not capacity to pay.

This short supplementary submission adds evidence and recommendations specific to Tasmania.

Tasmania shows how prolonged public waiting times, specialist workforce constraints, distance and financial disadvantage can combine to make care inaccessible. The problem is especially acute for older people, who are more likely to live with chronic or complex conditions, require several specialists or repeat appointments, and depend on fixed or modest incomes.

For an older person, a referral categorised as non-urgent can still involve sustained pain, reduced mobility, deterioration in function and growing reliance on family, community services or aged care.

Delayed specialist assessment can undermine the ability to remain independent at home. These consequences should be recognised in measuring access and patient outcomes, rather than treating the absence of an acute emergency as the absence of harm.

COTA Tasmania asks the Committee to apply a practical test: a specialist service is not meaningfully available merely because it exists somewhere in Tasmania. It must be accessible within a clinically reasonable time and at a total cost the patient can meet. If that test is not satisfied, referral pathways, travel support and alternative models of care should respond accordingly.

2. About COTA Tasmania

COTA Tasmania is the peak body for older Tasmanians. We bring the experiences of older people to public policy and work for an age-friendly Tasmania in which people can contribute, remain connected and exercise choice throughout later life.

Our constituency includes people with disability, dementia or multiple chronic conditions, people on low and fixed incomes, older carers, and people living in rural and regional communities.

For these groups, specialist access is inseparable from transport, digital inclusion, service navigation and support to remain at home.

3. Recommendations

1. Measure meaningful access: Publish referral-to-first-appointment waits by specialty, urgency and region, including numbers waiting and seen within clinical timeframes.
2. Protect people while they wait: Assign responsibility for review and escalation, and give patients and GPs realistic waiting-time and alternative-care information.
3. Use actual availability for travel assistance: Base support on timely access, not nominal service availability, and recognise transport, accommodation, escorts and repeat visits.
4. Build regional access: Fund regional capacity and outreach, supported telehealth and shared care, while retaining face-to-face care and digital assistance.
5. Show the whole cost: Provide an accessible written estimate of the likely total course-of-care cost through both the specialist and referring GP, alongside timely public alternatives.
6. Coordinate the pathway: Improve referrals, bookings, information sharing and navigation across general practice, specialists, hospitals, allied health and aged care.

4. The Tasmanian access gap

4.1 Long public waits are not harmless

In September 2026, AMA Tasmania warned that some Category 3 outpatients may never receive the specialist appointment for which they were referred. It identified limited workforce, clinic pressures, diagnostic delays and problems with referrals, bookings and information flow. AMA Tasmania's central point is important: triage is defensible only if every category still leads to care.[1]

For older people, the effect of delay may be cumulative rather than dramatic: persistent pain, worsening mobility, falls risk, inability to drive, reduced capacity to provide care or manage daily activities, and avoidable loss of independence. Waiting-time measures should therefore extend beyond elective surgery and should start when a complete referral is accepted, not only when a patient is placed on a procedure list.

Reporting alone is insufficient. Where a waiting time becomes clinically unreasonable, there should be a defined process for review and escalation, with both the patient and referring GP told what will happen next. A queue should not become a place where responsibility is recorded but no one remains responsible for the person.

4.2 An older population outside the capital

The Australian Bureau of Statistics reports that in 2025 the median age outside Greater Hobart was 45.5 years, compared with 39.7 years in Greater Hobart.[2] Specialist workforce and service planning must reflect the distribution of Tasmania's older population, rather than assuming that a capital-city service creates equitable statewide access.

Distance has consequences beyond kilometres.

Some older people cannot drive, need an escort, cannot manage a same-day return, or must arrange replacement care for a partner. Public transport may not align with appointment times or may be physically inaccessible. A nominal appointment can therefore carry travel, accommodation, parking and carer costs that are as important as the specialist's fee.

4.3 Travel support must reflect timely care

Tasmania's Patient Travel Assistance Scheme generally requires travel of more than 75 kilometres one way to the nearest eligible clinical service, with modified thresholds for oncology and renal dialysis. Eligible patients may also receive a subsidy for an approved escort. [3]

This assistance is valuable, but it is a contribution and does not necessarily meet the full cost or practical burden of travel.

The national inquiry should examine the gap that arises where a service technically exists in Tasmania but cannot be obtained within a clinically reasonable time. In those circumstances, access to interstate care and travel assistance should be determined by actual availability and clinical need.

Patients should not be forced to choose between an indefinite public wait and an unaffordable private or interstate pathway.

4.4 Affordability accumulates across the care pathway

COTA Australia's State of the Older Nation 2025 identifies cost and long waiting lists as the leading reported barriers among older people who had difficulty obtaining health care. Waiting-list barriers were particularly prominent in regional areas, Tasmania and among people holding a health care or concession card or without private insurance.[4]

Specialist affordability cannot be reduced to the fee for one consultation. An older person with several conditions may face repeated specialist appointments, diagnostic tests, allied health care, medicines, transport and accommodation. Better fee information is worthwhile, but it does not create access where a patient cannot afford the quoted amount and there is no timely public option.

Primary Health Tasmania's Health Needs Assessment 2025–28 also describes financial barriers, difficulty navigating services and weaknesses in coordination and information sharing for people with chronic conditions.[5] These are system-design issues. They require supported navigation, clearer responsibility and better links between specialists, general practice, hospitals and community care - not an expectation that patients will join the pieces themselves.

5. What reform should deliver

The Committee should judge proposed reforms against the lived outcome for the patient.

For older Tasmanians, success would mean:

- knowing whether and when a first specialist appointment is likely to occur;
- having deterioration reviewed and referrals escalated while waiting;

- being offered an affordable alternative where the local public pathway cannot provide timely care;
- receiving a realistic estimate of the total cost of the course of care, in a format that does not depend on digital confidence;
- having necessary travel and escort costs recognised;
- being able to use telehealth where suitable without losing the option of face-to-face assessment; and
- having specialist advice communicated promptly to the GP and other services involved in care.

Commonwealth and state responsibilities overlap throughout this pathway.

Reform will therefore need shared measures and explicit accountability. National reporting should expose regional inequity, while funding agreements should support specialist outreach, multidisciplinary models, navigation and safe information exchange. Consumer experience - including the effect of delay on function and independence - should be a core outcome measure.

COTA Tasmania supports COTA Australia's national recommendations on affordability and equity.

We ask the Committee to ensure that its findings also confront the distinctive Tasmanian combination of an older regional population, constrained specialist capacity, long public waits and substantial travel burdens. A service is accessible only when a person can reach and afford appropriate care in time for it to be useful.

Sources

[1] AMA Tasmania, "Category 3 outpatients may never be seen as lists grow too long", 23 September 2026

[2] Australian Bureau of Statistics, Regional population by age and sex, 2025

[3] Tasmanian Department of Health, Patient Travel Assistance Scheme: medical practitioner guidelines

[4] COTA Australia, State of the Older Nation 2025: summary report

[5] Primary Health Tasmania, Health Needs Assessment 2025–28

[6] House Standing Committee on Health, Aged Care and Disability, inquiry webpage