10th of April 2026

RE: Submission to the House of Representatives Standing Committee on Health, Aged Care and Disability: Inquiry into Access to Medical Specialist Services

1. I am a clinical psychologist, Director of RG Psychology and Chair NSW Farmers Armidale region. In my work as a clinical psychologist I provide mental health services to individuals across rural, regional and remote communities in every Australian state and territory. I have contributed to national policy discussions, including providing evidence to the Rural and Regional Affairs and Transport References Committee Inquiry into rural, regional and remote Medicare access and funding. Engage with industry, advocacy groups, and government stakeholders to inform policy and program development relevant to rural communities. Through my clinical and community engagement work, I have direct and ongoing insight into the systemic barriers affecting access to care outside metropolitan areas. This submission addresses the impact of recent Medicare Benefits Schedule (MBS) changes—particularly those affecting telehealth eligibility and MyMedicare requirements—on access to specialist services. These changes are significantly affecting referral pathways, delaying treatment, and contributing to inequitable access to care for rural and regional Australians specifically.
2. **Access to and affordability of specialist services -** Access to specialist services in rural and regional areas is heavily dependent on access to general practice, as GPs are the primary gateway to specialist referrals. Recent MBS changes requiring an established clinical relationship with a GP—either through face-to-face consultation or MyMedicare registration—are creating unintended barriers in communities where such continuity is not feasible. In many rural areas, access to a GP in person is severely constrained due to workforce shortages, geographic distance, and reliance on rotating locum practitioners. Patients often face long wait times and significant travel requirements. As a result, telehealth is often the only viable pathway to accessing primary care and, by extension, specialist services. Where patients are unable to meet telehealth eligibility requirements, they are prevented from obtaining referrals, reducing access to specialist care. Many are forced to pay out-of-pocket or forgo care entirely, increasing financial and geographic inequity compared to metropolitan populations.
3. **Outcomes for patients, including delays in treatment -** Barriers to accessing GP services and referrals are directly contributing to delays in treatment and poorer health outcomes. In mental health care, patients require a Mental Health Treatment Plan to access Medicare-subsidised psychological services. Where telehealth access is restricted, patients are unable to obtain these plans, resulting in delayed or foregone care. As highlighted in my previous submission and witness statement to the Rural and Regional Affairs and Transport References Committee Inquiry into rural, regional and remote Medicare access and funding, *"there's no continuity of care when care cannot be accessed."* Patients are presenting later with more severe or complex conditions, increasing the difficulty and cost of treatment and reducing the likelihood of positive outcomes.

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4. **Impact on the broader health system -** The restriction of access to primary care and specialist referral pathways is contributing to broader system pressures. When early intervention is delayed or unavailable, patients are more likely to present in crisis, leading to increased emergency department presentations and preventable hospital admissions. These outcomes represent inefficiencies within the health system and are avoidable with more accessible and flexible primary care and referral pathways. The current MBS settings are therefore contributing to increased demand on already overstretched rural health services.
5. **Specialist workforce distribution and capacity -** The maldistribution of the healthcare workforce is a fundamental issue underpinning these access challenges. Rural and regional communities frequently lack a stable GP workforce and instead rely on transient or locum providers. This makes it difficult for patients to establish the ongoing relationships required under current MBS telehealth eligibility rules. The assumption embedded in recent MBS changes, that patients can access and maintain continuity with a single GP, does not reflect the workforce realities in these areas. As a result, current policy settings are inadvertently disadvantaging communities already experiencing limited access to care.
6. **Referral pathways and coordination of care -** Referral pathways to specialist and mental health services are heavily dependent on GP access. Current MBS telehealth settings are disrupting these pathways by restricting access to GPs unless continuity requirements are met. This has significant implications for coordinated care. Psychologists and other allied health professionals rely on GP referrals to deliver Medicare-supported services. When patients cannot access a GP, the entire continuum of care is disrupted. Evidence from my clinical work and broader community engagement indicates that these barriers are widespread. At the 2026 Motherland National Conference in Toowoomba, attended by over 350 rural women, a substantial proportion of participants reported difficulty accessing GPs and, consequently, mental health care. Similar concerns have been raised within the NSW Farmers Armidale branch, highlighting the systemic nature of the issue.
7. **Out-of-pocket costs and financial barriers -** Where patients are unable to access Medicare-rebated telehealth services, they are often required to pay out-of-pocket for private care or travel long distances to attend in-person appointments. For many rural patients, these costs are prohibitive. In mental health care, inability to access a subsidised treatment plan frequently results in patients disengaging from care altogether. This further entrenches inequities and leads to poorer long-term outcomes.
8. **Any other related matters -** A key issue arising from these findings is the need for greater flexibility in telehealth policy to reflect rural realities. Telehealth should be recognised as a primary mode of care in rural and regional settings, not a supplementary option contingent on in-person access. Current MBS settings assume a level of continuity and access to a regular GP that is not achievable in many rural communities. This disproportionately disadvantages smaller, community-based providers while favouring larger corporate models that are better able to navigate or adapt to regulatory requirements. The result is that access to care is increasingly determined by structural and administrative factors rather than clinical need, increasing risk and inequity for rural populations.

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9. Recent MBS changes, while well-intentioned, are inadvertently creating structural barriers to accessing specialist and mental health care in rural and regional Australia. By applying metropolitan assumptions to rural healthcare systems, current telehealth eligibility requirements are limiting access where it is most needed.
10. **Recommended Reforms** - Based on my clinical and community experience, I recommend the following reforms: Medicare should include explicit rural exemptions where patients cannot reasonably access face-to-face GP care or maintain MyMedicare-compatible continuity; Telehealth should be recognised as a primary mode of care in rural, regional and remote Australia; Continuity of care should be broadened to include team-based and practice-based models; Future Medicare reforms should be subject to formal rural stress-testing prior to implementation
11. Without targeted reform to introduce greater flexibility and rural-responsive policy design, these settings will continue to delay care, worsen health outcomes, and deepen inequities for rural and remote communities.
12. I commend the Committee for undertaking this inquiry and would welcome the opportunity to provide further evidence or clarification as required.

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