# Access to and affordability of medical specialists in Australia

*House of Representatives Standing Committee on Health, Aged Care and Disability*

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## About MTAA

The Medical Technology Association of Australia (MTAA) is the peak body representing companies in the medical technology industry. MTAA's membership spans Australian start-ups and SMEs through to global MedTech leaders. Members develop, manufacture, supply and support technologies used in diagnosis, prevention, treatment, monitoring and management of disease and disability.

Relevant technologies include implantable and connected medical devices, diagnostic imaging and diagnostics, remote patient monitoring (RPM), software as a medical device (SaMD), digital therapeutics (DTx) and clinical decision support. Members also provide implementation, integration, education, training, technical support, maintenance, cybersecurity updates and post-market support required for safe and effective use.

## Executive summary

MTAA welcomes the opportunity to contribute to the inquiry. This submission particularly addresses referral reform, affordability across technology-enabled pathways, the effects of delay and missed care, and innovative and emerging models of care. It also identifies relevant implications for specialist capacity. MTAA does not seek to address matters such as specialist recruitment, retention or individual professional fee-setting, where medical technology does not provide a distinctive industry contribution.

Current assessment, funding and commissioning arrangements are still organised largely around conventional consultations, procedures, facilities and isolated product categories. Technology-enabled specialist pathways often cross those boundaries. An effective pathway may combine a medical technology, specialist review, referral intake and triage, enrolment, primary or community care, data integration, patient support, monitoring and escalation. If any essential component is unfunded or unavailable, the pathway may not be adopted even where the technology is safe, effective and valuable.

These reforms are particularly relevant in regional and remote Australia, where distance, limited local specialist availability and travel requirements can constrain access. Implementation must also address connectivity, accessibility and digital inclusion so that technology-enabled models reduce, rather than reinforce, inequity.

**Scope of submission:** MTAA's substantive focus is on Terms of Reference (b), (c), (d) and (e). Term (a) is addressed only to the extent that medical technologies create a relevant specialist-capacity issue.

**CORE PROPOSITION** **MTAA asks the Committee to recommend nationally consistent assessment, funding and commissioning arrangements that enable evidence-based medical technologies to extend specialist capability and move into routine care. These arrangements should recognise complete technology-enabled pathways across relevant Commonwealth, state, territory, public and private funding settings, rather than favouring conventional attendance-based services or relying on short-term pilots. Success should be measured not only by when a patient obtains a specialist appointment, but by how quickly the patient receives clinically useful specialist input and starts the treatment, monitoring, rehabilitation or other care that follows.**


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## Priority recommendations

| No. | Recommendation | Policy effect |
|---|---|---|
| 1 | **Fund complete technology-enabled specialist pathways** | Create funding models that recognise the medical technology and the specialist review, referral intake and triage, eligibility assessment, patient enrolment and onboarding, multidisciplinary support, care coordination, administration, integration, monitoring and escalation required to deliver the pathway safely and ensure referred patients commence appropriate care. |
| 2 | **Establish fit-for-purpose health technology assessment (HTA) and reimbursement** | Provide predictable assessment and funding routes for SaMD, RPM, connected diagnostics, DTx and other iterative technologies, using proportionate evidence, managed entry, real-world evidence and lifecycle reassessment where appropriate. |
| 3 | **Integrate specialist advice and clinically relevant information into referral reform** | Ensure national referral reform supports digital advice and guidance, structured diagnostic, device and monitoring information, interoperable exchange and closed-loop tracking from referral through to specialist advice, appointment or enrolment in care. Funding should recognise the clinical work required to prepare and respond to appropriate advice requests, and referral outcomes should be communicated back to the referrer. |
| 4 | **Reform commissioning and procurement for sustainable adoption** | Recognise implementation and lifecycle costs, allocate responsibilities according to actual roles, recognise equivalent assurance evidence already assessed by an appropriate authority, avoid duplicative local requirements and provide a pathway from successful pilots to routine adoption. |
| 5 | **Evaluate value across the complete pathway** | Assess time to clinically useful specialist input, time to commencement of care, referral-to-care conversion, specialist capacity, access, patient costs, travel, hospital utilisation, workforce effects, implementation costs and health-system value, rather than focusing only on the price of an individual technology or consultation. |

## The MTAA proposition

### Access to specialist capability

Access to specialist capability is broader than access to a booked appointment. For example, a specialist who receives structured diagnostic results and longitudinal monitoring data can advise a GP, adjust a care plan or escalate a high-risk patient without requiring every patient to travel for an initial or routine review. The same technology can also help the specialist focus appointments on patients who need examination, procedures or complex decisions. This is not simply remote consultation: it is a clinician-led pathway in which specialist expertise is applied through advice, interpretation, supervision, monitoring, treatment planning and escalation, with direct consultation or in-person care used when clinically required.

In practical terms, technology can extend specialist reach in two ways: by removing low-value or avoidable work so scarce specialist time is directed to higher-need patients, and by

bringing specialist input closer to patients through primary care, allied health, home-based care and remote review under appropriate clinical governance.

Extending specialist capability can also contribute to broader health and care system objectives. Where supported by evidence, technology-enabled pathways can enable earlier specialist intervention, support safe care closer to home and help avoid unnecessary escalation to institutional care. This is relevant to pressures at the interface between hospitals and aged care, and to the role of assistive and medical technologies in supporting independence and reducing avoidable long-term disability and care needs. These broader benefits should be considered in whole-of-pathway assessment and funding decisions.

### Modality-neutral policy where evidence supports it

Funding and commissioning should not favour a face-to-face attendance simply because it is the traditional model. Where a technology-enabled approach is clinically appropriate and supported by evidence, it should receive fair consideration for funding. Different technologies will still require regulatory, evidence and payment requirements that reflect their purpose and risk.

### Fund the technology and the care model

Technology-enabled care cannot scale if funding recognises only the conventional attendance it may complement or better target. Funding arrangements should recognise both the medical technology and the clinical and operational activities required to deliver the pathway safely. Depending on the technology, care model and funding environment, the value of software or digital technology may be recognised through a distinct reimbursement mechanism or appropriately incorporated into the funded service or care pathway. Where a technology has an identifiable effect and appropriate evidence, funding arrangements should ensure its value is recognised rather than treating it as an unfunded input to care.

Complete-pathway funding should also recognise the work that determines whether a referred patient actually starts care. This includes receiving and triaging referrals, confirming eligibility, contacting and enrolling patients, scheduling, coordinating with the referrer and usual care team, and following up patients who do not commence or who disengage. These activities should not become unfunded work simply because conventional funding arrangements are organised primarily around consultations, procedures and other billable encounters.

Safe and efficient technology-enabled pathways also depend on clinicians having access to relevant patient information across the care pathway. Authorised clinicians should be able to access clinically relevant records, pathology, imaging, discharge information and specialist advice and, where appropriate, contribute information back to the patient's usual care team. Interoperability arrangements should support this exchange without requiring clinicians or practice staff to re-enter information already captured electronically.

## Term of Reference (a): Relevant implications for access and specialist capacity

### MTAA position

Medical technology should be included in specialist capacity planning where evidence shows that it can extend the reach of scarce expertise. It can do this by enabling earlier specialist advice, supporting shared care closer to home, monitoring stable patients between encounters and directing in-person appointments to patients who most need them.


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### Evidence and reasoning

Connected diagnostics, remote monitoring, digital therapeutics and specialist-supported virtual care can help specialists review the right information earlier and manage selected patients without a conventional appointment at every step. Capacity planning should therefore measure how quickly a patient or treating clinician receives useful specialist input, as well as the wait for a booked appointment. It should also consider the time from specialist recommendation to commencement of the treatment, monitoring, rehabilitation or other care that follows, where that interval is relevant to the pathway.

Increasing effective specialist capacity also requires reducing avoidable clinical and administrative friction. Interoperable systems can reduce repeated data entry, manual transfer of results, incomplete referrals and time spent locating information already available elsewhere in the patient pathway. Where properly implemented, these efficiencies can release clinician time for direct patient care without requiring clinicians to work additional hours. Technology should therefore be evaluated not only for whether it substitutes for an appointment, but also for whether it reduces low-value work across the pathway.

Technology does not remove the need for workforce investment. It changes how tasks and information move across the pathway. Funding models should recognise the specialist, nursing, allied-health, primary-care and technical work required, rather than assuming that new monitoring or follow-up tasks will be absorbed without resources.

Assessment should examine measured effects on specialist capacity, response times and workload. MTAA does not propose broader positions on specialist recruitment, retention or training in this submission.

**RECOMMENDATION Embed evidence-based medical technologies in specialist workforce and capacity planning, with funding for the clinical work required to operate technology-enabled pathways.**

## Term of Reference (b): Priority focus — referral pathways

### MTAA position

Referral reform should give specialists the information needed to triage patients before an appointment and, where appropriate, provide advice or initiate management without requiring a routine face-to-face visit. This includes relevant information generated by medical devices, diagnostics and monitoring technologies.

Referral reform should also support a closed-loop pathway in which a referral is received and actioned, converted into appropriate specialist advice, an appointment or enrolment in care, and its outcome communicated back to the referrer. Digital referral reform should therefore be evaluated not only by whether information can be sent successfully, but by whether the patient reaches the appropriate next stage of care.

### Evidence and reasoning

Digitising a referral letter is not enough. Structured diagnostic results, images, longitudinal measurements, device information and monitoring trends can help a specialist decide whether the patient needs immediate escalation, further investigation, a direct consultation, or advice that can be implemented by the referring clinician. Better information can reduce avoidable appointments and reserve specialist capacity for patients who need direct specialist care.

A practical Australian example is Queensland's Mater eConsultant service, delivered through the Consultmed platform, through which GPs can request specialist advice for defined clinical questions without automatically referring the patient for a conventional outpatient appointment. The Queensland Government reports that more than 250 regional and rural GPs have used the service for more than 1,000 patients, with almost 92 per cent avoiding a face-to-face specialist appointment when the service was used. This demonstrates how referral reform can provide earlier access to specialist expertise while preserving conventional specialist appointments for patients who require direct assessment, procedures or more complex management.

Effective advice-and-guidance pathways also require appropriate recognition of clinician time. A useful specialist advice request requires a structured clinical summary, relevant investigations and a clear clinical question; the specialist must then review that information and provide clinically actionable advice. Funding models should avoid creating new unfunded administrative or clinical work for either primary care or specialists.

Interoperability should reduce workload rather than create an additional reporting obligation. Specialist advice, diagnostic results and relevant device and monitoring information should flow into the clinical systems used by the patient's usual care team in a structured and clinically usable form. National information-sharing requirements should, wherever practicable, support automated extraction and standards-based exchange rather than requiring clinicians or practice staff to re-enter information already captured electronically. National reforms should avoid bespoke integration being recreated for each provider or technology.

Commissioned pathways should clearly allocate clinical, technical and operational responsibilities, including responsibility for reviewing information, communicating results and managing escalation. Remote monitoring arrangements should use clinically governed alert settings that support safety without creating unmanageable false-positive or review burdens.

**RECOMMENDATION Integrate digital advice and guidance, structured diagnostic, device and monitoring information, interoperable exchange and closed-loop tracking into national referral reform. Funding should recognise the work required to prepare and respond to appropriate advice requests, and referral outcomes should be communicated back to the referrer.**

## Term of Reference (c): Priority focus — affordability of technology-enabled pathways

### MTAA position

Affordability should be addressed by funding the complete technology-enabled specialist pathway, recognising both the medical technology and the clinical and implementation services needed to deliver it safely, so that costs are neither shifted to patients and clinicians nor left to be cross-subsidised by providers or suppliers. MTAA's contribution concerns the costs and funding arrangements across technology-enabled specialist pathways. MTAA does not comment on the appropriate level of individual specialist professional fees.

### Evidence and reasoning

Affordability should be considered across the patient's complete pathway, including out-of-pocket expenditure on professional services and diagnostics, travel and accommodation, time away from work, caring responsibilities, and the costs of repeated or avoidable


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encounters. Where demonstrated for the relevant technology, population and pathway, technology-enabled care may reduce some of these burdens and enable selected care at home or closer to home.

A specialist may retain overall clinical governance, establish the care and escalation plan, and review clinically significant information, while nurses, allied-health professionals or primary-care teams provide local assessment, education and support within a clearly defined scope.

New models nevertheless require sustainable funding. Costs may include the technology, integration, onboarding, patient support, technical support, clinical review, multidisciplinary care and escalation. These elements may sit across the Medicare Benefits Schedule (MBS), hospital funding, private insurance, device funding and digital-health arrangements.

Policy should support complete-pathway funding while preserving fit-for-purpose product reimbursement. It should not require the technology component to be cross-subsidised indefinitely by providers or suppliers, nor shift unfunded monitoring and follow-up work to clinicians or patients.

**RECOMMENDATION Develop funding models that recognise both the medical technology and the associated clinical, referral-management, enrolment and implementation services across the complete specialist-care pathway.**

## Term of Reference (d): Priority focus — impact of delays and missed care

### MTAA position

Delay is not limited to the wait for a first specialist appointment. For some patients, a further delay occurs between specialist advice or recommendation and commencement of the treatment, monitoring, rehabilitation or other care that follows. Technology-enabled pathways should therefore be evaluated, where relevant, for their effect on time to clinically useful specialist input, time to commencement of care and the proportion of referred patients who commence appropriate care.

Technology can improve access through two complementary effects. First, it can increase specialist efficiency by reducing avoidable appointments, duplicative tests and low-value administrative review, allowing scarce specialist time to be directed to complex or high-risk patients. Second, it can bring specialist input closer to patients, either directly through remote review or indirectly through advice and supervision provided to primary care, allied health and home-based teams.

### Evidence and reasoning

Medical technologies may help collect information earlier, enable review across distance and support monitoring between encounters. Claims of reduced delay, travel, hospital use or cost should be supported by evidence for the particular technology, population and pathway rather than assumed.

Assessment should also capture implementation burden and workforce effects. A technology that reduces attendance but creates substantial unfunded review activity may not improve system capacity. Conversely, acquisition cost alone may understate value where the technology reduces travel, duplication, deterioration or hospital use elsewhere in the pathway.


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Technology-enabled care should complement specialist judgement and maintain access to synchronous or in-person assessment where clinically required. Appropriate alternatives should remain available for patients unable to use the digital model.

**RECOMMENDATION Adopt a whole-of-pathway evaluation framework for technology-enabled specialist care, including time to clinically useful specialist input, time to commencement of care, referral-to-care conversion, access, patient cost, specialist capacity, workforce effects, hospital use and implementation cost.**

## Term of Reference (e): Priority focus — innovative and emerging models of care

### MTAA position

Australia needs a clear national route for evidence-based digital and connected medical technologies to move from approval and assessment into funded, routine care. That route should link regulation, health technology assessment, reimbursement, service commissioning, implementation and later review, including where the benefits and costs are spread across different parts of the health system.

### Evidence and reasoning

Relevant models include digital advice and guidance, RPM, connected implant monitoring, digitally enabled rehabilitation, DTx, virtual care, connected diagnostics and SaMD-supported decision support. Their clinical role and evidence requirements will vary according to intended use and risk.

Conventional assessment routes may be poorly matched to iterative software, recurring services and technologies whose value is distributed across a pathway. Fit-for-purpose health technology assessment (HTA) should remain rigorous while accommodating proportionate evidence, validated real-world evidence, implementation effects and managed entry with defined reassessment where uncertainty can be responsibly managed.

Successful pilots need a defined route to routine commissioning. Procurement should recognise integration, workflow redesign, training, technical support, maintenance, cybersecurity, post-market responsibilities, data portability and service continuity. Procurement and commissioning should avoid duplicative assurance requirements where equivalent evidence has already been assessed by the Therapeutic Goods Administration, an appropriate accreditation body or another competent authority, without displacing applicable Australian regulatory, clinical-governance, privacy, cybersecurity or procurement obligations.

The same principle should apply to technologies and digitally enabled models developed through publicly funded research: where evidence supports clinical value, there should be a defined route from research funding and demonstration into assessment, commissioning and routine care, rather than requiring a promising model to restart its funding journey once research support ends.

Responsibilities should be allocated according to actual roles and control. Commissioning should distinguish clinical monitoring from supplier technical monitoring and define arrangements for interfaces, software updates, support and orderly exit.

**RECOMMENDATION Establish nationally consistent assessment and commissioning principles that support sustainable adoption of evidence-based technology-enabled specialist models and reduce duplicative requirements.**

## Principles for implementation

The opportunity is to use technology to extend specialist reach, support care closer to home and make better use of scarce clinical expertise. The following principles are intended to help health services adopt these models confidently and at scale; safeguards should enable adoption rather than become unnecessary barriers:

Technology should augment specialist judgement and enable specialists to focus on the patients and decisions that most need their expertise.
Care should be delivered through the most appropriate clinically supported modality for the patient and clinical question.
Technology-enabled pathways should connect specialist oversight with primary care, allied health, community and home-based care, with clear escalation to direct or in-person assessment when required.
Clinical, technical and operational responsibilities should be clearly allocated so teams can adopt new models with confidence.
Funding should recognise the technology, referral intake and triage, enrolment, data review, coordination, monitoring and follow-up work needed to operate the pathway safely and sustainably.
Technology-enabled pathways should connect with the patient's usual care, support closed-loop referral and provide a clear route for escalation.
Implementation should consider accessibility, connectivity and the needs of regional, remote and digitally excluded patients.
Models should be designed and evaluated with relevant clinicians and consumers.
Procurement should be transparent, outcomes-focused and consistent with existing clinical, privacy, competition and medical-device obligations.

## Conclusion

Medical technology will not address every cause of limited specialist access, and MTAA does not seek to offer positions on matters where the industry has no distinctive contribution. It can, however, improve access to specialist capability by extending specialist reach, improving information available for triage and management, supporting closed-loop referral and helping patients commence appropriate care sooner and closer to home. The central industry policy barrier is the absence of connected assessment, funding and commissioning arrangements that support the complete pathway.

MTAA urges the Committee to focus its technology-related recommendations on complete-pathway funding, fit-for-purpose health technology assessment and reimbursement, connected referral and information infrastructure that supports digital advice and guidance and closed-loop referral through to care, sustainable commissioning, measurement of time to clinically useful specialist input and commencement of care, and evidence-based evaluation of whole-pathway value. These reforms would complement workforce investment and clinical leadership while giving safe and effective medical technologies a practical route into routine care.


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## References and MTAA policy lineage


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