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SUBMISSION

Inquiry into access to and affordability of medical specialists in Australia

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Asthma Australia welcomes the opportunity to contribute to the Inquiry into access to and affordability of medical specialists in Australia.

People with asthma must have access to timely, appropriate care according to clinical need, regardless of where they live or their capacity to pay. Specialist assessment and ongoing review are essential for people with severe, complex or difficult-to-treat asthma. However, costs, waiting times and referral barriers can delay treatment and undermine continuity of care. These barriers are compounded for people living in regional, rural and remote communities and those experiencing financial disadvantage.

Asthma Australia recommends targeted investment in primary and specialist asthma care, improved recognition of the need for specialist assessment, and referral arrangements that support timely and continuing access to specialist services. Funding to establish and sustain multidisciplinary respiratory centres and regional networks, alongside workforce development and coordinated information sharing, is essential to bring care closer to home. These approaches should strengthen access to specialist expertise while improving the affordability, equity and continuity of asthma care.

While the Terms of Reference comprehensively address barriers to specialist care, they do not explicitly consider the consumer voice. Asthma Australia recommends that the Inquiry examine how patients and carers can help design specialist services that respond to the needs of people living with lifelong chronic conditions such as asthma.

Asthma Australia recommends government:

1. Invest in multidisciplinary respiratory services and workforce development, particularly outside metropolitan areas, enabling appropriately trained GPs, nurses and allied health professionals to deliver safe, coordinated care with respiratory specialist oversight.
2. Improve patient and practitioner recognition of severe and difficult-to-treat asthma, supporting timely specialist referral in accordance with clinical guidelines.

3. Ensure referral arrangements reflect clinical need and support ongoing respiratory and other specialist care, including greater use of indefinite referrals.
4. Provide ongoing funding to establish and sustain respiratory centres and regional networks to support the management of severe asthma, including consideration of blended funding models that support multidisciplinary teams, coordination, virtual care and specialist support without shifting additional costs or administrative burden to patients.

RESPONSES TO TERMS OF REFERENCE

a) Examine current access to medical specialists in cities, regional and rural communities, with consideration of workforce distribution, shortages, waiting times and barriers to recruitment, retention and training.

Australia has a significant geographic maldistribution of medical specialists[1]**.** The number of respiratory physicians nationally does not, by itself, describe whether people with asthma can access the care they need. While workforce modelling has not indicated a current or future undersupply of consultant respiratory physicians, like many medical specialties, they are not distributed in line with community need.

Access to specialist asthma care varies considerably by location and this is compounded by the limited availability of respiratory physicians with a particular clinical focus in severe and complex asthma, as identified by clinicians working in the field (personal communication, Clinical Professor John Blakey, Head of Respiratory Medicine at Sir Charles Gairdner Hospital in Perth). For people in regional, rural and remote communities, the nearest respiratory physician may be some distance away, while a service equipped to investigate and manage complex asthma may be further still. For example, Tasmania's public respiratory services vary by region: lung function testing is not offered in the North, respiratory care in the North West is provided through General Medicine, and the South has a dedicated Respiratory Function Unit[2].

Recruiting and retaining a physician is only part of the challenge. Even where a physician is available, the surrounding service may not have the team or testing capacity to provide complex asthma care. In private practice, it can be challenging to bring together the multidisciplinary team and specialised investigations needed to assess difficult-to-treat asthma[3].

Depending on the patient's needs, assessment may include lung function testing, measurement of fractional exhaled nitric oxide, specialist allergy assessment and multidisciplinary case review. Some people with complex or unexplained symptoms may also need more specialised respiratory or cardiopulmonary testing[4,5]. These investigations are not required for everyone with asthma, but when they are needed, hospital-based services are often better placed to provide them. For patients outside major centres, this likely means travelling for assessment at a cost in money, time away from work and, for children, time away from school and family routines.

Public hospitals may have the facilities and teams needed for complex asthma assessment, but they do not always have the capacity to provide timely specialist assessment[6]. Limited clinic space can prevent additional face-to-face appointments even when respiratory physicians are available, and dedicated asthma clinics in hospitals are not consistently funded in regional and remote health services.

Public clinics must accommodate continuing care alongside new referrals as use of biologic medicines for severe asthma grows: PBS prescriptions supplied increased from 69,314 in 2021 to 84,799 in 2022[7]. Reviews of existing patients receiving biologics alone occupy the equivalent of three clinics each week (personal communication, Clinical Professor John Blakey, Head of Respiratory Medicine at Sir Charles Gairdner Hospital in Perth). This ongoing workload limits capacity to assess new patients who may benefit from these treatments. Without sufficient funding for clinic capacity and staffing, access to hospital-based expertise does not necessarily translate into timely assessment and continuing care.

> "[The GP] was happy to refer me to a specialist, so I am on the path towards that now, although the wait time is about 6 months to see one locally."
>
> *Anonymous person with asthma*

The wait for specialist asthma care can begin before a referral is made. When asthma symptoms remain hard to manage in general practice, a patient should be referred on for specialist review. Yet through its asthma support services, Asthma Australia hears from people who struggle to access timely, ongoing and affordable GP care, even though they value their GP as a trusted source of information. Delays in seeing a GP can open a clinically inappropriate gap before assessment and referral, which adds another barrier to specialist care. In regional and rural communities, limited access to both GPs and specialists can compound these delays.

> "If you have breathing issues, 3 weeks is a long time to wait to see someone [a GP]."
>
> *Naomi*

b) Examine the effectiveness, transparency and equity of referral pathways from the perspective of patients, primary health care practitioners and medical specialists across the public and private health sectors, with consideration of factors affecting referral patterns and any systemic, regulatory or administrative barriers to the appropriate utilisation of these pathways.

The guidance on when to refer exists, but it does not consistently translate into timely specialist assessment. The Australian Asthma Handbook[8] sets out a stepped approach to asthma care, including assessment of persistent poor control and when specialist referral is recommended. The Global Initiative for Asthma[9] also provides guidance for identifying and assessing difficult-to-treat and severe asthma. The gap is not simply a lack of guidance, but a failure to translate clear referral criteria into consistent action when specialist care is needed.

The consequence shows in the data. Between 2012 and 2021, asthma outcomes among Australian adults have worsened [10]. The proportion reporting very poorly controlled symptoms rose from 22.9 to 26.8 per cent, while urgent asthma healthcare use rose from 28.6 to 37.9 per cent. One explanation is that poor asthma control can become normalised by patients and practitioners alike[11]. When repeated symptoms or flare-ups are addressed one episode at a time, the need for a more comprehensive review, and potentially a specialist referral, may be missed.

Asthma Australia hears from people who only became aware they might need specialist care after contacting our asthma support services. Some consumers have received several courses of oral

corticosteroids before being referred to a respiratory specialist. Others have consulted with multiple GPs looking for answers, without being told their asthma might be severe. These experiences highlight missed opportunities to recognise the need for specialist assessment and escalate care.

> "Once I realised that actually what was happening, was that I had maxed out what my GP could help with, that was really helpful. I felt much more like I was able to make the decision to find a GP who would refer me to a specialist after speaking with her [an asthma educator]."
>
> *Anonymous person with asthma*

Existing guidelines already describe when asthma needs further assessment. Using them consistently would help practitioners identify people who need specialist care and help patients understand why they are being referred. Referral pathways should flag suspected severe asthma and support timely escalation, particularly when poor control persists despite appropriate treatment and review. The patient, their GP and the receiving specialist should all understand why the referral is being made and what care should happen while the person with asthma waits. The pathway is only useful if it connects people to services with the capacity to see them.

Once someone is under specialist care, referral arrangements should follow clinical need, not an administrative timetable. Severe asthma often needs ongoing review by a respiratory physician and sometimes input from other specialists such as an allergist. GP referrals are generally valid for 12 months, but GPs can already issue indefinite referrals where continuing care is needed. These should be used routinely for established severe asthma. Doing so would spare patients the cost, time and mental load of tracking expiring dates and booking GP appointments only to renew a referral. Asthma Australia also supports a review of the link between referral validity and specialist billing, so an expired referral cannot interrupt an established course of treatment or leave patients out of pocket.

Cutting unnecessary repeat referrals must not mean less contact between clinicians. The National Strategic Framework for Chronic Conditions 2026–35[12] calls for clear referral pathways, multidisciplinary care and information sharing across primary care, specialist services and public and private settings. Shared health records and direct communication between specialists and GPs can keep the GP informed without relying on a referral expiry to prompt a visit. People should reach the right care when their asthma requires it and remain connected to that care for as long as they need it.

c) Examine the affordability of specialist services, including out of pocket costs for consultations, diagnostics, procedures, and patient access to specialists through public health services, as well as factors influencing fee setting by specialists in the public and private health sectors.

Cost remains a barrier to timely specialist asthma care for many people. The Australian Government's Medical Costs Finder reports that 71 per cent of patients attending an initial private appointment with a respiratory and sleep medicine physician incurred an out-of-pocket cost in 2023–24. This is typically around, $152 and can vary from state to state[13]. These costs fall hardest on lower-income households, including people whose ability to work has been affected by poorly controlled or severe asthma[14]. In regional, rural and remote communities, people also pay for travel, accommodation and time away from work, while limited specialist choice can reduce opportunities

to access more affordable care. When the ability to pay determines who gets access timely assessment and treatment, existing inequities in asthma outcomes widen.

For people seeking private care, the first consultation is only the start. Assessing severe or difficult-to-treat asthma can involve lung function testing, allergy assessment and specialised investigations of broader cardiopulmonary (heart and lung) health. Some of these, such as FeNO testing, have restricted Medicare rebates. Many people also require continuing respiratory review and input from an allergist or other allied health professionals, and each of these adds to the cost of managing their condition. Private health insurance cannot cover the gap for specialist consultations and tests provided outside hospital, so people with insurance face the same out-of-pocket costs as those without.

Public outpatient services provide lower-cost specialist asthma care, but long waits can delay assessment. Grattan's analysis of 2024 data found that approximately 10 per cent of patients referred for urgent respiratory appointments in Victoria and Queensland waited longer than the recommended 30 days[15]. In Tasmania, which has one of the highest rates of asthma in Australia, indicative waiting times for urgent respiratory referrals In August 2026 ranged from 32 days in the North West to 370 days in the North[16]. These waits can prolong poor asthma control and delay access to treatment that requires specialist assessment. Public services must also support both timely initial assessment and continuing symptom review if biological treatment begins.

PBS subsidy makes biologic medicines far more affordable, but it does not cover the specialist care needed to start and stay on them. Continuing approvals for several biological medicines are available for up to 24 weeks and require documented evidence of treatment response within a specified timeframe[17]. If that evidence is not provided in time, the patient is deemed to have failed treatment. In practice, this means at least two specialist reviews a year just to keep the subsidy, on top of routine care. A person whose asthma is well controlled on a biologic can lose access to it because they could not get or afford an appointment on time. This puts pressure on services as well as patients.

Specialists set their own fees, and Medicare pays a rebate based on the MBS schedule fee. The patient pays the difference. Over time, MBS rebates have not kept pace with the cost of providing care, so gaps have grown. Where specialists are scarce, as in many regional, rural and remote areas, patients have little or no choice of provider and cannot look for a lower fee. Asthma Australia does not comment on individual fee decisions, but notes that cost and scarcity together mean the people with the fewest options often face the highest barriers.

d) Examine the impact on patient outcomes by delays due to cost, distance and waiting times, and broader system impacts on primary care, emergency departments, public hospitals, chronic disease management, as well as impacts on people due to deferred or missed care

Most serious harm from asthma is preventable. Delays in care make it more likely. Up to 90 per cent of asthma-related hospitalisations could be prevented through accessible, high-quality primary health care and effective community-based prevention [18,19]. Yet asthma still causes more than 31,000 hospitalisations each year, almost half involving children under 15 [20,21,22]. It is the leading cause of disease burden in Australian children aged 5–14 years[23]. In 2024, 478 Australians died from asthma[24].

When asthma is poorly controlled, people have poorer quality of life, need more urgent health care and can experience significant mental health impacts[25]. Delays in specialist assessment can also prolong reliance on oral corticosteroids to manage repeated flare-ups. Although these medicines are

effective for treating serious exacerbations, repeated or prolonged use can cause cumulative harm, including decreased bone density, weight gain, and behavioural and metabolic effects[26]. Delayed care can therefore expose people to harm both from uncontrolled asthma and from the medicines used to manage it.

For people with severe asthma, timely specialist assessment can enable access to biological medicines that reduce exacerbations and oral corticosteroid exposure. Among people with severe asthma and high corticosteroid exposure, biological treatment is associated with fewer exacerbations, lower corticosteroid use and fewer asthma-related emergency department visits and hospitalisations.[27] Delayed access can prolong exposure to avoidable steroid-related harm.

For example, Asthma Australia has heard from a Caitlin, a person with severe asthma who lived with poorly controlled disease for years. When they could not get access to specialist care, they relied on high-dose oral corticosteroids to manage their asthma. They were eventually seen by a specialist and commenced biological therapy. Because of the delay, they now live with secondary adrenal insufficiency and other health impacts associated with long term corticosteroid use. Earlier specialist care may have prevented this harm.

> "The length of time between access to diagnosis and treatment has left me with other lifelong damages thanks to medications which should have only been a band-aid"
>
> *Caitlin*

Poor asthma control can also have consequences across the life course. Longitudinal evidence shows severe asthma in childhood is associated with an increased risk of chronic airflow obstruction and Chronic Obstructive Pulmonary Disease in adulthood[28]. Preventing prolonged poor asthma control is important not only for reducing immediate symptoms and exacerbations, but also for protecting longer-term lung health.

Delays can prolong poor asthma control and shift care towards more costly acute services.

In a national Australian survey, 63.5 per cent of adults with uncontrolled asthma who used little or no inhaled corticosteroid reported urgent asthma healthcare use in the previous year[29]. This reliance on urgent care contributes to the substantial burden of asthma, which cost the Australian health system $1.28 billion in 2023–24.[30]. Earlier access to appropriate care, including specialist assessment when required, could reduce avoidable urgent care and support planned, ongoing management in the community.

e) Assess innovative and emerging models of care that may improve access to medical specialists

People with asthma deserve access to safe, appropriate and timely care, no matter where they live. Asthma Australia recommends investment in multidisciplinary care, supported by hub-and-network models that extend specialist expertise beyond metropolitan centres.

Respiratory specialist expertise is critical for the diagnosis and management of severe, complex and difficult-to-treat asthma. Multidisciplinary models should build on this expertise, enabling appropriately trained nurses, GPs and allied health professionals to deliver agreed components of assessment, monitoring and support. Asthma Australia supports these approaches where they deliver safe, high-quality care and improve access, equity and continuity, with clear responsibilities and timely specialist reassessment.

Two Australian services show how this works in practice.

In Newcastle (the Newcastle Model), respiratory physicians, specialist nurses and allied health professionals, including physiotherapists and speech pathologists, work as one team[31]. Nurse-led clinics provide education, treatment support and monitoring alongside face-to-face and telehealth specialist assessment. Once a specialist has started a patient on a biologic medicine, ongoing treatment can be delivered in primary care, supported by training from the specialist service and ongoing specialist review.

At Toowoomba Hospital, nurses carry out ongoing biologic reviews, assessing lung function, symptoms, exacerbations, inhaler technique and how the medicine is being given. Patient care is discussed at multidisciplinary meetings, where respiratory consultants can issue repeat PBS prescriptions, and the patient's GP is kept informed. This model has reduced waitlist burden and increased consultant capacity for complex care and formal evaluation of waiting-time reductions is planned[32].

Hub-and-network models should connect severe asthma centres with regional respiratory services and primary care, supporting local assessment, investigations and monitoring with specialist input through virtual clinics and multidisciplinary case discussions. This would reduce repeated travel and improve access to ongoing specialist care.

Severe asthma centres and their regional networks need reliable, ongoing funding for multidisciplinary teams, workforce training and care coordination. Fee-for-service funding alone does not pay for the work that makes these models function, such as nurse-led reviews, case conferences and support for local clinicians.

A blended funding model, which combines ongoing block or program funding with fee-for-service, would pay for this non-billable work directly, giving centres the stability to retain specialist staff, extend virtual care and outreach to regional areas, and support local clinicians without passing the gap on to patients. Without it, will be required to depend on short-term grants or hospital budgets that can be cut at any time, so services reach fewer people and the specialist expertise built up in metropolitan centres stays there.

CONCLUSION

Asthma outcomes in Australia are getting worse and much of the harm is preventable. Too many people wait too long for specialist care; they are not referred in time, they cannot afford private care, or they are stuck on long public waiting lists. While they wait, they rely on repeated courses of oral corticosteroids, end up in emergency departments and some die. In 2024, 478 Australians died from asthma.

Care should be based on clinical need, not on where people live or what they can afford. Asthma Australia calls on the inquiry to recommend:

- Clear referral triggers, so people with poorly controlled or suspected severe asthma are identified and referred on time.
- Affordable specialist care, including MBS coverage for key diagnostic tests and PBS rules that do not take biologic medicines away from people who cannot get a timely review.

- Sustainably funded multidisciplinary networks that bring specialist expertise to regional, rural and remote communities.

These reforms would reduce avoidable harm, ease pressure on hospitals, and keep people connected to the care they need for as long as they need it.

ABOUT ASTHMA AUSTRALIA

Asthma Australia is the nation's peak body representing nearly 2.8 million Australians living with asthma. Our work is grounded in evidence and informed by the lived experience of people with asthma. Our programs reflect a commitment to outcomes-focused, equity-driven reform, integrating community insight and clinical expertise to strengthen person centred asthma care.

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REFERENCES

[1] Department of Health, Disability and Ageing, 2026, Whole of Medical Workforce Supply and Demand Compendium Report, [page no. 8,25], https://hwd.health.gov.au/resources/primary/whole-of-medical-workforce-compendium report-june-2026.pdf, retrieved 12/10/2026
[2] Respiratory and Sleep Medicine | Tasmanian Department of Health [Cited 2026 October 12]
[3] Chung, L.P., Hew, M., Bardin, P., McDonald, V.M. and Upham, J.W. (2018), Managing patients with severe asthma in Australia: Current challenges with the existing models of care. Intern Med J, 48: 1536-1541. https://doi.org/10.1111/imj.14103
[4] Crawford A, Baumwol K, Blakey J. Continuous Laryngoscopy during Exercise (CLE) is safe, feasible and guides clinical decision making. Journal of Science and Medicine in Sport, 26S103
[5] Foo CT, Langton D, Donovan GM, Thompson BR, Noble PB, Thien F. Assessment of ventilation heterogeneity in severe asthma using phase-resolved functional lung magnetic resonance imaging. Physiol Rep. 2025 Jun;13(12):e70423. doi: 10.14814/phy2.70423. PMID: 40534189; PMCID: PMC12177108.
[6] Wait times | Tasmanian Department of Health
[7] Analysis of dupilumab for uncontrolled severe asthma. Drug utilisation sub-committee (DUSC). February 2024. https://www.pbs.gov.au/industry/listing/participants/public-release-docs/2024-02/dupilumab-severe-asthma-DUSC-PRD-2024-02-FINAL.DOCX
[8] Australian Asthma Handbook | Managing difficult-to-treat asthma in...
[9] 2026 GINA Severe Asthma Guide - Global Initiative for Asthma - GINA
[10] H. K. Reddel, M. R. Ampon, L. M. Poulos, et al., "*Worsening Asthma Outcomes in Australian Adults: A Comparison of Stratified Sample Surveys in 2012 and 2021*," *Medical Journal of Australia* 224, no. 6 (2026): e70221, https://doi.org/10.5694/mja2.70221.
[11] Crawford AL, Jones GH, Scullion J, Ryan D and Blakey JD (2025) Health system characteristics and evidence-based asthma care. Front. Allergy 6:1528526. doi: 10.3389/falgy.2025.1528526
[12] National Strategic Framework for Chronic Conditions 2026-35
[13] Service | Medical Costs Finder | Australian Government Department of Health [Cited 2026 October 8]

[14] AIHW (Australian Institute of Health and Welfare) (2026) *Asthma*, AIHW, Australian Government, accessed 13 October 2026.
[15] Breadon, P., Geraghty, J., Jones, D., and Baldwin, E. (2025). Special treatment: Improving Australians' access to specialist care. Grattan Institute.
[16] Wait times | Tasmanian Department of Health – Cited 2026 October 8
[17] Severe asthma - adolescent and adult - continuing authority application form
[18] Australian Institute of Health and Welfare. Principal diagnosis data cubes. Separation statistics by principal diagnosis, Australia, 2023-24 [Internet]. Canberra: AIHW; 2025 [updated 2025 Jul 08; cited 2026 Jun 17]. Available from: https://www.aihw.gov.au/reports/hospitals/principal-diagnosis-data-cubes.
[19] Australian Institute of Health and Welfare. Admitted patient care 2023-24 8: Safety and quality of health systems [Internet]. Canberra: AIHW; 2025 [updated 2025 May 28; cited 2026 Jun 17]. Available from: https://www.aihw.gov.au/hospitals/latest-updates-and-downloads/data.
[20] Australian Institute of Health and Welfare. Australian Burden of Disease Study 2024 [Internet]. Canberra: AIHW; 2024 [updated 2024 Dec 12; cited 2026 Jun 17]. Available from: https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024.
[21] Australian Institute of Health and Welfare. Principal diagnosis data cubes. Separation statistics by principal diagnosis, Australia, 2022-23 [Internet]. Canberra: AIHW; 2025 [updated 2025 Jul 08; cited 2026 Jun 17]. Available from: https://www.aihw.gov.au/reports/hospitals/principal-diagnosis-data-cubes.

[22] Australian Institute of Health and Welfare. Principal diagnosis data cubes. Separation statistics by principal diagnosis, Australia, 2023-24 [Internet]. Canberra: AIHW; 2025 [updated 2025 Jul 08; cited 2026 Jun 17]. Available from: https://www.aihw.gov.au/reports/hospitals/principal-diagnosis-data-cubes.
[23] AIHW (Australian Institute of Health and Welfare) (2026) *Health of children*, AIHW, Australian Government, accessed 13 October 2026.
[24] ABS. Causes of Death, Australia, 2024 data cubes [Internet, cited 2026 July 2]. Available from www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2024
[25] Australian Bureau of Statistics. Asthma [Internet]. Canberra: ABS; 2022 [updated 2023 Dec 15]. Available from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/asthma/latest-release
[26] Blakey J et al. Oral corticosteroids stewardship for asthma in adults and adolescents: A position paper from the Thoracic Society of Australia and New Zealand. Respirology. 2021 Dec;26(12):1112-1130. doi: 10.1111/resp.14147. Epub 2021 Sep 29. PMID: 34587348; PMCID: PMC9291960.
[27] Chen W, Tran T, Sadatsafavi M et al. Impact of Initiating Biologics in Patients With Severe Asthma on Long-Term Oral Corticosteroids or Frequent Rescue Steroids (GLITTER): Data From the International Severe Asthma Registry. The Journal of Allergy and Clinical Immunology: In Practice, 2023; 11, 2732-2747
[28] Tai A, Tran H, Roberts M*, et al*. The association between childhood asthma and adult chronic obstructive pulmonary disease. *Thorax* 2014;**69:**805-810.
[29] H. K. Reddel, M. R. Ampon, L. M. Poulos, et al., *Worsening Asthma Outcomes in Australian Adults: A Comparison of Stratified Sample Surveys in 2012 and 2021*, *Medical Journal of Australia* 224, no. 6 (2026): e70221, https://doi.org/10.5694/mja2.70221.
[30] AIHW (Australian Institute of Health and Welfare) (2025) *Health system spending on disease and injury in Australia 2023–24*, AIHW, Australian Government, accessed 13 October 2026.
[31] McDonald VM, Harrington J, Clark VL, etal. Multidisciplinary care in chronic airway diseases: the Newcastle model. ERJ Open Res2022; 8: 00215-2022[DOI:10.1183/23120541.00215-2022].
[32] Nurse-Led Models Enhancing Outpatient Flow [Cited 2026 October 11]