



ANZCA
FPM

Standing Committee on Health, Aged Care and Disability

INQUIRY INTO THE ACCESS TO AND AFFORDABILITY OF MEDICAL SPECIALISTS IN AUSTRALIA

Australian and New Zealand College of Anaesthetists
(ANZCA) consultation response

5 October 2026



About ANZCA

The Australian and New Zealand College of Anaesthetists (ANZCA), comprising the Faculty of Pain Medicine (FPM) is the professional body responsible for the postgraduate training programs of specialist anaesthetists and specialist pain medicine physicians (SPMPs).

We are one of the largest medical colleges in Australia and New Zealand with 10,000 members.

A key role of the college is fostering the highest standards of clinical practice, safety and high-quality patient care in anaesthesia, pain medicine and perioperative medicine. We do this through our robust training programs, rigorous standards, continuous education, mentoring and supervision of junior doctors, advocacy, and research.

ANZCA consultation feedback

ANZCA's feedback is structured into the five terms of reference areas identified by the Standing Committee:

- a) Workforce distribution
- b) Referral pathways
- c) Affordability and access
- d) Impact on patient outcomes
- e) Innovative and emerging models of care.

ANZCA has identified 17 recommendations in our response, identified in the below sections:

a) Workforce distribution

Scope: 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.

Sufficient workforce supply to meet current and future demand

Demand for anaesthesia services is largely system-driven and closely linked to activity in other medical specialties, particularly surgery, but also gastroenterology. Demand for both anaesthesia and pain medicine services continues to increase, driven by rising surgical volumes, population growth and ageing, increasing prevalence of chronic disease, greater procedural complexity, and the growing burden of chronic pain.

The Australian Society of Anaesthetists (ASA) identifies demand for anaesthetic services is projected to increase by approximately 35.7 per cent between 2017 and 2032.¹ At the same time, chronic pain remains a major and growing health burden, an estimated one in five Australians lives with chronic pain, and the number of Australians affected is projected to rise to around 5 million by 2050.²

Meeting this growing demand requires sufficient workforce capacity but is also affected significantly by operating theatre capacity, hospital infrastructure, funding settings, and broader health system constraints. Where service capacity is limited, observed activity is an unreliable measure of underlying population need, as unmet demand remains hidden.

Workforce supply is influenced by training capacity, workforce participation patterns, attrition, geographic distribution, and evolving models of care. There are currently over 6000 active FANZCA specialists in Australia. The ability to increase specialist numbers is constrained by factors noted in the paragraph above, including the availability of qualified supervisors, operating theatre sessions, procedural volume, and the breadth of clinical exposure required to support high-quality specialist training. ANZCA is not an employer of trainees and does not limit trainee numbers provided sufficient hospital-based training opportunities exist.

Evidence indicates that demand for anaesthesia services is growing faster than workforce supply. A recent government workforce modelling report, currently being finalised, projects a significant shortage of specialist anaesthetists, with a conservative estimated shortfall exceeding 120 FTE in 2026, increasing to almost 400 FTE by 2038 and more than 1,200 FTE by 2048.

¹ <https://asa.org.au/publications/anaesthetist-workforce-modelling>

² www.painaustralia.org.au/static/uploads/files/painaustr-factsheet2-wfdahrmggvwp-wfovneiltuni.pdf

For pain medicine, there is currently no comprehensive, nationally endorsed workforce model that quantifies the specialist workforce required to meet community need. While the Australian Government undertakes medical workforce supply and demand modelling, analyses are conducted at an aggregated level and do not provide sufficiently robust projections for smaller specialties such as pain medicine. Further information on the undersupply of specialist pain medicine services is provided in section 'd) Impact on patient outcomes' below.

Impact to the Australian community: The consequences of workforce shortages are significant for patients, communities and the broader health system. Insufficient anaesthesia and pain medicine workforce capacity contributes to longer waiting times for surgery, diagnostic procedures and specialist pain management services, delaying timely access to care. Delays in treatment can result in worsening health outcomes, reduced workforce participation, and poorer quality of life for patients and their families.

When specialist services are unavailable or delayed, demand is often redirected to general practice, emergency departments and hospitals, increasing pressure on other parts of the health system and contributing to higher overall healthcare costs. The Australasian College for Emergency Medicine (ACEM) has identified that rising demand, longer waits and increasing pressures on EDs reflect broader access and patient flow challenges across the health system, with almost 286,000 additional annual public ED presentations recorded over the past five years, the equivalent of more than 780 extra patients each day.³ Ensuring sufficient workforce supply is therefore critical not only for improving access to specialist services, but also for supporting affordability, equity and better health outcomes across the community.

Recommendation 1: Governments should partner with specialist medical colleges, health services and employers to **implement coordinated, long-term workforce planning** for anaesthesia and pain medicine (and other specialties), including strengthened workforce modelling, expanded training capacity, funded training positions, and targeted strategies to improve specialist workforce distribution and retention in rural, regional and underserved communities. This should leverage the expertise of specialist medical colleges in workforce intelligence, training accreditation, standards setting and workforce planning to ensure workforce supply aligns with current and future community needs. It should be noted that Schedule G (Workforce) in the current National Health Reform Agreement (NHRA) seeks to implement this intent.

Metrocentric training programs

The majority of specialist medical training programs in Australia and New Zealand have historically been metrocentric, with training opportunities concentrated in major metropolitan centres. This reflects the location of large tertiary and quaternary hospitals, where trainees gain exposure to high-acuity, subspecialised care, complex procedures, and the clinical volumes required to meet training and accreditation standards. These settings also generally have the greatest availability of supervisors, multidisciplinary teams, and educational infrastructure.

For pain medicine, the metrocentric nature of training is further influenced by the concentration of multidisciplinary pain services and specialist pain clinics in major cities, limiting opportunities for trainees to complete core training requirements in regional and rural settings.

This training model has several implications for access to, and the affordability of, specialist services across Australia:

- **Workforce maldistribution:** Trainees often establish professional networks, family connections, and employment pathways in metropolitan areas, increasing the likelihood that they will remain in urban practice following qualification.
- **Reduced access to specialist services:** Communities in regional, rural, and remote areas may experience ongoing workforce shortages and reduced access to anaesthesia, pain medicine, and perioperative care services.
- **Limited exposure to rural practice:** Trainees may have fewer opportunities to develop experience in generalist specialist practice, rural health service delivery, and resource-constrained clinical environments, which can influence future practice preferences.

³ <https://acem.org.au/News/February-2026/ACEM-warns-new-data-shows-emergency-department-pre>

- **Barriers to training progression:** In some specialties and subspecialty areas, trainees require access to specific case volumes, procedural competencies, or multidisciplinary services that are only available in a limited number of metropolitan centres. This can create actual or perceived barriers to undertaking extended regional training placements and may contribute to longer training pathways. For anaesthesia, this is known to be relating to under two-year-old paediatric anaesthesia, cardiac anaesthesia and neuroanaesthesia.
- **Challenges in building regional training capacity:** The concentration of training infrastructure, supervisors, and clinical activity in metropolitan centres can make it difficult to establish sustainable regional and rural specialist training pathways and retain specialist expertise in these locations.

ANZCA has established a number of regional and rural-based training pathways and rotations across Australia. These training pathways allow trainees to complete 70-80 per cent of their training requirements in rural and regional centres, with short rotations into metropolitan centres to complete some of the sub-specialty requirements not available in rural or regional centres. Victoria's regional pathway, established in 2020, has now seen a total intake of 38 trainees and Queensland's dedicated regional pathway averages 30 trainees per year. These rurally based programs aim to improve access to specialist health services in rural and regional areas and assist with the development of the future rural workforce. ANZCA is continually looking to expand the number of dedicated regional and rural training pathways based on jurisdictional needs.

Impact to the Australian community: Without deliberate investment in regional and rural training pathways, metrocentric training models risk perpetuating specialist workforce shortages outside major cities, contributing to ongoing inequities in healthcare access, affordability, and health outcomes for regional, rural and remote communities.

Recommendation 2: The Australian Government should work with jurisdictions, specialist medical colleges and health services to **expand and sustainably fund regional and rural specialist training pathways**, including in anaesthesia and pain medicine (and other specialties), through investment in supervision, training infrastructure and flexible accreditation.

Rural and regional workforce maldistribution

As a geographically large country with a relatively small and dispersed population, Australia faces ongoing challenges in ensuring equitable access to specialist medical services. Workforce maldistribution remains a significant contributor to disparities in access, affordability and health outcomes for patients living outside major metropolitan centres.

Anaesthetists work across a broad range of healthcare settings, including large tertiary and trauma hospitals, regional and rural hospitals, day procedure centres and private practice. Despite the critical role they play in enabling surgical, obstetric, emergency and perioperative care, only 15 per cent of anaesthetists currently practise in regional, rural and remote areas. When narrowed to rural and remote locations alone, this figure falls to just 6 per cent. These proportions have remained largely unchanged over the past decade despite approximately 27 per cent of Australians living outside metropolitan areas.

The disparity is even more pronounced for SPMPs. Only 10 per cent of SPMPs practise in regional, rural and remote communities, with just 1 per cent located in rural and remote areas. This significant maldistribution limits access to multidisciplinary pain management services and contributes to delayed diagnosis and treatment, increased travel requirements and costs for patients, greater reliance on acute and emergency care, and poorer outcomes for people living with complex chronic pain.

Difficulty attracting and retaining specialist medical practitioners outside metropolitan centres creates a range of system challenges, including:

- Reliance on locum or short-term visiting specialists to maintain anaesthetic services in regional hospitals.
- Limited rural and regional exposure for some trainees who complete the majority of their training in metropolitan centres.
- Challenges recruiting specialists with subspecialty expertise, including paediatric anaesthesia, cardiac anaesthesia, neuroanaesthesia and pain medicine.

- Difficulty maintaining sustainable after-hours and on-call rosters in smaller hospitals.
- Reduced capacity to support local surgical, obstetric and emergency services, leading to service restrictions or patient transfers to metropolitan centres.

To help address workforce distribution issues, ANZCA's *Regional and Rural Strategy 2026-2028*⁴ identifies the development of a sustainable regional and rural workforce as a strategic priority. The strategy encourages jurisdictional trainee selection committees to implement positive selection mechanisms that recognise applicants of rural and regional origin and experience through selection criteria and scoring processes. Evidence consistently demonstrates that doctors with a rural background or rural training experience are more likely to practise in regional and rural communities following specialist qualification.

Impact to the Australian community: These workforce challenges can directly affect the availability, timeliness and affordability of specialist care. Limited access to specialist services in regional, rural and remote areas can result in delayed surgical procedures, greater travel burdens, postponed or forego pain management interventions and reduced access to multidisciplinary care, creating additional financial and social burdens. This can lead to worsening health conditions, prolonged disability, reduced workforce participation and increased financial hardship for patients and families.

Workforce shortages also place pressure on regional health services, increasing dependence on costly locum arrangements and patient transfers to metropolitan hospitals. These pressures contribute to longer waiting times, reduced service availability and higher costs for health systems and patients alike. For Aboriginal and Torres Strait Islander peoples, who are disproportionately represented in remote areas, workforce shortages can further exacerbate existing inequities in access to healthcare.

Ensuring a sustainable and appropriately distributed specialist workforce is therefore essential to improving equity of access, reducing avoidable health disparities and supporting the long-term viability of regional health services.

Recommendation 3: The Australian Government, in partnership with state and territory governments, specialist medical colleges, health services and training providers, should implement a **national specialist workforce distribution plan** under the *National Medical Workforce Strategy 2021-2031* and *Stronger Rural Health Strategy 2018-2028* to strengthen the recruitment, training and retention of anaesthetists, SPMPs and other specialists in regional, rural and remote communities. The plan should:

- Expand and sustain investment in rural and regional specialist training pathways and infrastructure.
- Support distributed and rurally based anaesthesia and pain medicine training models.
- Strengthen incentives for specialist recruitment and retention in underserved areas.
- Increase access to multidisciplinary pain services in regional and rural communities.
- House the Specialist Training Program (STP) reform funding model to better support workforce distribution objectives.
- Be developed in collaboration with specialist medical colleges, including ANZCA, to deliver evidence-based workforce planning and sustainable rural specialist workforce outcomes.

Balancing specialist expertise and generalist service needs

In recent years, policy discussions on vocational medical training have increasingly emphasised the importance of developing a broadly skilled and adaptable medical workforce. This approach seeks to ensure that medical practitioners possess the competencies required to manage undifferentiated presentations, complex comorbidities and system-level healthcare challenges, particularly in rural, regional and remote communities where workforce shortages and service gaps persist.

While this focus on generalist skills is important, it must be carefully balanced against growing demand for specialist and subspecialist expertise. Anaesthesia is a highly specialised field that

⁴ www.anzca.edu.au/news-and-safety-alerts/our-regional-and-rural-workforce-strategy-2026-2028

underpins the safety and delivery of surgical, obstetric, trauma, emergency and critical care services.

At the same time, there may also be prevailing cultural perceptions and institutional frameworks which inadvertently undervalue generalist practice and influence career decisions towards subspecialist careers.

Recognising the need for both specialist and generalist models of care, ANZCA has collaborated with the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) to develop and implement the 12-month Rural Generalist Anaesthesia (RGA) Training Program⁵. This program equips rural generalists with the skills required to provide safe anaesthesia and perioperative care for lower-risk elective and emergency surgical procedures in regional, rural and remote settings. This includes care for obstetric and paediatric patients within scope of practice, as well as the resuscitation, stabilisation and transfer of critically unwell patients when required.

The program has demonstrated significant success in strengthening rural service capability. Through the grandparenting process, 414 RGAs have been recognised nationally. Since the first trainees commenced in February 2023, 126 clinicians have successfully completed the program, with a further 76 trainees currently undertaking training.

RGAs play a critical and complementary role alongside specialist anaesthetists (FANZCAs). In many smaller regional, rural and remote communities where specialist anaesthetists are not available, RGAs provide essential anaesthesia and perioperative services that enable local access to surgery and procedural care. This collaborative model supports service continuity, reduces avoidable patient transfers and strengthens workforce sustainability in underserved areas. The latest workforce data below demonstrates the complementary distribution of RGAs and FANZCAs across Australia, highlighting the importance of maintaining both specialist and generalist pathways to meet community needs.

Location	RGA proportion (2025 data)	FANZCA proportion (2024 data)
MMM 1 – metropolitan	7%	85%
MMM 2 – regional	3%	10%
MMM 3-7 – rural to remote	80%	6%
Locum	10%	-

Impact to the Australian community: A sustainable balance between specialist anaesthetists and RGAs is essential to ensuring equitable access to healthcare for Australians regardless of where they live.

Without appropriate investment in both specialist and rural generalist training pathways, communities in regional, rural and remote areas face increased risks of reduced access to surgery, maternity services, emergency procedures and perioperative care.

Conversely, a well-supported workforce model that combines specialist expertise with rural generalist service delivery enables more patients to receive care closer to home, reduces pressure on metropolitan hospitals, supports the viability of rural health services and improves health equity across Australia. This is particularly important for First Nations communities, older Australians and patients with chronic and complex health conditions who are disproportionately affected by barriers to accessing specialist healthcare.

Recommendation 4: The Australian Government, in partnership with states and territories, specialist medical colleges and rural training organisations, should **expand pathways and workforce initiatives like the RGA Training Program**. This should recognise the complementary roles of specialist anaesthetists and RGAs, with ANZCA and other specialist medical colleges involved in the design and implementation of training and distribution initiatives to support equitable access to safe, high-quality anaesthesia and perioperative care.

⁵ www.anzca.edu.au/education-and-training/anaesthesia-training-and-pathways/rural-generalist-anaesthesia-training-program

Reliance on visiting and Specialist International Medical Graduate (SIMG) models

As a result of the above maldistribution issues many communities rely heavily on locum arrangements, visiting specialist services and SIMGs to maintain access to essential healthcare services.

SIMGs make a substantial contribution to the rural medical workforce and are disproportionately represented in underserved areas compared with domestically trained specialists. This reflects, in part, long-standing workforce policies that direct many SIMGs to areas of workforce shortage through distribution and location-based requirements. While these arrangements play an important role in addressing immediate workforce gaps, they do not represent a sustainable long-term solution to workforce maldistribution, with retention and integration challenges sometimes limiting the long-term effectiveness of these arrangements. It is important that SIMGs in more remote areas have been accurately assessed to have suitable expertise for delivery of safe and effective care in these locations in addition to support services, including expert clinical advice.

Impact to the Australian community: At a system level, reliance on locum and visiting specialist models can increase healthcare costs, reduce continuity of care and limit the development of stable, locally embedded healthcare services.

Recommendation 5: The Australian Government should work with state and territory governments, specialist medical colleges and health services to **expand training, recruitment and retention initiatives in regional, rural and remote areas and improve integration and long-term retention of appropriately qualified SIMGs**. Specialist medical colleges, including ANZCA, should be embedded in workforce planning and training reform to ensure workforce solutions align with community need, service sustainability and high-quality patient care.

Reliance on volunteers to support key medical teaching roles

High-quality supervision, teaching and training are fundamental to safe patient care and the ongoing supply of specialist anaesthetists and pain medicine physicians. Clinical supervision, workplace-based assessment, curriculum development, governance and educational leadership are essential components of specialist medical training and are core priorities for ANZCA.

The current specialist medical training system relies heavily on the goodwill and voluntary contributions of clinicians. Across anaesthesia and pain medicine, specialists dedicate substantial voluntary time to teaching, supervising, mentoring and assessing trainees, as well as undertaking educational and governance responsibilities that support training program delivery. While this model has historically enabled high-quality training outcomes and strong professional stewardship, it is increasingly under strain and may not be sustainable in the long term.

Although supervisors and training clinicians remain highly committed to education and trainee development, the time required to provide effective supervision and assessment often significantly exceeds the limited and inconsistently funded time allocated within health service workloads. As a result, much of the educational activity that underpins specialist training is undertaken in addition to existing clinical and service commitments.

Growing demand for healthcare services, workforce shortages, increasing clinical workload and pressure to maximise service delivery are reducing clinicians' capacity to absorb unpaid teaching responsibilities. At the same time, evolving workforce expectations, including greater emphasis on work-life balance, flexibility and appropriate recognition of professional contributions, are further challenging the sustainability of a volunteer-based training model.

Without adequate support, there is a risk that clinicians will have reduced capacity to participate in sufficient teaching and supervision activities, limiting training opportunities and constraining the future supply of specialist anaesthetists and pain medicine physicians. This is particularly significant in rural, regional and outer metropolitan settings, where workforce capacity is already stretched and training expansion is a key strategy for improving workforce distribution.

Impact to the Australian community: The sustainability of specialist medical training has direct implications for patient access to care. A continued reliance on unpaid supervision and teaching risks reducing training capacity, slowing workforce growth and exacerbating existing specialist shortages across Australia. For the Australian community, this may contribute to:

- Reduced capacity to expand training positions in areas of greatest workforce need.

- Potential impacts on training quality, innovation and the long-term sustainability of the specialist workforce.

Ensuring that teaching and supervision activities are appropriately recognised and supported is therefore not only a workforce issue but also a patient access and health system sustainability issue.

Recommendation 6: The Australian Government, in partnership with state and territory governments, specialist medical colleges and health services, should implement **sustainable funding and workforce arrangements that recognise and protect specialist medical teaching and supervision**, including dedicated funded supervisor time and integration of training responsibilities into workforce and service planning.

b) Referral pathways

Scope: 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.

Summary of referrals for anaesthesia, pain medicine and perioperative medicine

For routine anaesthesia pre-operative consultations, a specific referral is not required. Referrals related to high-risk patient assessments, specialised clinics (such as pain management or allergies), and, in some jurisdictions, specialised obstetric or paediatric services can occur. Referrals (to anaesthetists and pain medicine specialists) are generally initiated by a surgeon, GP, or treating team to optimise patient health before surgery or other diagnostic or interventional procedures, to ensure safety and comfort. Referrals may also be made for in-hospital acute pain management such as following trauma or for patients with complex pain histories. Referrals in perioperative medicine are designed to optimise patient health before, during, and after surgery, particularly for high-risk, frail, or medically complex individuals. Perioperative medicine is discussed further in section 'e) Innovative and emerging models of care' below.

Chronic and complex conditions referrals

Referrals to SPMPs are typically required for the management of chronic or complex, non-cancer pain, often requiring a multidisciplinary team approach. Pain conditions span primary care, specialist services, hospitals, allied health, mental health and community settings. These specialists are experts in diagnosing and treating pain that has persisted for more than three months, significantly impacts daily function, or has not responded to initial treatments. Referrals are normally provided from a GP or another medical specialist.

The current referral system was designed to primarily support management of acute illnesses, rather than chronic and complex conditions which are increasingly becoming more evident. Australian Bureau of Statistics (ABS) data identifies that in 2022, 50 per cent of Australians had at least one chronic condition, up from 42 per cent in 2007-08, while the proportion living with two or more chronic conditions (multimorbidity) increased from 17 per cent to 22 per cent over the same period.⁶

The current Medicare Benefits Schedule (MBS or Medicare) settings limit access to complex time-based consultation items for some pain specialists and may disincentivise longer cognitive care. Therefore, billing behaviour is currently shaped by MBS item availability and eligibility rules.

This is the case for pain medicine, where chronic pain patients present with substantial clinical, social and psychological complexity.

SPMPs also play an important role in supporting primary care by providing diagnostic clarification, risk assessment of pharmacological therapies, and multidisciplinary management plans that enable ongoing care to be delivered safely within community settings. As such, chronic pain is a long-term condition that requires longitudinal specialist involvement and coordinated multidisciplinary care.

⁶ www.abs.gov.au/statistics/measuring-what-matters/measuring-what-matters-themes-and-indicators/healthy/prevalence-chronic-conditions

Impact to the Australian community: Comprehensive specialist assessment and multidisciplinary care planning can reduce unnecessary investigations, duplicated appointments, avoidable hospital presentations, and reliance on emergency care. This better management of chronic pain can help maintain workforce participation, reduce absenteeism and reliance on social supports, and lessen the impact of pain on patients, families and carers.

Recommendation 7: Referral reform should **recognise chronic pain as a standalone condition requiring longitudinal care**, aligned with contemporary chronic disease management practices. This aligns with ICD-11 International Classification of Diseases (ICD) of the World Health Organization (WHO) officially recognising chronic pain as a distinct, actionable health condition rather than just a symptom. Referral arrangements should ensure that patients requiring specialist pain medicine assessment are able to access these consultations in a timely manner to support coordinated care and reduce downstream health system costs.

Further to this, **introduce Medicare items that support extended, time-limited specialist pain medicine consultations for patients with chronic and complex pain conditions**, enabling comprehensive assessment, multidisciplinary care planning, and specialist support for primary care management.

Referral length of validity

The current Medicare referral validity is known to be the following:

- **GP to specialist referral:** Usually valid for 12 months from the date of the first appointment with the specialist, not from the date the referral was written.
- **Specialist to another specialist referral:** Usually valid for 3 months from the date of the first consultation with the new specialist.
- **Indefinite referrals:** A GP can write an indefinite referral for ongoing management of a chronic or long-term condition, meaning the referral does not expire unless a new or unrelated condition requires assessment.

The college would consider that the three-month non-GP to non-GP referral window should be increased. There should be flexibility to adjust the period depending on the patient's condition, patient preferences (if there is flexibility on when they can undertake the service) and nature of the referrer, rather than having in place a universal or default approach. If the primary rationale for shorter validity periods is to preserve GP oversight, this may need reconsideration. Healthcare delivery and consumer expectations are evolving rapidly, and care is increasingly multidisciplinary and specialist led. In many cases, continuity is no longer exclusively GP-centred. Accordingly, where there is documented, ongoing specialist involvement and active management, longer or conditional indefinite validity periods may be appropriate. For example, an indefinite referral could remain valid provided the patient has continuous follow-up with the specialist, with no break greater than six months (or another agreed time period) between appointments. If that continuity is not maintained (e.g. a patient sees an endocrinologist twice and then does not return for two years), the referral should default back to a defined validity period (e.g. 12 or 24 months) and a new referral should be required to ensure reassessment and updated clinical context. This is particularly relevant for chronic conditions such as persistent pain, where patients may require specialist review over many years. Requiring repeated referral renewal for patients already under active specialist management may create unnecessary administrative burden without improving care coordination.

For GP to non-GP specialist referral – in some instances 12 months would be sufficient and in others a longer period is necessary. A 24-month validity period would be reasonable in most cases. However, where a patient is engaged in ongoing, regular specialist care, it is difficult to justify the need for repeated referrals purely for administrative purposes. In such circumstances, an indefinite referral, provided certain conditions are met, could be appropriate. As above, validity could be contingent on continuous follow-up, with reversion to a defined time limit if care lapses.

Making referrals longer or indefinite by default reflects a tension between administrative efficiency and patient convenience on one hand and coordinated primary care oversight on the other. Australia's health system has traditionally been built around GP-led continuity of care. Making referrals indefinite by default could weaken that structural safeguard unless alternative coordination mechanisms are developed and strengthened. That said, such alternative models may ultimately prove more fit-for-purpose in the future, as patients increasingly prioritise convenience and greater control over their healthcare.

Time-limited referrals currently encourage patients to return to their GP for review, reinforcing the GP's coordinating role. Removing this requirement may reduce those touchpoints. However, healthcare utilisation patterns are changing. Many patients now seek 24/7 access, often via telehealth and after-hours services, and fewer people, particularly in regions with GP shortages, have an ongoing relationship with a single regular GP. In bulk-billing or high-turnover practices, patients may see a different GP at each visit. For many, the traditional "one GP" continuity model is already diminished or non-existent.

Without clear responsibility for oversight, there is a risk of increased fragmentation of care unless another clinician or system assumes an explicit coordinating function. The greatest clinical risk would likely be among patients with chronic, complex, multi-morbid conditions. However, these patients are also the group most likely to maintain regular GP contact regardless of referral settings. This is also particularly relevant in perioperative care, where perioperative medicine clinicians provide a key coordinating role across multidisciplinary teams, helping optimise patients, manage risk and support continuity of care before, during and after surgery. Perioperative medicine is discussed further in section 'e) Innovative and emerging models of care' below.

Overall, a more patient-centred approach to referral validity could better reflect contemporary multidisciplinary models of care while improving system efficiency and access to services.

Impact to the Australian community: A more flexible referral framework could improve access to specialist care, reduce unnecessary administrative burden and lower costs for patients, particularly those with chronic conditions requiring long-term specialist management and those in regional, rural and remote communities where access to healthcare can be limited.

Recommendation 8: The Australian Government should **amend Medicare referral validity requirements to provide greater flexibility for specialist referrals**, including extending the current three-month specialist-to-specialist referral validity period and permitting longer or conditional indefinite referral arrangements where patients are under documented, ongoing specialist management. Referral validity should be proportionate to the patient's clinical circumstances and continuity of care, with longer validity periods contingent on active engagement with the treating specialist and appropriate mechanisms to maintain clinical oversight, care coordination and patient safety. These referral processes and pathways should be co designed between primary care, pain specialists and allied health, including standardised referral templates and feedback loops.

Referral pathway barriers limiting patient access to perioperative medicine services

In section 'e) innovative and emerging models of care' below we have identified perioperative medicine as an innovative model of care that can improve access, affordability and outcomes. However, Australia lacks consistent referral pathways for perioperative medicine services, with several barriers that currently limit patient access:

- **Lack of formal referral triggers for high-risk patients.** Many patients who would benefit most from perioperative medicine services are not systematically identified or referred, including older patients with frailty, patients with multiple chronic conditions, patients undergoing major or complex surgery etc. This means referral often depends on local clinician awareness rather than consistent, evidence-based criteria, resulting in variable access and missed opportunities for optimisation before surgery.
- **Referral occurs too late in the surgical journey.** Patients are frequently referred only after a decision for surgery has been made and shortly before the procedure. This may mean there is insufficient time to optimise diabetes, anaemia, malnutrition, smoking cessation or frailty, and limited opportunity to reduce perioperative risk, avoid cancellations, or improve postoperative recovery.
- **Lack of recognition of perioperative medicine as a distinct referral destination.** GPs and specialists may be unfamiliar with perioperative medicine services or unsure when referral is appropriate or there may not be a known referral pathway for perioperative assessment. This may mean referrals occur directly to a surgeon without consideration of multidisciplinary optimisation.
- **Poor integration between primary care and hospital services.** Information transfer between GPs, specialists, hospitals and perioperative teams is often fragmented, resulting

in duplication of investigations, incomplete medication histories and delayed access to relevant health information, and overall increased costs, care delays and inefficiencies.

Impact to the Australian community: Barriers to timely referral for perioperative medicine reduce opportunities to optimise high-risk patients before surgery, contributing to avoidable complications, surgical delays, longer hospital stays and higher healthcare costs. Fragmented referral pathways and poor coordination between primary care and hospital services also create inefficiencies and inequities in access, particularly for patients with complex health needs and minority groups. Strengthening referral pathways would improve patient outcomes, system efficiency and access to safer surgical care.

Recommendation 9: Nationally consistent referral pathways for perioperative medicine should be established, including early identification and referral criteria for high-risk surgical patients, greater integration between primary care and hospital services, and improved recognition of perioperative medicine as a dedicated multidisciplinary referral destination. MBS arrangements that support multidisciplinary perioperative assessment and optimisation of higher-risk surgical patients should be introduced in line with referral pathways.

c) Affordability and access

Scope: 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.

Medicare rebate rates

Australia's health system delivers some of the best health outcomes in the world, but it operates within a complex mix of public and private funding arrangements that create significant affordability and access challenges for patients:

- **MBS rebates and private health insurance benefits have remained largely stagnant for many years.**

ANZCA supports initiatives that improve transparency around healthcare costs, including platforms such as the Medical Costs Finder. However, genuine transparency and informed decision-making require consumers to be presented with the full funding picture. This should include the Medicare rebate, any private health insurance benefit payable, and any additional fees associated with care, including booking or administration fees where applicable. Presenting only specialist fees without corresponding rebate information risks obscuring the broader drivers of out-of-pocket costs. Community concerns are driven not only by the fees charged for medical services, but also by the growing gap between those fees and the rebates provided by government and private health insurers. Understanding this gap is essential to placing healthcare costs in their proper context. Focusing solely on the obligations of individual practitioners risks overlooking the broader system factors that contribute to rising out-of-pocket expenses.

- **Private health insurance generally does not cover outpatient medical services.**

Affordability pressures are particularly acute in the outpatient setting, where patients are often required to pay significant out-of-pocket costs for specialist consultations, diagnostic imaging, pathology and other investigations. While patients may access treatment through the public hospital system or use private health insurance to offset many inpatient costs, there is no equivalent protection against the costs associated with specialist assessment and diagnosis. For many Australians, these services represent the most immediate and significant financial barriers to care. The widening gap between Medicare rebates and the cost of delivering outpatient services risks delaying diagnosis and access to specialist intervention, particularly for people on lower incomes and those living in rural and regional communities.

- **Medicare rebates have failed to keep pace with rising practice costs, resulting in a widening gap between rebates and the actual cost of providing specialist care.**

Medicare rebates should be informed by the real-world costs of delivering specialist services, including staffing, practice overheads, ongoing professional development,

equipment, and inflationary pressures. These challenges are particularly pronounced in rural and remote areas, where the costs of providing outreach services continue to rise. For example, evidence shows regional airfares have increased well above CPI, increasing the cost of outreach care. The Australian Airports Association reported that 62 per cent of regional and remote routes are serviced by only one airline, reducing competition and choice for regional communities.⁷ Without these services, patients may be required to travel to metropolitan centres, increasing both patient burden and overall system costs.

Addressing these challenges requires a genuine whole-of-system approach that recognises the shared responsibilities of governments, private health insurers, hospitals and healthcare providers in maintaining affordable and accessible healthcare for all Australians.

Impact to the Australian community: Inadequate Medicare rebates contribute to rising out-of-pocket costs for specialist services, creating financial barriers that can delay diagnosis, treatment and ongoing care. These impacts are felt most acutely by people on lower incomes, those with chronic and complex health conditions, and patients living in rural and regional communities. Delayed access to specialist assessment can lead to poorer health outcomes, increased demand on public hospitals, reduced workforce participation and higher long-term healthcare costs. Ensuring Medicare rebates better reflect the cost of delivering care would support more timely access to specialist services, improve affordability for patients and strengthen equity across the health system.

Recommendation 10: The Australian Government should **undertake a comprehensive review of Medicare specialist rebates to ensure they better reflect the contemporary costs of delivering care**, including practice overheads, workforce costs, inflation and rural outreach expenses. Initiatives relating to the **transparency of healthcare costs should comprise whole-of-system aspects**, requiring the publication of Medicare rebates, private health insurance benefits and expected patient out-of-pocket costs alongside provider fees.

MBS item numbers inequity

The current MBS arrangements create inequitable access to funding for SPMPs, despite all SPMPs undertaking the same accredited specialist pain medicine training and delivering equivalent clinical services to patients with complex and persistent pain.

SPMPs enter the specialty from a range of primary specialist backgrounds, including anaesthesia, general practice, rehabilitation medicine, psychiatry, obstetrics and gynaecology, and other recognised specialties. However, access to MBS consultation items varies according to a clinician's original specialty qualification rather than their specialist pain medicine expertise or the complexity of the patient's needs.

SPMPs with a physician base qualification (i.e. holding a fellowship qualification with RACP) can access consultant physician Group A4 items (MBS items 132 and 133), SPMPs from anaesthesia, general practice or other pathways cannot. Many SPMPs are limited to billing MBS items 2801 and 2806 for complex consultations. These items do not adequately reflect the time, expertise and multidisciplinary assessment required to manage patients with chronic pain, many of whom present with multiple comorbidities, functional impairment, mental health conditions, medication complexity and long-term opioid exposure.

This results in inequitable remuneration within a single medical specialty, based solely on a clinician's primary specialty pathway rather than the clinical care provided. The current funding settings act as a disincentive to deliver the extended, cognitive and multidisciplinary consultations that are central to contemporary pain medicine practice. They also reduce the viability of community-based specialist pain services, limiting patient access to timely care and increasing the risk that individuals with chronic pain present to emergency departments or require hospital-based services that could otherwise be avoided.

There are strong precedents for extending access to longer Medicare consultation items where specialist practice involves managing complex, chronic conditions. The 2019 MBS Review Taskforce⁸ recommended that SPMPs gain access to consultant physician attendance items, including items 132 and 133. More recently, Sport and Exercise Medicine Physicians were granted

⁷ https://airports.asn.au/wp-content/uploads/2026/03/AAA-Media-Release_Airline-Monitoring-Report_March-2026_FINAL.pdf

⁸ www.health.gov.au/resources/collections/mbs-review-final-taskforce-reports-findings-and-recommendations?language=en

access to these items from 1 July 2025, recognising the need for longer consultations and chronic condition management. The Government also introduced new long-consultation items for complex gynaecological conditions, including endometriosis and chronic pelvic pain, from 1 July 2025. These reforms reflect the same principles underpinning specialist pain medicine practice: comprehensive assessment, management of complex chronic conditions, multidisciplinary care coordination, and the potential to reduce downstream health system costs.

Similar inequities exist in perioperative medicine (discussed below in section 'e) innovative and emerging models of care'), where the MBS currently provides markedly different rebates for equivalent preoperative perioperative medicine consultations depending on whether they are provided by a consultant physician (such as a geriatrician) compared to an anaesthetist. This funding disparity does not reflect differences in patient complexity, consultation length or clinical value, and creates barriers to the establishment and sustainability of anaesthetist-led perioperative medicine services. Reform is required to ensure that funding arrangements recognise the complexity of perioperative medicine care and support equitable remuneration regardless of a clinician's primary specialty qualification.

Impact to the Australian community: Inequitable MBS access for SPMPs limits the availability of community-based pain services and creates barriers to timely care for Australians living with complex and persistent pain. This can contribute to poorer health outcomes, reduced workforce participation, and increased reliance on hospital and emergency department services. Equitable funding arrangements would improve access to specialist pain care, support better patient outcomes, and reduce pressure on the broader health system.

Recommendation 11: As the MBS is the principal mechanism for funding specialist medical services, **all SPMPs and perioperative medicine medical practitioners should be recognised as consultant physicians for MBS purposes, regardless of their original specialty qualification.** This would provide equitable access to Group A4 consultation items, including MBS items 132 and 133.

Inherent technical complexity of anaesthesia

Clinical complexity and variability are a core driver of anaesthesia fees as anaesthesia billing is not procedure-based alone, it reflects procedure complexity and type, duration of anaesthesia, patient comorbidities and physical status, additional anaesthesia-provided therapeutic and diagnostic procedures, and clinical urgency (elective vs emergency).

Fees are often calculated using a combination of base units + time units + modifiers. This may include after-hours loadings, emergency modifiers, ASA classification modifiers (patient risk level), and/or regional/remote incentives. These modifiers can significantly alter final patient costs and are not always understood.

This means there is high variability between patients/cases with a wide fee dispersion even for the "same" procedure, which limits the usefulness of "average" or "indicative" fees for anaesthetists, and creates small inaccuracies in time capture (as anaesthesia is heavily time-driven) all of which materially affects billing outcomes.

Impact to the Australian community: The complexity and highly individualised nature of anaesthesia means that fees can vary considerably between patients undergoing what appears on the surface to be the same procedure. Without appropriate context, fee transparency measures may unintentionally confuse consumers, create unrealistic expectations about likely costs, and provide misleading comparisons between providers. Any approach to improving transparency should recognise the clinical, time-based and patient-specific factors that influence anaesthesia fees.

Recommendation 12: The committee should ensure that any **fee transparency or reporting measures, such as the Medical Costs Finder platform, recognise the clinical complexity and time-based nature of anaesthesia services.** Consumer information should provide clear explanations of the factors that influence anaesthesia fees and avoid reliance on average or indicative fees that may not accurately reflect individual patient circumstances.

Leveraging private practice in accessing services

Across Australia, based on National Health Workforce Data, we know that more than a quarter of anaesthetists and half of SPMPs work in private settings (with the SPMPs working at multidisciplinary pain clinics or centres).

Training of specialists is a core function of the college and faculty, which provides education, mentoring, and supervision of junior doctors by mostly volunteer specialist anaesthetists and SPMPs. Training of specialists is usually conducted in public teaching hospital settings, however specialist training in private hospitals is increasingly common, supported by initiatives like the Australian government's Specialist Training Program (STP) to provide trainees with experience in diverse healthcare settings beyond traditional public teaching hospitals.

This allows for a broader range of cases (often helping to satisfy volumes of practice requirements), taps into hospital list capacity and provides exposure to different management styles, contributing to a more skilled and better distributed specialist workforce.

Training can take various forms, such as rotations into private hospitals or placements that are entirely within private facilities. ANZCA already has mechanisms whereby this clinical exposure and training can occur in private hospitals. Although these functions do not directly dictate or impact pricing or costing aspects, they do impact private hospital decision-making and partnerships between public and private hospitals.

ANZCA supports collaboration and use of private hospitals, particularly regional private hospitals. Regional private hospitals are important for maintaining patient access to surgery, anaesthesia, procedural care and pain medicine services closer to home. Maintaining a sustainable regional private hospital sector also supports workforce attraction and retention and can reduce demand on public hospitals.

Impact to the Australian community: Private hospitals play an important role in delivering timely access to surgery, procedural care, anaesthesia and specialist pain medicine services across Australia. Leveraging private hospitals as partners in specialist training and service delivery helps maximise existing healthcare capacity, supports more efficient use of infrastructure, and contributes to a sustainable specialist workforce. In regional and rural communities, private hospitals are particularly important in maintaining local access to care, reducing the need for patients to travel long distances for treatment, and supporting the attraction and retention of specialist clinicians. Strong collaboration between public and private sectors can also help reduce pressure on public hospital waiting lists and improve overall access to healthcare services for Australian patients.

Recommendation 13: The Australian Government should support policies and funding arrangements that enable **greater collaboration between public and private hospitals**, including specialist training opportunities in private settings, to strengthen workforce capacity, improve access to care, and maintain the sustainability of regional healthcare services.

Dual qualified anaesthetists and intensivists – workforce reform initiative to improve specialist access

ANZCA, together with the College of Intensive Care Medicine (CICM) recently launched an innovative recognition of prior learning process for combining dual anaesthesia and intensive care training⁹.

The process recognises the significant overlap in foundational knowledge, clinical skills and patient management experience between the two specialties. It demonstrates how recognition of prior learning can reduce unnecessary duplication, improve training efficiency and support the development of a more adaptable specialist workforce, while ensuring trainees continue to meet all specialty-specific requirements and maintaining rigorous standards of patient safety and clinical competence.

Successful completion of the dual training recognition process can reduce the overall time required to complete both specialist training programs by up to 2.5 years.

⁹ www.anzca.edu.au/education-and-training/anaesthesia-training-and-pathways/anzca-cicm-dual-training-recognition-process

This reform makes better use of existing workforce capability and has the potential to increase access to specialist services, particularly in areas of high community need. Dual-qualified specialists bring highly transferable skills that are especially valuable in regional, rural and remote settings, as well as during after-hours service delivery, where workforce shortages can limit service availability. Their ability to work across both specialties enhances workforce flexibility, strengthens service resilience and supports more sustainable models of care.

Since the launch in August 2026, ANZCA and CICM have received 36 applications, with 29 applicants eligible to progress through the assessment process. The colleges have also received two expressions of interest from clinicians seeking to act as regional champions.

Impact to the Australian community: The ANZCA-CICM dual training recognition process will help improve access to specialist anaesthesia and intensive care services by reducing unnecessary duplication in training and accelerating the development of dual-qualified specialists. This reform supports a more flexible and sustainable workforce, particularly in regional, rural and remote communities where specialist shortages are most acute. By strengthening workforce capacity and service resilience, it has the potential to improve timely access to care and better meet growing community demand for specialist services.

Recommendation 14: Governments **support the further expansion of the anaesthesia and intensive care dual training recognition process** through:

- Supporting the development of integrated final-year dual training positions to support the training and retention of dual-qualified specialists.
- Establishing sustainable funding arrangements for dual training positions, with a particular focus on regional, rural and remote areas where specialist workforce shortages are most pronounced.

d) Impact on patient outcomes

Scope: 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.

Limited access to specialist pain medicine services

Available evidence points to a significant undersupply of specialist pain medicine services. The workforce remains small, with approximately 450 practising SPMPs nationally and is unevenly distributed across Australia. Many rural and regional communities have limited or no local access to specialist pain medicine care, while some jurisdictions have no resident SPMP at all. Current workforce capacity is unlikely to meet existing demand, let alone future need. Growth in the workforce is further constrained by limited funded training positions and service capacity.

Inadequate access to specialist pain medicine services can have profound consequences. Chronic pain is associated with reduced quality of life, mental health impacts, loss of employment, reduced productivity, and increased reliance on health, disability and social support services. A Deloitte Access Economics *The Cost of Pain in Australia* report (2019) estimated \$48.3 billion in productivity losses, \$12.2 billion in health system costs, and \$66.1 billion in reduced wellbeing attributable to chronic pain.¹⁰

Impact to the Australian community: Delayed access to multidisciplinary pain management may result in avoidable deterioration, increased medication use, more complex and costly care needs, and poorer long-term outcomes for patients. These impacts can affect a person's ability to work, participate in family and community life, and maintain independence, leading to poorer health outcomes and increased demand across the broader health system (i.e. repeated presentations to general practice and emergency departments).

Recommendation 15: The Australian Government should **improve timely access to multidisciplinary pain services**, including sustainable funding models that support integrating

¹⁰ www.deloitte.com/au/en/services/economics/analysis/cost-pain-australia.html

medical, psychological and physical therapies. Targeted investment should prioritise underserved populations, including rural and remote communities, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, and people on low incomes, to reduce inequities in access to pain care.

e) Innovative and emerging models of care

Scope: Assess innovative and emerging models of care that may improve access to medical specialists.

Perioperative medicine

Perioperative medicine is an innovative and emerging model of care that is transforming how patients are supported before, during and after surgery. Rather than focusing predominantly on the intraoperative episode, perioperative medicine provides coordinated, multidisciplinary care across the entire surgical journey, particularly for patients with complex medical conditions, multiple comorbidities and increased surgical risk. This includes shared decision making regarding the need for, and best-suited type of, surgery.

Patients are typically referred by GPs, surgeons or pre-admission clinic staff as soon as surgery is contemplated. The perioperative medical practitioner works collaboratively with the patient and their broader healthcare team, including their GP and other treating specialists, to plan and coordinate strategies that reduce the risk of complications throughout the perioperative journey. Shared decision making is central to this process and continues throughout the perioperative pathway rather than occurring as a single decision point. From the outset, the perioperative medical practitioner works with the patient to weigh the anticipated benefits of surgery against the patient's individual risk profile and personal goals of care. Where surgery is the preferred pathway, the perioperative medical practitioner systematically implements cost-effective, evidence-based interventions to optimise the patient's health and physical fitness prior to surgery. Such interventions include optimisation of comorbidities, targeted prehabilitation, and early engagement of allied health. Post surgery, the perioperative care team oversees more efficient and structured patient recovery including prevention or early recognition and intervention of postoperative complications. This coordinated, team-based approach supports continuity of care between hospital and community settings and helps ensure that recovery trajectories remain aligned with the patient's overall health goals.

This emerging preventive health model aligns strongly with the Australian Government's *National Preventive Health Strategy 2021-2030*¹¹. By using the surgical journey as an opportunity to identify and address modifiable risk factors, optimise management of chronic disease, improve health literacy and support long-term behaviour change, perioperative medicine contributes to healthier ageing, reduced health inequities and improved population health outcomes. The model demonstrates how preventive healthcare can be embedded within specialist services to reduce the future burden of disease and improve the sustainability of the health system.

ANZCA has developed a short video and case study booklet summarising perioperative medicine and its benefits for patients, clinicians and health services, available on the ANZCA website¹².

Australia's population is ageing and the prevalence of chronic and complex disease continues to rise, increasing demand for more integrated approaches to surgical care. Traditional models, where responsibility for patient management is fragmented across multiple providers, can contribute to avoidable delays, duplicated assessments, decision regret (unnecessary surgery), complications and prolonged hospital length of stay. Perioperative medicine addresses these challenges by providing comprehensive preoperative assessment, risk stratification, shared decision making, optimisation of chronic conditions, postoperative care planning and coordinated transitions back to the community.

ANZCA is leading perioperative medicine in Australia and New Zealand in collaboration with other medical colleges. Specialist anaesthetists are uniquely positioned to lead and deliver perioperative medicine services due to their expertise in acute and chronic disease management, patient risk assessment, critical care and whole-of-patient care. This leadership has resulted in the

¹¹ www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030?language=en

¹² www.anzca.edu.au/chapter-of-perioperative-medicine/advocating-for-perioperative-medicine

establishment of the ANZCA Course in Perioperative Medicine¹³ in 2023, the first in the world to offer clinical immersion.

To date, 770 individuals have been grandparented with recognition of prior learning and 34 clinicians have graduated via the course pathway, including 25 FANZCAs, seven physicians, one general practitioner and one international fellow. In addition, 40 accredited clinical immersion sites have been established across Australia and New Zealand, creating a growing workforce with expertise in perioperative medicine.

Evidence indicates that multidisciplinary perioperative medicine models represent one of the most effective system-level approaches to improving patient outcomes, reducing elective surgery waiting lists and reframing waiting lists as preparation lists, transforming what is otherwise idle time into a structured window for optimisation before surgery. Overall, supporting more efficient use of health system resources. These benefits are particularly important for patients with complex health needs and for rural and regional communities, where access to specialist services may be limited and receiving care closer to home is a priority.

The expansion of perioperative medicine offers a significant opportunity to improve access to specialist care and increase the efficiency of the health system. By improving patient optimisation before surgery, perioperative medicine can reduce avoidable cancellations, decrease postoperative complications, shorten hospital stays and support more efficient use of operating theatre capacity. Furthermore, the perioperative medical practitioner's role in optimising patient health and wellbeing has effects that extend well beyond the individual surgical episode, contributing to broader and longer-term public health outcomes. Perioperative medicine is therefore particularly important as health services seek to manage growing surgical demand, reduce elective surgery waiting times, and address the ever-increasing burden of non-communicable disease.

Impact to the Australian community: Perioperative medicine improves access to coordinated specialist care for surgical patients, particularly those with chronic and complex health conditions. By supporting earlier assessment, patient optimisation and coordinated care throughout the surgical journey, it can improve outcomes, reduce complications and enhance recovery. It also supports more efficient use of health system resources by reducing avoidable cancellations, length of hospital stays and pressure on surgical services. Beyond its clinical and system-level benefits, the period of preparation for surgery represents a significant public health opportunity. It provides a timely and motivated window in which to address modifiable lifestyle factors, such as nutrition, physical activity, smoking, that not only improve a patient's fitness for surgery but also support their broader health and wellbeing well beyond the perioperative period. These benefits are particularly important in rural and regional communities, where improved care coordination can help address access barriers and support timely, high-quality care closer to home.

Recommendation 16: The Australian Government should support the **expansion, evaluation and integration of perioperative medicine services across public and private healthcare settings** as an innovative model of specialist care that improves patient outcomes, enhances system efficiency and strengthens the sustainability of surgical services. This may include scaling up proven perioperative medicine models that work.

Flexible and innovative models of pain medicine care

Addressing growing demand for pain medicine services requires flexible models of care that maximise specialist expertise, improve access for underserved communities, and support earlier intervention. Innovative service models can enhance patient outcomes while making more efficient use of limited specialist workforce capacity. Some examples include:

- **Hub-and-spoke and virtual care models**

Specialist multidisciplinary pain services can operate as regional hubs, providing clinical leadership and support to rural and regional providers through telehealth consultations, case conferencing, shared-care arrangements, and outreach clinics. Telehealth-enabled pain programs that integrate medical, psychological and physical therapies can reduce travel requirements, increase access for patients in regional and remote communities, and improve continuity of care.

¹³ www.anzca.edu.au/education-and-training/anzca-course-in-perioperative-medicine

- **Integrated primary-specialist care**

Collaborative models that strengthen links between primary care and specialist pain services can assist patients to receive timely support closer to home. Structured advice services, electronic consultations, and joint case conferencing enable GPs and other community-based practitioners to access specialist expertise while continuing to manage patients locally. Embedding pain medicine capability within community health and primary care multidisciplinary teams can support stepped-care approaches, reserving specialist services for patients with the most complex needs.

- **Early intervention and secondary prevention**

Earlier identification and management of patients at risk of developing chronic pain offers an opportunity to improve outcomes and reduce future health system demand. Targeted programs for high-risk patients following surgery, injury, or acute pain episodes can facilitate early specialist assessment and intervention where required. Integrating evidence-based pain management principles into chronic disease and mental health programs can also support more coordinated care for people with multiple and complex health conditions.

- **Training and workforce innovation**

Expanding geographically distributed FPM training opportunities can help build sustainable local workforce capacity and improve access to specialist services outside metropolitan centres. Interdisciplinary training and education models can also strengthen the broader health workforce by enhancing capability in contemporary pain science, multidisciplinary care, and biopsychosocial approaches to pain management. Upskilling clinicians including anaesthetists, rehabilitation physicians, rheumatologists, GPs and allied health professionals can support earlier intervention and improve community-based management of chronic pain.

Impact to the Australian community: Flexible pain medicine models can improve access to specialist care, particularly for people living in regional, rural and remote areas, reduce delays in treatment, and support more effective management of chronic pain closer to home. Earlier intervention and stronger integration between primary and specialist care can improve patient outcomes, reduce disability, and lessen pressure on hospitals and specialist waiting lists.

Recommendation 17: The Australian Government should **support the expansion of innovative pain medicine models of care** with sustainable funding and evaluation, including telehealth-enabled multidisciplinary services, integrated primary-specialist shared-care arrangements, early intervention programs, and geographically distributed specialist training pathways to improve equitable access to pain management services across Australia. This would comprise FPM advising on clinical safety, workforce needs and outcome measurement.



Dr Lance Emerson
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