Royal Far West

Children's health, country-wide

Submission on access to and affordability of medical specialists in Australia - House of Representatives Standing Committee on Health, Aged Care and Disability

October 2026

Royal Far West
Children's health, country-wide

Children living in rural and remote communities face a double disadvantage: they have higher developmental and mental health needs, yet less access to the paediatric and child psychiatry expertise required to assess and respond to those needs.

Executive summary

Royal Far West (RFW) supports children and families in regional, rural and remote communities. Our experience shows that specialist access in rural and remote communities is a systems problem involving referral, wait times, travel, affordability, multidisciplinary assessment, treatment planning and continuity of care.

Every child should have equitable access to specialist healthcare, regardless of where they live. Yet for many rural and remote families, distance and workforce shortages create barriers to care, with extensive national evidence highlighting this geographical inequity. Half of remote and very remote locations in Australia receive fewer than one specialist service per person each year, while no major-city area falls below that level. Rural services also face workforce shortages, dependence on locums and limited specialist training outside major cities (Grattan Institute, 2025).

For children with complex developmental, behavioural and mental health needs, delay compounds need. Families can wait years, travel long distances or fall between public eligibility thresholds and unaffordable private care. By the time specialist advice is available, presentations may be more complex and schools, families and local clinicians may have carried risk without adequate support.

RFW recommends that the Australian Government:

- Set and report a national minimum level of access to paediatric and child and adolescent psychiatry services, with transparent and comparable waiting-time data.
- Fund flexible rural models that combine telehealth, outreach, visiting specialists, local coordination and multidisciplinary care. (We have included examples of RFW models currently working in communities)
- Reform Medicare so developmental paediatrics and child psychiatry rebates better reflect the time required for assessment, family and teacher consultation, case conferencing and care coordination.
- Consider a remoteness loading in Medicare Benefits Schedule (MBS) rebates and a specific specialist loading, linked to Modified Monash Model (MMM) classification, to help address higher costs of health delivery in these under-serviced rural areas.
- Expand rural specialist training and support flexible accreditation, supervision and generalist pathways that are workable in smaller communities.
- Direct additional public specialist capacity to the least-served regions and protect continuity where workforce supply is fragile.
- Invest in navigation and coordination so families can enter, understand and remain engaged with complex pathways.

1. About Royal Far West and the families we support

RFW is a specialist child development health service, focusing on the unique needs of children and their families, living in rural and remote communities. As a for purpose organisation, we provide developmental, mental health, and disability support for children up to the age of 12 years, using a mixed model of care that includes telehealth and face to face care, including in-community and on-site programs. Our 150 trauma-informed, allied health and medical specialist staff support country children with their developmental health needs, including speech and language delays, behavioural and learning difficulties and mental health. We work in 243 rural and remote communities in four States throughout Australia, including 355 schools and 78 early learning centres, as well as in-community clinics. Last year we supported 4349 children and helped over 30,000 carers, teachers, parents, students and children.

Complexity is increasing and the gap is widening

The 2024 Australian Early Development Census (AEDC) shows clear geographic disadvantage between children in metropolitan and rural and remote areas. Compared with children in major cities, children in remote and very remote areas were almost three times as likely to be vulnerable in language and cognitive skills.

The increasing vulnerability of rural and remote children is reflected in a growing prevalence of complex needs. This rising complexity makes it difficult for schools – teachers are not adequately trained to support children with these developmental issues and vulnerabilities. And there is inadequate funding to support children and the adults around them.

Children and young people's use of mental health services is also considerably lower in rural and remote areas of Australia, despite research showing children living in rural areas experience poorer mental health (Peters et al.,2019).

We work with highly vulnerable families. Research with RFW client families conducted in collaboration with Growing Minds Australia and The University of Sydney identified the psychosocial complexities of rural and remote children and families seeking developmental and mental health support (Sivak et al, 2026). Caregivers reported high rates of adverse childhood experiences (ACEs) for their children. 27% reported ACEs scores in the high-risk zone (4+ ACEs), with 56% experiencing intermediate risk (1-3 ACEs). Children were reported to commonly experience parental mental health issues (61%), family breakdown (42%), exposure to family violence (39%) and community violence (35%). 87% of families were living in the two most disadvantaged socioeconomic quintiles, while 70% reported financial stress.

Royal Far West
Children's health, country-wide

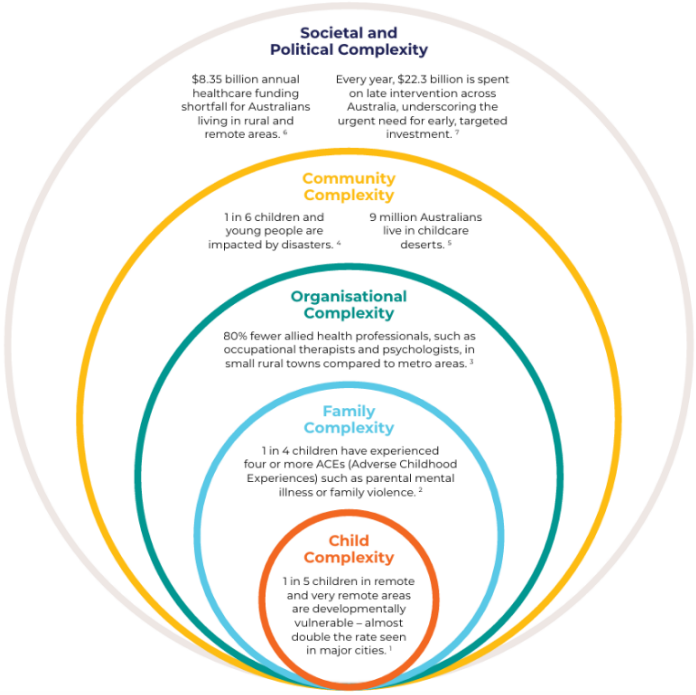
The Need

Too many country children are missing out on the support they need to thrive.

Across rural and remote Australia, children are growing up in environments where disadvantage is layered, persistent and deeply complex. From limited access to healthcare and early education, to the impacts of trauma, natural disasters and systemic underinvestment, these challenges begin early and compound over time.

This is why Royal Far West is needed more than ever.

Our work is designed to meet this complexity head-on – providing integrated, responsive care that reflects the real lives of country kids and their families.



1. AEDC National Report 2024, Australian Government Department of Education
2. Supporting the Complex Development and Mental Health Needs of Rural and Remote Children – Findings of Growing Minds Australia study presented to RFW by Leda Sivak, 2025
3. The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia, National Rural Health Alliance, 2025
4. The economic and social impact of disasters on children and young people, Deloitte Australia and UNICEF Australia, 2025
5. Childcare deserts & oases: How accessible is childcare in Australia, Mitchell Institute, 2022
6. The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia, National Rural Health Alliance, 2025
7. The Cost of Late Intervention Report, The Front Project, 2025

Why specialist input matters

For a child with complex developmental or mental health needs, a specialist appointment is often one part of a longer pathway.

Specialist input supports diagnosis, medication and treatment decisions, risk assessment and the integration of medical, developmental, behavioural and psychosocial information. It can also strengthen the capability of local paediatricians and other clinicians who continue the child's care.

In 2025–26, RFW paediatricians and psychiatrists provided 1,339 appointments to 428 children, representing 1,197 hours of direct appointment time. They contributed a further 400 hours to case conferences and clinical team meetings, working as part of a multidisciplinary team, to ensure high-quality care - equivalent to an additional 30% of direct appointment time. This illustrates why specialist care for complex children cannot be funded or measured only as face-to-face consultation time.

2. Where access breaks down

Geography, supply and under-served communities

Our experience shows that one of the greatest barriers to many rural and remote children achieving their full potential is the lack of timely, affordable access to medical specialists, particularly paediatricians and child and adolescent psychiatrists. This lack of access has continuing and costly impacts across the child's life.

Current access to paediatricians and child psychiatrists in rural areas is dramatically lower than in the cities. There are long, sometimes multi-year waiting lists for access to even initial

assessments. There is a dearth of private providers, and public access is variable, limited and inconsistent, particularly for children with developmental, behavioural and mental health issues. Commonwealth health outreach programs provide a contribution but are limited and not always transparently focused on areas of greatest need. As a result, our clients nominate 'long waiting times' as the number one barrier to access specialist services locally.

Workforce shortages create long waits, higher locum costs and reduced continuity. They also limit the ability of public services to compensate for gaps in private supply. National waiting-time information remains fragmented. The Productivity Commission's 2026 Report on Government Services identified no measures or data collection for specialist outpatient waiting times. Without comparable data, governments cannot reliably identify black spots or judge whether investment is improving access.

Without access to specialists, the resultant reliance on GPs in many rural and remote areas is paramount. However, GP shortages remain severe in MMM 5-7 areas and the bulk are aged over 55 years. The most pronounced child specialist workforce shortages are evident in MMM 4 and 5 areas – this is the area where RFW provides the vast majority of its services.

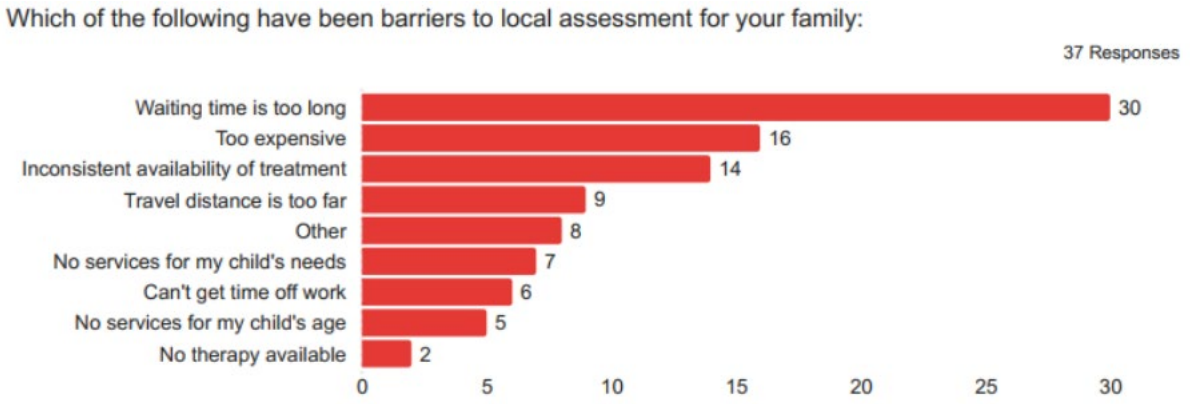
Current barriers faced by RFW clients

The inequities in access to medical specialists are well known:

People in rural communities … disproportionately miss out. If there aren't enough specialists nearby or virtual care options available, an appointment might mean extra time off work, travel, and accommodation costs. Half of remote and very remote areas receive less than one specialist service per person, per year. There are no parts of major cities where this is the case. (Breadon et al., 2025)

However, access should be measured as the child's ability to move through assessment, advice and ongoing care, not simply whether an appointment exists.

Often the first hurdle for parents is getting an assessment of their child, let alone treatment. We asked families bringing children to our Paediatric Developmental Program earlier this year, what barriers they faced in getting a local assessment and their responses are challenging for health service planning:



Referral pathways are fragile

Access to paediatric specialists depends on referral pathways that are vulnerable to disruption. Limited access to GPs can delay the initial referral, while long waits for public outpatient clinics create further barriers. RFW's Psychiatry Assessment Clinic demonstrates how gaps in paediatrician availability can also prevent children from being referred to psychiatrists. Even when a rural child is referred to a metropolitan specialist, the family may still face a long wait, costly travel, an assessment without access to local therapy, or a telehealth appointment without the equipment, privacy, reliable broadband or trusted local support needed for it to be effective. A single consultation may identify a child's needs, but it does not provide the sustained intervention and coordination usually required to achieve developmental change.

A specialist appointment is usually only one step in a complex pathway. Families may first need to obtain a GP referral in communities where primary care is scarce. They must then navigate different public eligibility criteria, private fees, disability pathways and travel assistance schemes. Children with complex but non-acute needs may not meet the eligibility criteria for Child and Adolescent Mental Health Services, while private psychiatry may be unaffordable or unavailable.

Referral pathways also rely on sufficient local allied health and education capacity to implement specialist recommendations. Advice is less likely to improve outcomes when allied health waitlists are long, positions are vacant or no local service can deliver the recommended intervention.

The true cost is broader than the consultation

For rural and remote families, affordability includes travel, accommodation, time away from work and school, lost income, and the administrative burden of repeated referrals. Distance can also impede culturally safe care for Aboriginal children and families. Grattan recommends choosing between virtual care, outreach, fly-in fly-out services and patient transport according to local circumstances rather than assuming a conventional clinic is viable in every community (Grattan Institute, 2025).

The cost burdens on families extend far beyond the cost of specialist consultations to travel, accommodation and lost income in travelling to and from appointments. Cost is listed as the second most mentioned barrier to accessing local services by RFW clients.

3. The impact of delayed or missed specialist care

The impacts on children not being able to access a specialist for speech, learning difficulties or mental health/behavioural challenges early in life, has a significant impact, affecting their immediate and longer-term health, education, employment and wellbeing. There is now also strong evidence of an association between early childhood development vulnerabilities and lower NAPLAN scores at primary and high schools. In turn this affects later life outcomes.

Developmental and mental health concerns often emerge early, but comprehensive assessment may be delayed by limited local services and long specialist waits. At later ages,

difficulties may be affecting learning, relationships, behaviour, family functioning and participation, making support more complex and costly.

Families and local systems carry the consequences

- Families repeat their story across services and may need to choose between high private costs, long public waits or no care.
- Children miss school for travel and appointments, while parents and carers lose work time and income.
- Schools and early childhood services manage needs that require clinical input, often without sufficient training or access to local clinicians.
- GPs, paediatricians and allied health practitioners carry clinical responsibility without timely access to specialist consultation.
- Late intervention can require more intensive coordination and reduce the opportunity for early, lower-cost support.

4. Models that can improve access

Flexible, locally connected specialist multidisciplinary care

Telehealth is a valuable and effective service model and can extend scarce expertise, but it is only one part of the solution. Effective rural care combines specialist input with local relationships, preparation, coordination, multidisciplinary discussion and follow-up. Depending on community circumstances, the right mix may include telehealth, outreach, visiting clinicians, Aboriginal Community Controlled Health Organisations, transport assistance and local workforce development.

National policy should allow local areas and commissioned providers to meet access targets through this mix. Funding should recognise the higher cost of rural delivery and protect continuity rather than rewarding isolated occasions of service.

Workforce development must follow community need

Rural services will remain constrained without a stronger training pipeline. Around 34% of medical students undertake at least six months of rural clinical training, but only 14% of specialist trainees train outside major cities. Rural training experience is associated with later rural practice (Grattan Institute, 2025).

Training investment should be planned against community need by specialty and location. Accreditation and supervision rules should be transparent and flexible enough for safe rural training, including shared and remote supervision where appropriate. Selection and curricula should support rural-background applicants and generalist roles. Smaller communities may not sustain every subspecialty, so workforce planning must balance generalists and subspecialists.

What successful innovative models have in common

- A clearly defined population and referral pathway.
- A local coordinator who prepares families, assembles information and links providers.
- Specialist time for consultation, case conferencing and advice to local clinicians.
- Multidisciplinary capability and a pathway for intervention after assessment.
- Reliable technology, culturally safe engagement and alternatives where virtual care is unsuitable.
- Evaluation of access, experience, clinical decisions, local capability and continuity.

The following RFW case studies show how specialists can improve outcomes when they work within multidisciplinary teams supported by flexible, innovative models of care.

Case Study one: the Paediatric Developmental Program – Amy's Story

Amy* is a ten-year-old girl living in a very small town, one hours drive from the closest regional centre. She loves animals, the ocean, and learning about the Titanic. She lives with her two mothers and four siblings and identifies as Aboriginal and/or Torres Strait Islander. Amy has irregular contact with her biological father. Her family has experienced long-term financial hardship and ongoing challenges of living in a geographically isolated area including periods where there was not enough water in household tanks for a daily shower. The family also has a significant history of mental health and neurodevelopmental conditions, including depression, ADHD and autism.

Amy was referred by her local GP to RFW for a multidisciplinary neurodevelopmental assessment. At the time, she was experiencing low self-esteem, suicidal ideation, episodes of self-harm, and traits consistent with autism. Amy's school attendance was approximately 20–30% before shifting to home schooling. Amy had refused to engage with local mental health and health services.

RFW's multidisciplinary team's tailored response for Amy included:

- With support from an RFW social worker, an initial week of telehealth assessments, where Amy met with our paediatrician and psychiatrist as well as our allied health staff.
- Five months later Amy and her family travelled to RFW's Centre for Country Kids in Sydney for a comprehensive, week-long, face to face assessment. Amy engaged well and completed further assessments. Amy was diagnosed with Generalized Anxiety Disorder, Autism Spectrum Disorder (Level 2), difficulties with language, motor skill challenges, literacy difficulties, myopia, and sleep difficulties.
- Providing psychological support through RFW's Treatment and Transition program, focusing on helping Amy build independence and strengthen her engagement with

family and community as well as speech pathology sessions to support her language, literacy, and engagement skills.

- Ongoing telepsychiatry reviews to monitor and manage her mental health, conducted by RFW's psychiatrist.

RFW also helped the family navigate its NDIS application to secure long-term funding and services. In addition, the RFW school team is supporting the family to structure Amy's home-schooling, so it meets her learning needs and keeps future pathways open.
RFW uses a combination of NSW Government funding, Medicare rebates, philanthropic and corporate partnerships to deliver this service.

Case study two: the Paediatric Developmental Program – Riley's Story

Riley* is a bright and curious seven-year-old Kamilaroi girl from Western NSW who loves gaming, maths and drawing. Despite her strengths, Riley has faced developmental challenges, including delayed walking and speech, sensory sensitivities and difficulties with emotional regulation and social interaction.

Her story reflects a broader trend seen across remote and very remote areas, where nearly 60% of children are not developmentally on track, and the rate of children vulnerable on two or more domains (DV2) reaches up to 29.7% - more than double the national average (AEDC, 2025). These early gaps mean many children, like Riley, are entering school already behind in communication, behaviour, learning and emotional wellbeing.

Referred by her GP with a query of autism, Riley's family were seeking answers and support. Her mother, Shellie, shared concerns about her behaviour, fine motor skills and the lack of cultural connection in their current town. Riley receives some support at school through a support class and a School Learning Support Officer; however, her needs are complex and require a deeper understanding. Riley faced a very long wait to see a specialist paediatrician near the town where she lives.

That's why Riley and Shellie attended Royal Far West's Dubbo in-community clinic, where Riley was assessed by a multidisciplinary team including a paediatrician, psychologist, speech pathologist, occupational therapist, social worker and Aboriginal education officer. This clinic is part of a new partnership launched in April 2025 between RFW and the Western NSW Local Health District, aimed at expanding specialist paediatric services in the region.

Through this initiative, multidisciplinary teams deliver comprehensive assessments and support to families, schools and local clinicians via in-community visits to Dubbo Paediatric Outpatient Hospital, alongside weekly clinics led by RFW's Chief Medical Officer, Dr Marcel Zimmet.

This kind of coordinated care is essential in rural contexts, where systemic underinvestment has led to long wait times – up to four years for paediatric care – and significant workforce shortages, with rural towns having 80% less access to occupational therapists compared to metro areas (National Rural Health Alliance, 2025). Early outcomes from the Dubbo pilot show improved access, reduced travel burden and strengthened care pathways – benefits that Riley and her Shellie are already experiencing.

During Riley's occupational therapy session, activities revealed challenges with coordination, balance and sensory processing. Shellie also shared insights into how noise and tactile sensitivities affect Riley's daily life. The clinic provided a comprehensive view of Riley's developmental profile and helped identify the right supports for her. With this knowledge, Riley's school and family are better equipped to advocate for the services she needs, and Shellie now feels more empowered to navigate the system.

Riley and Shellie are now preparing to travel to Manly for a second week of comprehensive assessment at our Centre for Country Kids.

RFW has a long-standing history of supporting children and families across western and far west NSW – and we continue to expand our reach, delivering specialist child development services to children, families, educators and communities from over 50 towns across the region. In FY25, we supported 453 children, 302 parents and carers and 496 educators in the area. The western and far west regions of NSW made up over a third of our referrals to the Centre for Country Kids in Manly.

Case study three - Psychiatry Assessment Clinic (PAC)

A recent analysis by the Royal Australian and New Zealand College of Psychiatrists on the child and adolescent psychiatry workforce (RANZCP, 2026) found the current workforce is heavily concentrated in major cities. It also found that substantial gaps exist in all areas, but the consequences fall hardest on those most vulnerable: children in rural areas, First Nations young people, disabled children, and those in low socioeconomic areas that have the least access to specialist care.

RFW receives referrals each year from local paediatricians seeking a second opinion from a child and adolescent psychiatrist regarding medications and psychosocial interventions for their clients with escalating behaviours despite a variety of pharmacological interventions. These children can have complex developmental, behavioural and mental health needs who require specialist psychiatric input but have limited access to local child psychiatry and are often unable to attend the service face to face in Sydney due to their high level of risk and high support needs.

While these clients often have chronic and complex conditions, they typically do not present as sufficiently acute to be eligible for the local Child and Youth Mental Health Service (CYMHS) and therefore continue to be managed by their local paediatrician.

The Telecare Psychiatry Assessment Clinic (PAC) was designed in response to this need and is a service that sees children and their families for the purpose of psychiatric assessment. This assessment will help us to work with parents/carers, the child's paediatrician, and other local care providers to enhance the child's current treatment plan.

Funded by Murrumbidgee and Western PHNs, it operates as a specialist-to-specialist consultation model: the child remains under the care of their local paediatrician, while an experienced Clinical Nurse Consultant gathers detailed clinical and contextual information, supports the family and coordinates other stakeholders. A RFW child and adolescent psychiatrist then assesses the child by telehealth and provides diagnostic and management advice, followed by a feedback consultation with the referring paediatrician.

An evaluation of 20 children found high acceptance among psychiatrists, paediatricians and families. All participating paediatricians said PAC fitted their practice and that they would use it again, while the Clinical Nurse Consultant role was consistently identified as central to making the model work. Evidence also indicated changes to diagnosis and treatment and some capacity-building for local paediatricians.

Crucially, the PAC model relies on receiving timely referrals from paediatricians. Functioning outpatient clinics are necessary for these referrals to occur, highlighting the interconnected referral pathways needed to ensure care, and the vulnerability of these pathways to funding or staffing gaps.

Paediatricians' feedback has been very positive about the model of care coordination and the improved access to psychiatry.

"Most children, especially primary school children aged, are not clearly eligible for psychiatrist review in our area outside of mental health crisis symptoms".

"Really valuable to have this service, otherwise it is almost impossible to have children <13y assessed by a psychiatrist in our area"

Demand for RFW services far exceeds what can currently be provided. Our experience is typical of the delays experienced by rural and remote families. In one study of mental-health related Medicare services by children, those in outer regional, remote and very remote areas were nearly one-third less likely to see a psychiatrist. (Watkeys et al., 2024)

Medicare rebates do not cover the cost of deep work many psychiatrists and paediatricians do. For the PAC, the available Medicare rebate covers less than one-third of the total cost of the service.

Conclusion

Children living in rural and remote communities should not have to wait longer, travel further or reach a higher level of crisis before receiving specialist care. RFW's experience shows that targeted specialist input can make a practical difference when it is connected to families, local clinicians and multidisciplinary support. The Commonwealth Government can improve equity by setting clear access expectations, investing in flexible rural delivery and training, and funding the coordination required to turn specialist advice into sustained care.

Royal Far West is happy to expand or provide further details on this submission.

For further information contact:

Jenny Stevenson
Head of Policy and Government Relations
Royal Far West
E: jennys@royalfarwest.org.au