



APS Position Paper: Clinical Allergy Services in Regional Australia

April 2026

Every child in Australia should have timely access to safe, evidence-based allergy care delivered locally where possible, with seamless escalation to specialist services when required.

Executive summary

Problem

- 30% of Australians live outside metropolitan centres with inequitable access to allergy care
- Workforce capability and service access are highly variable.

APS Position

- Care should be local wherever safe, supported by real-time specialist input.
- This model is fully aligned with the National Allergy Council (NAC) Access to Care Guideline and operates within existing ASCIA clinical guidelines. It provides a practical service delivery and workforce implementation pathway, particularly for paediatric and regional populations.

Solution

- A tiered, hub-and-spoke model with:
 - Workforce upskilling
 - Regional capability building
 - Rapid specialist support

Outcome

- Reduced tertiary burden
- Improved equity, safety, and timeliness

This position statement complements national policy and access frameworks by focusing on clinical service delivery, workforce capability, and implementation rather than clinical guideline development.

Key Recommendations

1. Establish a **nationally supported tiered model of allergy care**
2. Fund **regional allergy coordinators** and clinical champions
3. Implement **real-time clinician-to-specialist** support systems
4. Develop **regional food challenge and testing capability**
5. Embed **allergy education** across all health training pathways
6. Create a **national evaluation and data framework**

Background

30% of Australians live outside of metropolitan centres and are frequently disadvantaged by the tyranny of distance and overstretched and under resourced local health services.



Allergy care for children should be timely, local where possible, and supported by scalable specialist expertise. This reflects the need to deliver high-quality care within the child's broader developmental, medical and psychosocial context, particularly in regional, rural and remote settings.

The APS recommendations focused on developing practical implementable strategies for improving equitable access to high-quality allergy care access across Australia, considering various healthcare settings including community, hospital, public and private, metropolitan, regional, rural and remote locations. This paper provides a practical implementation strategies and evaluation methods for a new tiered system of allergy care delivery. The model emphasises workforce upskilling, regional capability building, real-time specialist support, and multidisciplinary care, with clear escalation pathways to ensure patient safety and system efficiency.

The Modified Monash Model (MMM) provides a useful framework for describing geographic distribution of populations; however, service delivery does not align strictly with MMM categories.

MMM Category Description

MMM1	Metropolitan
MMM2–3	Regional centres
MMM4–5	Rural towns
MMM6–7	Remote / very remote

Some services located in MMM1 centres function as de facto regional hubs, providing care to large catchment populations across MMM2–MMM7 regions, including rural and remote communities. Hub designation and funding should therefore be based on functional service role and catchment population, rather than geographic classification alone. Failure to recognise cross-MMM service provision risks underestimating demand and underfunding services that are critical to regional access.

Current State of Regional Allergy Care

Allergy education and knowledge among health professionals is very variable and services at primary care level are not well developed particularly outside MM1 and MM2. This variability is particularly consequential in paediatric care, where allergy intersects with growth, development, nutrition, mental health, and school participation.

Current four tier system of care

Tier	Workforce	Approx %	Role
Level 1	GPs, pharmacists, MCHN	80%	First-line care
Level 2	Paediatricians, trained GPs	10%	Enhanced care
Level 3	Clinical allergists	7%	Specialist input
Level 4	Tertiary immunologists	3%	Complex care



Proposed Regional Model

1. Model Structure

- *Hub-and-spoke system*

Build local expertise with seamless access to evidence-based specialist support from Tiers 3 or Tier 4 services depending on the clinical complexity. This would dramatically reduce the load on tier 4 services and provide high quality evidence based local services for the majority of clinical issues. This leaves tier 3 and 4 to provide the expert level support rather than dealing with clinical issues better dealt with close to home by well-informed clinicians.

- *Regional hubs supported by tertiary centres*

Hub and spoke model recommended for each region. In many regions, the functional “hub” may be a regional paediatric service with established capability, supported by tertiary centres, which remain essential for complex care, system leadership and specialist expertise.

2. Core Principles

- *Care delivered locally* wherever safe and feasible,
- *Clear escalation pathways* for complex cases (strong links to tertiary centres for support is absolutely vital with opportunity for discussion and even expedited referral of more complex cases (not going onto the bottom of a 2 year wait list)
- *Defined scope of practice*, with support for clinicians to recognise and work within their limits while accessing escalation pathways when required
- *Peer recognition* - The Associateship of Clinical Allergy (ACA) formally recognises a clinical skill level derived from diverse and flexible pathways to allergy upskilling, including the ACA course, the UNSW Allergy course with clinical exposure, the RCH Diploma course, immersion allergy training for FRACP fellows, and ongoing experienced clinical allergy practice. The ACA complements, but does not replace, formal specialist training pathways in clinical immunology and allergy.
- *Collegiate respectful communication* - Direct barrier free communication channels (phone, online, in person WhatsApp)

3. Workforce Model

- *Regional coordinator* with funded administrative support
- *Funded local clinical champion(s)*
- *Multidisciplinary teams* including case-based discussion groups

4. Clinical Capability

Build confidence and capability to provide local assessment and management, consistent with ASCIA clinical guidelines and protocols, including local

- *triage,*



- *skin prick testing and*
- *food challenge services*, supported by training, protocols and specialist backup e.g. Ballarat model

5. What this model adds

- Real-time clinician-to-clinician support (“rapid mentoring” or “phone-a-friend”) as a core, funded component of safe regional care, operating within appropriate clinical governance, documentation and medico-legal frameworks
- Formalised regional networks
- Peer acknowledgement of clinical ability through ACA with structured upskilling pathway (ACA course) in addition to direct “immersion” experience
- Scalable national implementation
- Mentorship of clinicians interested in building competency in allergy medicine
- These models should complement existing formal advisory services (e.g. “allergy assist” and jurisdictional specialist advice services), enhancing timeliness and accessibility of specialist input.

6. APS-Supported Infrastructure

- APS Annual Allergy Masterclass workshops (case-based, practical upskilling)
- National Community of Practice (peer discussion, case sharing, moderated forum)
- Paediatric Allergy Interest Group (PAIG) education and recordings
- Associateship of Clinical Allergy (ACA) pathway (in partnership with ASCIA/NAC)
- Paediatric Rapid Allergy Mentor (real-time specialist support for clinicians)

Proposed Metropolitan Mode

While metropolitan areas have greater access to specialist services, similar principles apply, including the need to upskill Tier 1 and Tier 2 providers and reduce unnecessary reliance on tertiary services.

Many similarities to above although without as much tyranny of distance limitation

- The ACA model could be adapted to include metropolitan applicants as more resources are made available building the pool of tier 2 and 3 clinicians
- Upskilling and education of Tier 1 professionals is just as crucial in metropolitan areas
- More training opportunities for allergy and immunology to build tier 4 capacity

Current vs Gaps vs Solution

Current Strengths

- ASCIA annual meetings
- UNSW course
- ACA course



- APS Annual Allergy Masterclass Workshop
- Paediatric Allergy Interest Group meetings
- Online resources through ASCIA, NAC and AAA and Tertiary units with community education focus
- Allergy Assist program
- ACA WhatsApp group
- Hospital updates

Critical Gaps

- No structured allergy training of healthcare professionals, allied health, nursing trainees, dieticians during prevocational and postgraduate education,
- Regional case-based community of practice (belonging is important)
- No significant allergy focus within health professional education RACGP, ACRRM, Medical schools, RACP, nutrition science
- Limited integration of allergy training into core paediatric, general practice and allied health education pathways.

Why Paediatric Allergy Requires a Different Model

Paediatric allergy care differs from adult care in several important respects:

- Interaction with growth, nutrition, and developmental stages
- Dependence on caregivers and family systems
- Impact on school, early childhood education and social participation
- Greater prevalence of multi-morbidity (eczema, asthma, food allergy)
- Need for longitudinal care and anticipatory guidance

These factors reinforce the central coordinating role of general paediatricians, working in collaboration with clinical immunology/allergy specialists, general practitioners and multidisciplinary teams, in supporting families over time.

This model provides a practical implementation pathway for national allergy access reform and aligns with the National Allergy Council Shared Care framework. The Australian Paediatric Society is well positioned to support implementation, particularly in paediatric and regional settings, through existing education, mentoring and clinical networks.

Implementation Plan

Phase 1: Mapping & Consultation

- Capability mapping
- Workforce survey

Phase 2: Establishment

- Recruit regional coordinators
- Build networks and set up administrative support systems



- Develop improved communication networks
- Formal recognition and funding of regional clinical networks / mentoring systems

Phase 3: Service Delivery

- Launch regional services including local assessment and food challenge services
- Implement mentoring systems

Evaluation Framework

Access

- Time to care
- Reduction in tertiary waitlists

Quality

- Patient outcomes
- Safety indicators

Workforce

- Clinician confidence
- Scope adherence

System Impact

- Network utilisation
- Regional capability growth

This model provides a practical, scalable pathway to deliver equitable, high-quality allergy care for children across Australia, reducing pressure on tertiary services while improving outcomes for families. It aligns with national policy direction and offers an immediately implementable framework to support system-wide improvement in allergy care access.



APPENDIX ONE

Modified Monash Model classifications table

Modified Monash category	Inclusions
MM 1	Metropolitan areas: Major cities accounting for 70% of Australia's population. All areas categorised ASGS-RA1.
MM 2	Regional centres: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are in, or within 20km road distance, of a town with a population greater than 50,000.
MM 3	Large rural towns: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 and are in, or within 15km road distance, of a town with a population between 15,000 and 50,000.
MM 4	Medium rural towns: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 or MM 3 and are in, or within 10km road distance, of a town with a population between 5,000 and 15,000.
MM 5	Small rural towns: All other areas in ASGS-RA 2 and 3.
MM 6	Remote communities: All areas categorised ASGS-RA 4 and islands that are separated from the mainland in the ABS geography and are less than 5km offshore. Islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland (2019 Modified Monash Model classification only).
MM 7	Very remote communities: All other areas that are categorised ASGS-RA 5 and populated islands separated from the mainland in the ABS geography that are more than 5km offshore.