PEOPLE WITH DISABILITY AUSTRALIA

A voice of our own

Access to and affordability of medical specialists in Australia

Submission to the: House of Representatives Standing Committee on Health, Aged Care and Disability

NOVEMBER 2026

Copyright information

Access to and affordability of medical specialists in Australia – Submission to the House or Representatives Standing Committee on Health, Aged Care and Disability

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About PWDA

People with Disability Australia (PWDA) is a national disability rights and advocacy organisation made up of, and led by, people with disability.

We have a vision of a socially just, accessible and inclusive community in which the contribution, potential and diversity of people with disability are not only recognised and respected but also celebrated.

PWDA was established in 1981, during the International Year of Disabled Persons.

We are a peak, non-profit, non-government organisation that represents the interests of people with all kinds of disability.

We also represent people with disability at the United Nations, particularly in relation to the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

Our work is grounded in a human rights framework that recognises the CRPD and related mechanisms as fundamental tools for advancing the rights of people with disability.

PWDA is a member of Disabled People's Organisations Australia (DPO Australia), along with the First People's Disability Network, National Ethnic Disability Alliance and Women with Disabilities Australia.

DPOs collectively form a disability rights movement that places people with disability at the centre of decision-making in all aspects of our lives.

'Nothing About Us, Without Us' is the motto of Disabled Peoples' International.

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Introduction

People with disability face a range of barriers to accessing specialist care. This includes geographical, cost, physical accessibility, transport and facilitation to reach care, and communication of information about care with the specialist and their team.

Poor knowledge of disability by specialists, an inability or unwillingness to accommodate the need for adjustments, can compromise care. Intersectional issues such as living in a regional area, having a low income, being from a culturally or linguistically diverse background, being Aboriginal or Torres Strait Islander or being LGBTQIA+ can also contribute further to a person's disadvantage in accessing timely and effective specialist care.

People with disability and their disability representative organizations (DROs) have had long practice solving problems, and innovating solutions to help themselves and others. PWDA calls for greater use of co-designed solutions, the inclusion of people with disability in governance and decision making, and for ways to fund the innovative approaches that improve and expand equitable and inclusive access to specialist care.

Summary of Recommendations

Recommendation 1: Invest in developing and rolling out public clinics to expand services, starting with the communities that currently have the worst access to specialist care

Recommendation 2: Develop and fund a scheme to address immediate barriers to accessing specialist care, including providing more appointments in under-served areas

Recommendation 3: Change the funding model so that people who have to travel for care have the costs covered up-front, rather than having to pay and then wait for weeks for reimbursement

Recommendation 4: Establish a co-design committee composed of people with disability and their DROs to advise on both clinic design, and the access scheme for specialist care

Recommendation 5: Require the publication of specialist waiting times.

Recommendation 6: Enable GP consultation with specialists to inform local care where relevant, and apply the cost savings to improving access where specialist referral is essential to patient care

Recommendation 7: PWDA recommends regulation to require fee caps for specialist services, with penalties for exceeding them, and incentives for staying within them

Recommendation 8: PWDA recommends expanding the availability of bulk billed specialist care through the provision of public clinics

Recommendation 9: PWDA recommends evaluating and re-prioritising the delivery of specialist care based on health need

Recommendation 10: PWDA recommends changes to ensure that equal access to specialist care is delivered to all Australians

Recommendation 11: PWDA recommends that state and local area health organisations that set care priorities include representation from people with disability

Recommendation 12: PWDA recommends supporting programs and projects co-designed with people with disability that are shown to improve access to specialist care

Recommendation 13: PWDA recommends developing a funding model that enables innovators addressing health access issues to sustain and grow their programs.

Terms of Reference

The House of Representatives Standing Committee on Health, Aged Care and Disability will inquire into and report on access to and affordability of medical specialists in Australia, with the aim to:

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

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

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

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

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

Our research with people with disability

In August 2025, PWDA launched a national survey to inform our submission for the review of the National Safety and Quality Health Service (NSQHS) Standards.

The survey was conducted from 7 August 2025 to 7 September 2025, closing at 5:00 pm AEST. A total of 269 responses were received. If a person found the on-line survey inaccessible, they were invited to call our free number so that they could access assistance from our team to complete it.

Among respondents, 89.61% (207) identified as a person with a disability, and 39.56% (89) identified that they care for someone with a disability, or that they help them to access healthcare.

The survey explored experiences with hospitals, general practitioners (GP), specialists, allied health, and mental healthcare. Respondents also provided demographic data, whether they had a caring role, and information about whether they were located in a metropolitan, rural or regional area.

A total of 20 questions were asked, combining multiple-choice and open-text.

- 77% of respondents had accessed mental health services.
- 90.98% see the same doctor when they visit the GP
- Women and girls with disability made up most respondents (63.81%)
- 23.33% of respondents identify as LGBTQIA+ and 5.71%% as trans and/or gender diverse.
- 11.90% as CALD and 3.81% First Nations.
- 3.81% of people identify as a young person with disability (under 25 years)
- Most respondents (58.52%) live in major cities

- Over one-third (36.68%) live in rural or regional areas

As part of our research with members and people with disability for the NSQHS Submission, we asked questions about 'Other Healthcare':

"Other Healthcare

By other healthcare we mean services you use less regularly, or for specific reasons. This could include:

- Specialists
- Allied health such as physiotherapy, dietician, or occupational therapy
- Health screening like breast-screen, skin checks, cervical smear/ PAP test, prostate test, or bowel screen
- Diagnostic services like x-rays, MRI, pathologist tests like blood or urine.

Thinking about other types of healthcare you have experienced, what worked well?

What needs to change to make your experience better?"

We went back to the raw data from these survey questions, and evaluated it with respect to the issues arising in the Terms of Reference for this submission.

"Thinking about other types of healthcare you have experienced, what worked well?"

Answers often touched on multiple issues. Of the 209 responses to this question:

33% (69) either commented about specialist care or a specific specialist

14% (30) raised communication either as a barrier to receiving quality care, to the coordination of care between health professionals or to highlight its importance when it goes well

12% (27) raised issues related to knowledge of or expertise in disability

9% (19) described their experience of specialist and other healthcare as good

8% (17) raised issues with diagnostic tests other than breast screen

6% (13) responses highlighted cost barriers

4% (9) raised issues of availability

3% (8) raised telehealth

3% (8) identified taking enough time to listen or having long enough appointments

3% (8) raised the inaccessibility of breast screen

3% (8) raised physical accessibility barriers to care

3% (7) raised access/ availability issues related to living in a rural or regional area

3% (7) raised the need for holistic care

2% (6) raised appointment punctuality and waiting times

2% (5) called for home visits

1% (4) raised transport related barriers

1% (3) raised fragrance as a barrier to care

It is worth highlighting that three of the respondents were breast cancer survivors, who described the types of treatments and specialist care they needed to access, whilst two others explained that they could not be screened due to the inaccessibility of the test for a wheelchair user.

> "Have not had a pap test or breast screening, skin check [for] decades. These are too hard when you are disabled."

"What needs to change to make your experience better?"

Answers often touched on multiple issues. Of the 219 responses to this question:

22% (50) responses raised improving the affordability of care, private healthcare, reducing cost barriers, gap fees, or increasing bulk billing

19% (42) raised issues related to knowledge of, or expertise in, disability

18% (41) raised communication either as a barrier to receiving quality care, to the coordination of care between health professionals or to highlight its importance when it goes well. Three respondents specifically raised the lack of accessible communication, two specifying Auslan, the other difficulties with lip reading when the person would not face them.

9% (21) raised issues of appointment availability

5% (13) raised physical accessibility barriers to care

4% (10) raised access/ availability issues related to living in a rural or regional area

3% (8) raised the need for holistic care

3% (7) raised appointment punctuality and waiting times

2% (6) timing/ wait time of appointment

2% (5) raised the need for home visits

2% (5) identified taking enough time to listen or having long enough appointments

1% (4) raised telehealth

> "Cost is major prohibitive factor."
>
> "Mammogram machines should be completely redesigned. If this were for testing for testicular cancer the machine would *never* have made it past the drawing board. I'm sure I'm not alone in finding the procedure deeply distressing and painful. The people operating them need to *listen* including when someone is in tears and says "just hurry and finish it!" rather than stopping."
>
> "Disclosure of waitlists for all health services otherwise we are [wasting] our time going on waitlists unnecessarily- we are even required to disclose health information without being given an appointment which is a waste of our time if it is

> unlikely to happen. Reorientation of health system and services to support people with more complex needs first. Some health providers seem to 'cherry pick' easier clients and are paid the same for it as someone treating a complex client. Some health providers use the excuse it is beyond our scope of practice, but do nothing to expand their scope of practice which could be seen as discrimination or laziness at best."

> "Consult our lived experience in co-production, codesign, co-research and co-led education, training, supervision & evaluation."

These responses raise the issue of cost barriers, but also accessibility issues related to using essential scanning machinery, lengthy wait-times that are not disclosed before a person goes on the waiting list for a specialist appointment, and the issue of people with more complex health needs being denied care.

It is worth mentioning that arrogance, poor/dismissive attitudes, minimising pain and discrimination were mentioned accompanying the need for training in disability awareness. Equally kindness, patience and accommodating people's specific needs was often mentioned as part of positive feedback or specific positive mentions of communication.

Have you ever seen someone for mental health care or support?

Thinking about your experience with these types of mental health care, what worked well for you?

234 people responded, and 35 skipped the question.

Some respondents referred to practitioner (4), provider (4), or therapist (3), or did not specify the qualification of the person they saw (117). Others mentioned psychiatrist (7), psychologist (29), neurologist (2) and counsellors (3).

Unlike responses to questions about specialist and other health care, it is clear that some respondents had been treated against their will.

17% (41) respondents had a positive treatment experience

13% (31) identified the importance of communication

12% (30) respondents had a negative experience

There was an overlap of 4 people who had both positive and negative experiences.

8% (20) shared the importance of telehealth for them

One respondent could not find anyone who could use and understand Augmentative and Alternative Communication, and this meant they had to take a support worker to translate or assist them with communication, which compromised their privacy.

Another reported a positive communication experience:

> "I had a Psychologist who could use Auslan…I found the psychologist was able to understand me and we agreed to continue the sessions without the hassle of different Auslan Interpreters for my sessions."

6% (16) raised the barrier of cost, the need for bulk billing, or that the NDIS had to fund access in some way

5% (14) raised the issue of availability or wait lists

4% (10) raised the issue of lack of knowledge of their disability or their specific condition, or the accommodations that needed to be provided to improve their experience

2% (5) raised the importance of taking time to listen or having a longer appointment

2% (5) raised the issues of public vs private systems- with public systems being identified as worse

3% (9) Medication was raised with positive comments by 7 respondents about what was prescribed, and negative comments by 2

1% (4) Raised transport barriers to accessing care

1% (4) Raised accessibility of the treatment setting, with 3 focussed on physical accessibility, and the other person raising treatment advice not being accessible as they were blind and the advice focussed on techniques that required sight.

1% (3) received home visits as part of their care

1% (3) raised the barrier of living in a rural or regional area when trying to access care, where this care was unavailable

It is worth remembering that this survey question asked people about their experiences if they had accessed mental health care. This necessarily excludes the feedback of people who were unable to gain access due to unavailability in their area, or the unaffordability of care.

In parts of the survey 3 participants made comments raising the need for better medical coordination, between specialists and the NDIS or between different aspects of healthcare because of the difficulty attending different locations to obtain tests.

> 'Tests and scans or blood and urine tests are all at different places and I need the help of a Support Worker to get to them.'

The 50% cut to the social, economic and community participation budget of NDIS participants is likely to further reduce people's capacity to reach medical appointments, or to travel to attend different locations to obtain tests.

Health Travel Assistance

The issue of needing to travel to receive specialist care was raised by survey participants who either said travel costs were high, or that due to these travel costs they were unable to receive care.

In NSW the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), helps people with travel and accommodation costs if they need to travel 100km one way or 200km within a week for specialised medical treatment unavailable locally.

However, the rates of reimbursement, fall well short of the actual costs someone would incur to access treatment.[1]

Transport type	Subsidy rate
Private vehicle	40 cents per kilometre.
Public transport (minus GST)	Full reimbursement at economy class rates.
Air travel (minus GST)	Full reimbursement for approved air travel at economy rates.
Taxi	1 day - $20.00 (Maximum subsidy) 2-7 days - $40.00 (Maximum subsidy) 8-14 days - $80.00 (Maximum subsidy) 15 days - $160 (Maximum subsidy)
Not-for-profit or commercial accommodation	1-7 days $75 per night 8 nights or more $120 per night
Private	$40 per night if you are staying with family or friends (Airbnb will be paid at this rate)

[1] NSW Government, IPTAAS, Isolated Patients Travel and Accommodation Assistance Scheme, last accessed 20 April 2026, https://www.iptaas.health.nsw.gov.au/for-patients/subsidy-rates

Full reimbursement of public transport at economy class rates is inapplicable in many cases, as the places where there is no access to specialist care, often also have no public transport. Where train or bus services exist, the vehicle service or the infrastructure to access it such as bus or train stops, is often inaccessible to people with disability.

Current NSW rates of reimbursement for accommodation are so low that they are unlikely to cover more than half the cost of accommodation anywhere near a health precinct where specialist care can be accessed. The adequacy of taxi reimbursements depends on the distances that need to be travelled.

Looking at the equivalent scheme in Queensland, some of the reimbursement rates are less (e.g. milage $0.34 per km, $70 per night for accommodation).[2] Other states have similar schemes with small variations between them.[3] But a crucial point made within our survey, is that 'reimbursement' requires a person to have the money available to pay out initially themselves- and for some this is not possible.

> "Care plans are useless now. The whole point is to help but when these services require up-front payment that you have to wait for reimbursement from, it makes it impossible to afford. I desperately need these services but I go without due to cost."

[2] Queensland Health, Guideline for the patient travel subsidy scheme, last accessed 20th April 2026, https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-travel-subsidy-scheme/guideline-for-the-patient-travel-subsidy-scheme

[3] Northern Territory Government, Guideline for the patient travel subsidy scheme last accessed 21 April 2026, https://nt.gov.au/wellbeing/health-subsidies-support-and-home-visits/patient-assistance-travel-scheme, Tasmanian Government, Department of Health, Patient Travel Assistance Scheme (PTAS) last accessed 21 April 2026 https://www.health.tas.gov.au/patients/health-costs/ptas, Government of South Australia, SA Health, The Patient Assistance Transport Scheme, last accessed 21 April 2026, https://www.pats.sa.gov.au/, Government of Western Australia, WA Country Health Service, Patient Assisted Travel Scheme, last accessed 21 April 2026 https://www.wacountry.health.wa.gov.au/Our-patients/Patient-Assisted-Travel-Scheme-PATS

At a time when hospitals are facing increased admissions and extreme pressures, ambulance ramping, overcrowding and loss of life due to care delays, it is imperative that we remove obstacles people are facing to accessing the care.

Addressing the Terms of Reference

Access to specialists

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

The Grattan Institute's analysis reveals that of the 1.9 million Australians each year who miss out on the care they need, around half do so because of cost. But like our research, they highlight a range of other barriers including:

- Reduced availability of specialists in poorer, rural and remote communities,
- The low or non-availability of certain specialists in some areas
- Transport barriers
- Communication barriers.[4]

In light of this and our research, PWDA supports the Grattan Institute's calls for investment in public clinics where they are needed the most, with a focus on expanding services in the areas with the worst access to care.

PWDA's research didn't extend to some of the areas covered by the Grattan Institute, such as the Grattan Institute's findings that:

- Small rural towns have 26% fewer GPs than metro areas and remote communities have 37% fewer
- Major cities have ten times more specialists per person than small rural towns

[4] Breadon, P., Geraghty, J., Jones, D., and Baldwin, E., Grattan Institute, (2025). Special treatment: Improving Australians' access to specialist care, P 10, last accessed 15/10/2026 https://grattan.edu.au/wp-content/uploads/2025/06/Grattan-Institute-Special-Treatment.pdf

- Around $1200 per person is spent in Medicare benefits on people in cities and regional hubs, but only $600 per person in remote communities and $335 per person in very remote communities
- People living in rural and remote areas are hospitalised at rates, two to three times higher than those in urban areas for preventable conditions.[5]

However it is clear that this disparity contributes to poor life expectancy in rural and remote communities.[6] Of the 5.5 million Australians with disability in 2022 (21% of the population), a higher proportion of those living in *Inner regional* (27%), and *Outer regional and remote areas* (26%) of Australia reported having disability when compared with those living in *Major cities* (19%).[7] This means that people with disability are disproportionately impacted by this disparity.

In addition, our research participants have also raised other barriers to accessing specialist services including:

- Physical accessibility of facilities or procedures
- The unaffordability of the current travel reimbursement scheme
- That care plans are no longer effective because completing the different elements of care required is unaffordable now,
- The need for a carer to facilitate access.

In addition to developing new clinics over 2-5 years, there is an urgent need to address immediate barriers that people with disability face to accessing healthcare.

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[5] Breadon, P., Geraghty, J., Jones, D., and Baldwin, E., Grattan Institute, (2025). Special treatment: Improving Australians' access to specialist care, last accessed 15/10/2026 https://grattan.edu.au/wp-content/uploads/2025/06/Grattan-Institute-Special-Treatment.pdf

[6] The Australia Institute, Matt Grudnoff, Research shows people living in rural areas have a much lower life expectancy (2024), least accessed 20/10/2026, https://australiainstitute.org.au/post/research-shows-people-living-in-rural-areas-have-a-much-lower-life-expectancy/

[7] AIHW (Australian Institute of Health and Welfare) (2025), AIHW, Australian Government, accessed 20 October 2026 *Rural and remote health*, https://www.aihw.gov.au/reports/rural-and-remote-health .

Recommendation 1: Invest in developing and rolling out public clinics to expand services, starting with the communities that currently have the worst access to specialist care

Recommendation 2: Develop and fund a scheme to address immediate barriers to accessing specialist care, including providing more appointments in under-served areas

Recommendation 3: Change the funding model so that people who have to travel for care have the costs covered up-front, rather than having to pay and then wait for weeks for reimbursement

Recommendation 4: Establish a co-design committee composed of people with disability and their DROs to advise on both clinic design, and the access scheme for specialist care.

Referral pathways

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

Referrals for specialist care are not effective if a person cannot access the specialist in a timely manner, or at all, due to the many barriers people with disability face. Specialist wait-lists need to be publicised so that people avoid being placed on waitlists that are so long they cannot receive timely care.

For health issues where a GP can mange care, we support the Grattan Institute's proposal that a system be set up to enable GP's to obtain a secondary consultation with a specialist to plan treatment and discuss care, so that they can provide it locally to the patient. This already happens in Queensland's eConsultant Partnership Program, and expanding this

type of care could avoid more than 60,000 referrals and save patients $4 million in specialist fees per year.[8]

We would then like these savings re-invested to ensure greater affordable access to more complex medical care, surgery and other cases where specialist referral is essential.

Recommendation 5: Require the publication of specialist waiting times.

Recommendation 6: Enable GP consultation with specialists to inform local care where relevant, and apply the cost savings to improving access where specialist referral is essential to patient care

Affordability

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

Of the millions of Australians who need to see a specialist doctor two thirds of the appointments require payment. The average annual amount paid is $300, although 10% of low-income patients are billed pay almost $500 a year. According to the Grattan Institute 20% of Australians needing specialist care delay or avoid care, 1.9 million people miss out on treatment, and half do so because of cost.

Free clinics in public hospitals provide 30% of all specialist care, but their force many patients to wait months longer than clinical guidelines recommend for urgent appointments.

[8] Breadon, P., Geraghty, J., Jones, D., and Baldwin, E., Grattan Institute, (2025). Special treatment: Improving Australians' access to specialist care, last accessed 15/10/2026 https://grattan.edu.au/wp-content/uploads/2025/06/Grattan-Institute-Special-Treatment.pdf

Specialist fees have increased by 73% since 2010, with an initial consultation with a cardiologist or endocrinologist costing up to $370, and up to $670 for a psychiatrist. Almost a million people delay or skip specialist care each year because of the cost.[9]

People with disability in our research have highlighted cost barriers to accessing specialist care, and the associated tests. PWDA lacks the resources or information to comment on the factors that may be contributing to these costs, or which charges should be considered excessive. Our research participants have called for more bulk billing for all medical services, from GP and tests to specialists and allied health.

Whilst fee transparency has been proposed as a solution to overcharging, the difficulty for many people in regional and remote communities is that there may be only one provider. During PWDA's work on co-designing the Aviation Disability Standards,[10] we heard from a workshop participant how difficult it can be to get a specialist from another state to give them an appointment, even though there is no alternative available in their state.

For people who have private health insurance, some insurers limit which specialists or which hospitals they will cover, further complicating healthcare access if that hospital is inaccessible. All of these situations can make negotiating fees impossible, even with fee transparency, because of the power imbalance and access barriers patients with disability face, especially in rural and regional communities.

Recommendation 7: PWDA recommends regulation to require fee caps for specialist services, with penalties for exceeding them, and incentives for staying within them

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[9] Breadon, P., Geraghty, J., Jones, D., and Baldwin, E., Grattan Institute, (2025). Special treatment: Improving Australians' access to specialist care, P 10, last accessed 15/10/2026 https://grattan.edu.au/wp-content/uploads/2025/06/Grattan-Institute-Special-Treatment.pdf

[10] Australian Government, Department of Infrastructure, transport, Regional Development, Sport and the Arts, last accessed Aviation Disability Standards, last accessed 9/11/2026 https://www.infrastructure.gov.au/infrastructure-transport-vehicles/transport-accessibility/aviation-accessibility

Recommendation 8: PWDA recommends expanding the availability of bulk billed specialist care through the provision of public clinics

Patient Outcomes

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

Medical procedures unrelated to an emergency admission are usually considered 'elective'. However, describing healthcare or surgery delivered by specialists as 'elective', and the fact a procedure lacks universal, affordable access, can create a misperception that it is optional rather than essential.

This type of care can include surgeries or procedures some people with disability need to reduce pain, maintain function, prevent the progression of a condition, improve wellbeing or sustain life. A person who is unable to access specialist care may have access to disability support equipment, services or therapies delayed or denied. This risks the exacerbation of pain, the reduction of health, wellbeing, independence, and it increases the likelihood that the person will require hospital admission or more complex care as the delay exacerbates the issue.

This kind of care can also include surgery essential to activities of daily life. Without a joint replacement, a person may be unable to work and lose their job and home, but knee and hip replacements are referred to as 'elective surgery' and require large out of pocket costs in the private system, or long delays in the public system. Some disabilities increase the likelihood that a person will need a joint replacement, but lengthy delays or excessive costs present an even greater risk of harm to a person who may already have higher costs related to their disability, or for whom delay risks more rapid deterioration in their health.

Other types of critical care undertaken by specialists includes for chronic and non-infectious disease. The 1 in 8 blood cancer patients skipping or delaying treatment

because they cannot afford it,[11] or the rural women opting for mastectomy only treatment,[12] or the people missing out on early diagnosis and effective management of their diabetes,[13] all risk life-altering complications and premature death.

All of these treatments require specialists, and barriers to access jeopardise survival, and compound health and wellbeing issues for people with disability. Failure to treat these conditions in a timely way also raises the likelihood that a person will then need emergency medical care.

Patients with disability, who live in rural or regional areas, have lower incomes, who are Aboriginal or Torres Strait Islander are all less likely to the access to specialist care that they need.[14] This is unfair and needs addressing urgently.

Recommendation 9: PWDA recommends evaluating and re-prioritising the delivery of specialist care based on health need

Recommendation 10: PWDA recommends changes to ensure that equal access to specialist care is delivered to all Australians

Recommendation 11: PWDA recommends that state and local area health organisations that set care priorities include representation from people with disability

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[11] Leukemia Foundation last accessed 21/10/2026 https://www.instagram.com/reel/DcsYEF4SYZ2/

[12] ABC, Annie Guest, Rural Queensland breast cancer patients opting out of radiation therapy: study, last accessed 21/10/2026, https://www.abc.net.au/news/2016-01-21/rural-breast-cancer-patients-choose-mastectomies-over-radiation/7100840 Youl P, Morris B, Anderson J, Morstyn L. What factors influence the treatment decisions of women with breast cancer? Does residential location play a role? Rural and Remote Health 2019; 19: 4497. https://doi.org/10.22605/RRH4497

[13] People living in *Remote* and v*ery remote* areas are 2.3 times as likely to be hospitalised for diabetes as people living in *Major cities*, after adjusting for age. AIHW (Australian Institute of Health and Welfare) (2026) *Diabetes: Australian facts*, AIHW, Australian Government, accessed 21 October 2026.

[14] P. Breadon & E. Baldwin, The Guardian, Poorer and rural Australians are sicker, yet they get less healthcare. It's a broken system, last accessed 30/10/2026, https://www.theguardian.com/commentisfree/2025/jun/16/poorer-and-rural-australians-are-sicker-yet-they-get-less-healthcare-its-a-broken-system

Innovative Care

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

Some participants in our research highlighted the importance of telehealth, and how this has made it easier for them to access care. Others have raised barriers to access that digital platforms can create, including enrolling with a doctor, or maintaining health records. Whilst digital technology can improve some aspects of healthcare, it is only a small part of the picture.

Communication issues, cost, travel to access care, physical accessibility issues for testing, care and treatment, knowledge of disability and respectful practices have all been identified in our research, and innovation is needed to address them. PWDA has seen successful projects developed and led by people with disability that improve healthcare,[15] but when project funding ends, so do they, in spite of success.

It can be difficult for innovators to get the support they need to address gaps in care, especially when existing services that bring health screening and services to people like mobile breast screening,[16] mobile hearing services,[17] and skin cancer screening,[18] face funding cuts or rely on donations to survive. As the cost-of-living crisis increases financial

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[15] Public Health Network Western Victoria, The Supporting People with Intellectual Disability to Access Health (SPIDAH) Project, last accessed 30/10/2026 https://westvicphn.com.au/health-professionals/health-topics/priority-populations/people-with-an-intellectual-disability/primary-care-enhancement-program/spidah-project/ VALiD, The Driving Change Project, last accessed 30/10/2026 https://valid.org.au/driving-change/

[16] Breast Cancer Network Australia, BCNA welcomes BreastScreen review, warns on funding, last accessed 30/10/2026 https://www.bcna.org.au/latest-news/bcna-news/bcna-welcomes-breastscreen-review-warns-on-funding

[17] Ken McCutcheon, ABC, Western NSW mobile children's hearing clinic faces closure last accessed 30/10/2026 https://www.abc.net.au/news/2026-10-30/western-nsw-mobile-childrens-hearing-clinic-faces-closure/107295888

[18] Australian Skin Cancer Foundation, last accessed 30/10/2026 https://www.australianskincancerfoundation.org/news/last-nights-federal-budget-delivered-major-investment-into-healthcare-across-australia

pressure on household budgets, donations are likely to decrease at the same time as access to healthcare becomes more difficult for people.

The United Kingdom (UK) has a model for reviewing healthcare technologies that improve treatment options based on the cost per 'quality adjusted life year'.[19] Australia has similar processes for to deciding whether a medicine or medical device should be approved for listing on the Pharmaceutical Benefits Scheme,[20] enabling subsidised access when prescribed.

UK innovators have been able to argue for funding from National Health Service (NHS) trusts to support innovative health projects, on the basis of a proportion share of the cost savings their programs deliver to the NHS by helping people reduce or avoid disease more effectively than standard care.[21] Delivering care earlier, and in community settings, is invariably far more cost effective than a person ending up in hospital.

Healthcare in Australia and the patient population could benefit from expanding the evaluation of care beyond medicines to health projects and technologies, and from funding them, especially where they have proven effective and address inequity and access barriers. Sharing the cost savings to hospitals and health services with innovators and programs that have proven to be effective, can then provide a sustainable funding stream. This can enable more people and organisations to develop technologies, programs and processes that improve access and equitable access to healthcare for Australians.

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[19] M. Anderson, M. Drummond, D, Taylor, A McGuire, P. Carter, E. Mossialos, Promoting innovation while controlling cost: The UK's approach to health technology assessment, Health Policy, V126, I3, March 2022, Pages 224-233, last accessed 30/10/2026 https://doi.org/10.1016/j.healthpol.2022.01.013

[20] Pearson SA, Pratt N, de Oliveira Costa J, et. Al., Generating Real-World Evidence on the Quality Use, Benefits and Safety of Medicines in Australia: History, Challenges and a Roadmap for the Future. Int J Environ Res Public Health. 2021 Dec 18;18(24):13345. doi: 10.3390/ijerph182413345. PMID: 34948955; PMCID: PMC8707536. Patient Voice Initiative, last accessed 30/10/2026 https://www.patientvoiceinitiative.org/patient-experience-and-participation/pharmaceutical-benefits-scheme/

[21] B. Wallace., Reducing Lifestile Diseases Using Community Based Sport, Western Sydney University, (2021) last accessed 30/10/2026 https://researchers.westernsydney.edu.au/en/studentTheses/reducing-lifestyle-diseases-using-community-based-sport/

Recommendation 12: PWDA recommends supporting programs and projects co-designed with people with disability that are shown to improve access to specialist care

Recommendation 13: PWDA recommends developing a funding model that enables innovators addressing health access issues to sustain and grow their programs.

Conclusion

Inequitable, inaccessible specialist care is a barrier to health and wellbeing for people with disability, but it also imposes extra costs on our health system as more people become sicker and need longer hospital stays. Reform is needed to better develop health systems and processes that include and value the perspectives, innovative approaches and solutions developed by and with people with disability. PWDA calls for greater co-design with people with disability, inclusion of their perspectives in decision making, and support for the projects and solutions that have demonstrated success improving equity and access to specialist care.

PEOPLE WITH DISABILITY AUSTRALIA

People with Disability Australia (PWDA) is a national disability rights and advocacy organisation made up of, and led by, people with disability.

For individual advocacy support contact PWDA between 9 am and 5 pm (AEST/AEDT) Monday to Friday via phone (toll free) on **1800 843 929** or via email at pwd@pwd.org.au

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