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Ensuring equitable access to cancer medicine and care in Australia: A human-rights lens, including people experiencing homelessness

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ABSTRACT

Australia has strong cancer survival. Yet many people still struggle to get timely diagnosis, medicines, and supportive care. Gaps are widest for Aboriginal and Torres Strait Islander peoples, rural and remote communities, culturally and linguistically diverse groups, people with disability, temporary visa holders, and people experiencing homelessness.

Objective: To set out practical, rights-aligned actions that turn universal coverage into universal access.

Approach: This short communication applies a rights-based analytic framing, distinct from a checklist, to reinterpret policy choices through the lenses of accountability, justiciability, and participation.

Actionable implications: Using this framing, synthesising recent evidence on affordability, diagnostics, and service capacity, we prioritise four actionable levers: cap financial toxicity (with standardised travel/accommodation support and public OOP reporting); fund and benchmark companion diagnostics (national turnaround and equity dashboards); scale tele-oncology/tele-trials with minimum local capacity and travel stipends (monitoring priority populations); and adopt distributional cost-effectiveness analysis in HTA and program design to make equity trade-offs explicit. This framing specifies who must act, by when, and with what evidence, offering a practical route to equitable, sustainable cancer.

Conclusion: Universal coverage alone does not guarantee equity. Implementing a rights-aligned plan with clear duty-bearers, timelines, and the four actionable levers we outline can narrow access gaps and support timely, affordable, culturally safe cancer care, including for people experiencing homelessness.

Australia achieves world-leading survival for many cancers, yet access to timely diagnosis, essential medicines, and high-quality supportive care remains uneven. These disparities cluster along social and geographic lines, affecting Aboriginal and Torres Strait Islander peoples, those living in rural and remote settings, culturally and linguistically diverse communities, people with disability, temporary visa holders, and people experiencing homelessness. A human-rights framing, centred on availability, accessibility, acceptability, and quality-positions these gaps not as inevitable consequences of circumstance but as remediable inequities that policy can address. This viewpoint synthesises evidence and policy commitments in the Australian Cancer Plan to articulate how structural barriers contribute to avoidable morbidity, premature mortality, and cumulative financial strain, and proposes a rights-aligned agenda to narrow access gaps [1–4].

In this communication, we treat the right to health not as a descriptive checklist but as an analytic framework reinterpret policy choices. In practice, this reframes (i) duty-bearers and accountability: identifying which public authorities are responsible for removing specific access barriers and enabling monitoring against explicit standards; (ii) justiciability and enforceability: clarifying where decisions (e.g. eligibility rules, waiting times, or administrative hurdles) create remediable harms that are open to review or redress; (iii) participation and co-design: requiring structured involvement of affected communities (e.g. First Nations peoples, people with disability, and those experiencing homelessness) in setting priorities and judging proportionality of trade-offs. This rights-based framing therefore moves beyond describing structural barriers to specifying who must act, on what timeline, and with what evidence of remedy.

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Although Medicare and the Pharmaceutical Benefits Scheme (PBS) mitigates financial risks, service availability varies markedly [5,6]. Rural and remote communities face longer travel for screening, pathology, advanced imaging, radiotherapy, and systemic therapy, contributing to delays in diagnosis and treatment. Workforce shortages outside metropolitan centres further fragmented care. For Aboriginal and Torres Strait Islander peoples, uneven culturally safe pathways and under-resourcing continue to constrain outcomes, and Optimal Care Pathways standards are not uniformly implementated [7–11].

Affordability challenges persist [5,6]. Out-of-pocket payments for consultations, diagnostics, companion testing, and supportive medicines place pressure on households, particularly in rural areas. Indirect costs from travel, accommodation, and lost wages create additional strain coordinated policy responses are needed to reduce this burden [11,12]. Administrative requirements such as PBS authority approvals and variation in public–private coverage create delays, especially for those with limited support. These challenges intensify for people experiencing homelessness or unstable housing, who may lack safe storage, transport, or stable communication [13,14].

Timeliness and navigation remain highly uneven across Australia. AIHW data show that people in remote and very remote areas face 20–35 % longer wait times for specialist consultations, diagnostics than those in major cities, alongside 20–40 % lower access to advanced imaging [13,14]. Clinical trial access shows similar inequity: historically $>$ 85 % of oncology trial enrolment has occurred in metropolitan centres, with rural participation below 10 %; early Australian Tele-trial Program evaluations indicate an increase to 15–18 %, though significant gaps persist [13,14]. These variations have measurable downstream impacts on stage at diagnosis and treatment initiation [1–3].

The diffusion of new technologies introduces further equity considerations. Health Technology Assessment (HTA) and PBS listing processes appropriately emphasise evidence and value for money, yet the 2024 HTA Policy and Methods Review acknowledges the need to improve timeliness, transparency, and consumer engagement [15]. Managed Entry Schemes and risk-sharing agreements can enable earlier access where uncertainty remains, but their administrative complexity may inadvertently widen access gaps if not designed with equity in mind [16–20]. In precision oncology, companion diagnostics and comprehensive genomic profiling often gatekeep therapy eligibility; inconsistent funding and turnaround times can produce postcode-dependent access [21,22].

The lived impacts of these barriers are visible along the pathway. Later stage at diagnosis is more prevalent in rural and remote populations and in communities facing disadvantage, and treatment initiation is more likely to be delayed. Treatment interruptions and early discontinuation occur when toxicity management, nutrition, mental health, and palliative support are under-resourced or difficult to access. People experiencing homelessness face distinctive challenges that compound clinical risk: missed appointments and unscheduled emergency care are more frequent; safe storage for oral therapies and supplies for wound care may be unavailable; and contact mechanisms reliant on fixed addresses or personal phones repeatedly fail. International evidence shows markedly higher cancer mortality in homeless populations, highlighting the need for targeted Australian services adaptations [22–24].

Why distributional cost-effectiveness analysis (DCEA) in a rights-based analysis? Because a rights-based approach centres accountability for inequities, DCEA provides a compatible decision tool: it makes explicit the trade-offs between maximising overall health and reducing unfair health inequalities, allowing governments to set and monitor equity-sensitive thresholds and to justify differential investment where disadvantage is concentrated [16–20]. A rights-aligned response places non-discrimination, participation, accountability, and transparency at the centre of cancer policy. In practice, this means ensuring sufficient capacity in pathology, imaging, radiotherapy, and oncology services; reducing financial barriers to guideline-concordant diagnostics and treatments in public settings; and integrating culturally safe navigation and language services as core elements of care rather than optional adjuncts. For Aboriginal and Torres Strait Islander peoples, co-design with Aboriginal community-controlled health organisations and investment in on-Country pathways are essential to build trust and continuity. For people experiencing homelessness, oncology care should be linked to accommodation and transport support, flexible appointment systems, and navigator roles that coordinate identification documents, entitlements, and PBS access; service addresses and alternative contact points can prevent administrative exclusion [1,7,12–14].

1. Implications/actions

Drawing from this framing, we identified four rights-based levers for immediate and medium-term action:

Four priority levers (rights-based and actionable)

Priority levers	Rights-aligned and actionable
Cap financial toxicity in public care.	Introduce episode caps for out-of-pocket (OOP) costs in public oncology and standardise travel/accommodation schemes nationally; publish hospital-level OOP dashboards for accountability.
Fund and benchmark companion diagnostics.	Publicly fund gatekeeping tests (including CGP) with national turnaround-time standards and equity dashboards by geography and priority population; align with HTA reforms.
Scale tele-oncology and tele-trials with local capacity.	Tie tele-trial accreditation to minimum local infusion/pharmacy/supportive-care capacity and travel stipends to avoid shifting burdens to patients; monitor participation by priority groups.
Adopt DCEA in HTA and program design.	Use DCEA to set equity-sensitive thresholds, evaluate distributional impacts of PBS/HTA decisions, and target reinvestment where inequities are largest.

Research and evaluation need to keep pace with policy. Prospective equity impact assessments for major PBS listings would reveal whether new technologies narrow or widen disparities. Routine capture of housing status in clinical information systems, with linkage to homelessness services data, would illuminate the effects of accommodation support, navigation, and flexible delivery models on adherence, toxicity management, and survival. Implementation science can guide the scale-up of navigator-led pathways, culturally safe tele-oncology, and accommodation-supported treatment, while economic evaluations incorporating distributional effects will help prioritise interventions that deliver both aggregate value and equity.

2. Conclusion

Universal coverage is not synonymous with universal access. When geography, culture, disability, visa status, and housing insecurity constrain entry to modern diagnostics and therapies, the resulting differences in outcomes reflect policy choices rather than fixed realities. A coherent, rights-aligned agenda, covering financing, assessment, diagnostics, workforce, data infrastructure, and community governance, can translate Australia's strong national performance into equitable experiences and outcomes for every person with cancer, including those without a stable home. The ethical imperative is clear: a system that leads the world in survival must also lead in fairness, ensuring that lifesaving medicines and high-quality care are timely, affordable, culturally safe, and responsive to people in all circumstances.

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Author contribution statement

The author was solely responsible for the conception, drafting, critical revision, and final approval of the manuscript.

Ethics statement

Ethical approval was not required for this study, as it is based on analysis of publicly available data and does not involve human participants or animal subjects.

CRediT authorship contribution statement

Rashidul Alam Mahumud: Writing – review & editing, Writing – original draft, Visualization, Validation, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of Competing Interest

I am the sole author of this short communication manuscript. I declare that I have no competing interests.

Data availability statement

All data underlying this study are publicly available from reputable sources, including the Australian Institute of Health and Welfare (AIHW), Cancer Australia, the Australian Bureau of Statistics (ABS), and the Global Cancer Observatory (GLOBOCAN, International Agency for Research on Cancer). No new data were generated or analysed specifically for this manuscript.

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