Submission to the Inquiry into Access to and Affordability of Medical Specialists in Australia

Prepared by the Multicultural Centre for Women's Health

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Multicultural Centre for Women's Health is a feminist organisation led by migrant and refugee women to achieve equity in women's health and wellbeing.

About the Multicultural Centre for Women's Health

This submission has been developed by the Multicultural Centre for Women's Health (MCWH), a women's health service established in 1978 that works both nationally and across Victoria to promote the health and wellbeing of migrant and refugee[1] women and gender diverse people across Australia[2]. We do this through research and publication, participation in advisory groups and committees, written submissions, and training and capacity building. Additionally, MCWH has been providing bilingual health education led by, and delivered for, migrant and refugee women for over 40 years. We reach migrant and refugee women wherever they are to deliver tailored health information and education, in their own languages, including information on navigating Australia's health and referral systems.

[1] The term 'migrant and refugee' refers to people who have migrated from overseas from main non-English speaking countries and their children regardless of visa status. It includes people who are part of both newly emerging and longer established communities.

[2] MCWH advocates for the health, safety and wellbeing of migrant and refugee women and gender diverse people. However, within this submission we refer predominantly to women which reflects our existing evidence base and program experience. We note, however, that our advocacy to prevent gender-based violence strives to include gender diverse migrants and refugees.

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Executive Summary

In Australia, more than half the population was born overseas or has at least one parent born overseas. More than 23% of the population speaks a language other than English at home, and more than 2.6 million women who have made Australia their home were born in a country where the main language is not English (Australian Bureau of Statistics, 2021). However, when it comes to access to health services, migrant and refugee women in Australia consistently experience poorer health access and often poorer health outcomes. This is no different for access to specialist care, where migrant and refugee women face a host of barriers to access including exclusion from Medicare and lack of culturally and linguistically responsive services. The impacts of this exclusion are severe, with migrant and refugee women reporting particularly troubling outcomes as a result of lack of access to medical specialists, especially during pregnancy and birth. However, there are significant opportunities to improve migrant and refugee women's access to specialist care in Australia that build on strong, already existing work. Indeed, there are also opportunities to strengthen preventative health approaches to include migrant and refugee women to ultimately reduce the need for specialist intervention.

This submission draws on MCWH's research and practice insight on migrant and refugee women's access to healthcare. It responds to all terms of reference for the Inquiry into Access to and Affordability of Medical Specialists in Australia, providing evidence on:

a) **Current access to medical specialists:** Migrant and refugee women face intersecting barriers to medical specialists for many of the same reasons they face limited access to equitable healthcare more generally including lack of interpreter access, lack of services in regional and rural areas, long wait-times, and limited access to medical professionals who speak their languages and understand their health journeys.
b) **Effectiveness, transparency and equity of referral pathways**: Australia's fragmented health system, and referral pathways for specialist care, are often difficult and confusing to navigate. For migrant and refugee women, referral pathways are often made less accessible due to lack of tailored information in languages other than English and outreach education on navigating the health system. Many migrant and refugee women who have experienced direct-access health systems, experience Australia's gatekeeper model of specialist referral as inefficient and even inequitable. Some migrant and refugee women report experiencing bias and discrimination from primary care providers that foreclose their access to specialist care. Similarly, for those who have experienced FGM/C (Female genital mutilation and/or cutting), referral pathways for vital specialist care remain poor.
c) **Affordability of specialist services**: The cost of specialist services is prohibitive for migrant and refugee women, many of whom do not have access to Medicare and are often lower income due to labour market inequalities. The cost of diagnostics and specialist care also carries a gendered bias, with sexual and reproductive healthcare for women attracting lower rebates. For migrant and refugee women with limited financial resources, this gendered cost disparity can lead many to forego or delay seeking specialist care.
d) **Impact on patient outcomes:** Lack of access to specialist care has significant impacts on the health outcomes of migrant and refugee women, especially in the realm of sexual and reproductive health, maternal and child health, cancer, and chronic disease and pain management. Beyond individual patient outcomes, migrant and refugee women shared how

poorer health outcomes impacted their families and communities as a whole. As a result, many have sought specialist healthcare in their countries of origin where care was perceived to be cheaper, more comprehensive and more accessible to them. However, this inequity may lead to delayed and fragmented care.

e) **Innovative and emerging models of care:** Despite barriers to access, innovative and emerging models of care already exist. These include recognising the skills of specialist international medical graduates who come to Australia, resourcing bilingual and bicultural navigator programs, such as MCWH's *Health in my Language* (HiML) program, and strengthening public health and prevention efforts more broadly. Further, co-designed and community-led specialist clinics for migrant and refugee women is a promising model to provide culturally tailored specialist care. Scaling, resourcing and embedding these programs in Australia's existing health systems can support better health outcomes and better access to medical specialists for migrant and refugee women.

As such, MCWH makes the following recommendations:

Recommendations

1. Support the expansion and sustainability of the national bilingual health education workforce and efforts like the ***Health in My Language (HiML) Program***. A national bilingual health education workforce should be supported to:
    - Provide service navigation support to migrant and refugee women and gender diverse people in their own languages to support their access to specialist services. This can be done through the embedding of bilingual health educators in Australia's healthcare systems, including at clinics, hospitals and other first points of contact.
    - Provide preventative health education and support to migrant and refugee women wherever they are to promote health outcomes and reduce need for specialist support. Effort should be made to support outreach efforts and the development of further infrastructure to make bilingual health education more accessible, such as the development of drop-in bilingual health education centres in multicultural hubs.
2. Fund multicultural women's health organisations to develop tailored information on navigating the Australian health system and accessing specialist care in languages other than English, including information on potential cost for those without Medicare.
3. Invest in, support, and value Australia's interpreting workforce including by:
    - Funding specialist interpreter training for complex medical topics like pregnancy related care and sexual and reproductive health.
    - Improving employment security for Australian interpreters who remain a highly casualised workforce.
    - Provide subsidies for longer health appointments when an interpreter is needed.
4. Commission and support community-led research on:
    - Migrant and refugee women and gender diverse people's health system navigation, including existing pathways, available services, and promising practice.
    - Gender diverse migrant and refugees' access to healthcare, including specialist care.
5. Invest in strengthening FGM/C (Female Genital Mutilation/Cutting) workforce capability and expanding access to specialist healthcare services. This should include training specialist

practitioners to provide appropriate clinical care, including deinfibulation and reconstructive surgery where clinically indicated, improving access to specialist multidisciplinary services outside maternity settings, and strengthening primary healthcare practitioners' knowledge of FGM/C and appropriate referral pathways. This could be supported through further investment in national workforce development initiatives such as **MCWH's Supporting Workers in FGM/C Training (SWIFT) Program**.

6. Expand access to Medicare to all in Australia to ensure that everyone can access affordable specialist care in Australia regardless of visa status. Ensure that public specialist clinics are available to all, regardless of visa status.
7. Support all health practitioners to develop their capacity to provide culturally responsive, trauma-informed and non-discriminatory care for migrant and refugee women and gender diverse people including by training primary health practitioners to be aware of the way Australia's gatekeeper specialist healthcare access model may differ from specialist access models in other countries.
8. Improve pathways to secure practice for Specialist International Medical Graduates by:
    - Providing consistent pathways to permanency and secure long-term employment contracts to ensure practitioners can stay in the workforce, including in regional and rural areas.
    - Reduce barriers to employment like lack of recognition of overseas experience and improve opportunities for specialist international medical graduates to build their capacity to provide care in the Australian health system.
9. Support the development of free and affordable multicultural women's health clinics, like the Victorian Royal Women's Hospital's African Women's Clinic which provides tailored, culturally responsive specialist support to migrant and refugee women.
10. Improve access to sick and carers leave for all workers by:
    - Strengthening enforcement of casual and contractual employment definitions to reduce the contractualisation and casualisation of work, including for migrant and refugee women and gender diverse people who are often concentrated in highly casualised industries.
    - Improve access to carer and sick leave for those employed in casual and contractual work such as through schemes similar to Victoria's pandemic Sick Pay Guarantee.
11. Improve support to specialist healthcare for migrants and refugees in regional and remote areas including through:
    - Advocating to expand state-based regional and rural health transport schemes that cover the cost of transport to specialist healthcare to be eligible for all regardless of visa status or Medicare eligibility.
    - Ensure that employers who employ migrant workers in remote locations (such as PALM scheme workers, working holiday makers) make reasonable efforts to ensure that workers can access healthcare, for example by providing time-off to attend appointments, information on how to access services, a means of contacting services and support to access transport to services.

Response to the Terms of Reference

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.

In Australia, migrant and refugee women in cities, regional and rural communities face limited access to medical specialists for many of the same reasons they face limited access to healthcare more generally. Healthcare services often fail to provide culturally responsive services, nor services that are accessible in languages other than English (Multicultural Centre for Women's Health, 2021; Sullivan et al., 2020; C. Vaughan et al., 2016). Despite Australia's healthcare workforce being largely made up of migrant and refugee workers, workers are often still not provided with the capacity building or support required to provide culturally and linguistically responsible services (Khatri & Assefa, 2023).

Across MCWH's own research in the areas of mental health, discrimination in healthcare, chronic pain and gender-based violence, migrant and refugee women often shared their experiences attempting to access specialist care. Common issues raised by participants in accessing specialist care included lack of interpreter access, lack of regional and rural services, discrimination and concern for the lack of qualification recognition for overseas-born specialists on workforce shortages. For migrant and refugee women who may have caring or work responsibilities, especially those without access to Medicare, Centrelink or subsidised childcare, finding time to attend primary care appointments for referrals and specialist appointments is limited.

Interpreter access

Lack of or inconsistent use of interpreters in Australian healthcare services is a well-known issue that limits migrant and refugee women's access (Khatri & Assefa, 2023). Across MCWH's research, participants shared their need for interpreters especially for complex assessments associated with specialist care, including psychiatric care, pregnancy and birth-related care (Labra-Odde et al., 2025; Tran et al., 2023) . Lack of availability of interpreters compounded waiting times for specialists, especially in regional areas. As one participant living in a regional area shared:

> *"My mum needs the regular psychiatrist consultation for her assessment and medication adjustment. Though long waiting for the appointment, only telephone appointment is available. Even interpreter via the telephone is not easy to get, face-to-face interpreter is more far away...I am tired of it now. (Tran et al., 2023).*

A Tasmanian study found refugee women who resettled in regional Australia often faced barriers to access from specialist mental-health services, having their referrals rejected on the basis that the service could not provide culturally sensitive services or provide interpreters (Shannon, 2021). Another study found that in some instances children were being asked to provide interpreting services for parents, a wholly inappropriate solution given lack of confidentiality and the risk of vicarious trauma to the child (Hawkes et al., 2021).

Regional and rural access

There is a serious shortage of specialists in regional and remote Australia, resulting in longer wait times and less frequent medical consultations (Mude, 2026). Increasingly migrants and refugees are being encouraged through migration policy to settle in regional and remote areas (Boese & Moran, 2021). However, this has been done without regard for the necessary health infrastructure required to support them. As one participant in our mental health research shared:

> *"My mum suffered from mental health issues since she was in the refugee camp... She was diagnosed with PTSD when she arrived in Australia. That was thirteen years ago... I'm now her carer. I have to be around her all the time and I am unable to work... No psychiatrist is available in ... (name of her area)."(MCWH, 2024)*

In Australia, there is an ongoing shortage of psychiatrists in rural areas as the majority of psychiatrists work in major cities (Hayter et al., 2024). This is the same for specialists more generally (Cortie et al., 2024). Further, there is high turnover of health professionals in regional areas, with most specialist health professionals being visiting consultants (Mude, 2026, p. 160). Unsurprisingly, this also means that many migrant and refugee women in regional areas must travel in order to access specialist care. In most jurisdictions in Australia, schemes that provide financial support for those living in regional or rural areas to travel to specialist care appointments and treatments often explicitly exclude some migrants. For example, Victoria's Patient Transport Assistance Scheme (VPTAS) is not available to temporary residents (Department of Health Victoria, 2026), while those who are not eligible for Medicare are also excluded from similar schemes in Western Australia (Government of Western Australia, 2026), Queensland (Queensland Government, 2025) and New South Wales (NSW Government, 2023).

Migrants make up a large proportion of Australia's harvest workforce (seasonal picking and packing in horticulture), including but not limited to migrants on temporary visas such as working-holiday visas or on the PALM scheme (a Pacific Island seasonal guestworker program) (Campbell, 2019). These workers overwhelmingly live and work in regional and rural areas. However temporary migrant workers' access to specialists is often limited by factors beyond lack of specialists in regional and rural areas. For example, workers are often denied the agency to access healthcare on their own. PALM workers, for example, often have no independent transport and were reliant on employers to be taken to appointments (Kanan, 2025; G. Vaughan et al., 2026). Employer support for access to healthcare varies. Some workers shared the ways their health concerns were dismissed by employers. Others spoke about the fear of employer repercussions if they sought healthcare support (G. Vaughan et al., 2026). Further, in MCWHs own research, migrant and refugee women in horticulture work shared the ways that horticultural work comes with unique occupational hazards like exposure to chemicals and poisons, repetitive manual handling, and extreme weather, often without breaks. Participants shared that their workplaces often did not support them to access healthcare for pain arising from workplace injury (MCWH, 2024).

Some seasonal migrant workers have expressed that employers should assist in facilitating travel to support health access, including through scheduled trips, or through arranging designated drivers for health related travel. Notably, however, workers also express that employers support to access healthcare should not come at the cost of workers' autonomy (Fox et al., 2025). In other

jurisdictions, a greater onus has been placed on employers to support the health access of temporary migrant workers while supporting healthcare autonomy. For example, in Canada, legislation was introduced in 2022 to require employers make 'reasonable effort' to provide temporary migrant workers with access to a health provider. Examples of 'reasonable effort' included providing time off, ensuring there is a means of contacting emergency services, providing information on what to do and where to go, and helping a worker get transportation to a health provider. These reforms also protected the right for workers to speak to health care providers without employers present (Employment and Social Development Canada, 2026).

Logistical barriers: leave and caring responsibilities

On top of travel, migrant and refugee women often face logistical barriers that prevent them from accessing timely healthcare and support. Especially for those who face financial hardship, earning an income and the prospect of losing employment are added challenges for taking time off work or study to address healthcare concerns. Casual and contract workers – of which migrant and refugee women are overrepresented (Multicultural Centre for Women's Health & Ethnic Communities Council of Victoria, 2021) – do not have access to sick, parental and annual leave, meaning time to access primary care and specialist appointments is restricted. As one migrant woman who responded to our survey on women's pain shared:

> *I was low income for many years. It is difficult to get leave from work to attend medical appointments. The quality of services was very low in the area I lived (often losing my medical history records)." (MCWH, 2024, p. 30)*

Another woman shared:

> *"It took 15 years of back and forth with the medical system to receive a diagnosis of endometriosis, I've missed studies and work due to this. I have also worked while in severe pain as I haven't been sure if my workplace will be understanding/or provide me with leave for this." (MCWH, 2024, p. 30)*

Many migrant and refugee women face hold caring responsibility for children and other family members. A combination of factors including gender norms, separation from extended support networks in their countries of origin, and exclusion from accessing public child-care subsidies, increases the share of care work migrant and refugee women undertake when they come to Australia (Ho, 2006; Services Australia, 2026; Westcott & Robertson, 2017). In MCWH's research on informal care work, migrant and refugee women shared their experiences of having to juggle paid employment with multiple caring responsibilities including caring for children, grandchildren, children with disability, elderly parents, and spouses with chronic illness (Aryal-Lee, 2017). Time and logistics are some of the most significant barriers to specialist care for migrant and refugee women. Specialist appointments may involve longer wait times, daytime-only scheduling and multiple follow-up visits, none of which accommodate the realities of unsubsidised time off and multiple caregiving responsibilities.

Discrimination, wait-times and limited care

Existing research on migrants' experiences of accessing specialist care has found that long wait times limit and discourage service use (Adhikari et al., 2021). Further, wait-times and limited time with specialists have also led to some migrant and refugee women reporting experiences of bias and discrimination in healthcare. In MCWH's 2025 research into migrant and refugee women's healthcare experiences (Labra-Odde et al., 2025, p. 31), several participants reported feeling that they were being overlooked or treated differently by specialists on the basis of their race and class.

As one participant shared:

> *"You're allowed 10 minutes of his time, despite paying him. It's not covered by Medicare. He grabs your paperwork whilst accompanying you out with his eyes still on the timer. That's how specialists are now, they only care about the time."*

While another shared:

> *"I waited so long while others went in, I have no idea. They might discriminate against us because we don't speak English or because we're Asian. Maybe it's discrimination because of skin colour or because with specialists, people who go see specialist might be more classy than us, we are too ordinary for them to see us."*

These experiences of limited or poor access damage migrant and refugee women's trust in health services and specialist care. Indeed, researchers have noted that 'rushed' approaches to providing healthcare may compromise quality of care leading to potential misdiagnosis or inadequate treatment (Nisar et al., 2025). In our own research on migrant and refugee women's experiences of accessing healthcare, many noted that feeling rushed or overlooked because of the language they spoke led to providers not adequately obtaining informed consent (Labra-Odde et al., 2025).

Discrimination and insecure employment faced by specialist medical graduates

Increasingly, Australia has looked towards migration to remedy specialist shortages in remote and regional areas. For example, specialist international medical graduates (IMGs) make up around 50% of psychiatrists in outer regional, rural and remote areas (Hayter et al., 2024). Notably, psychiatrists (along with dermatologists and ophthalmologists) are expected to be under-supplied in comparison to health-need in Australia by 2030 (Breadon et al., 2025). However, existing research shows that the lack of recognition of overseas qualifications has forced many migrants to work outside of their trained profession, in lower-skilled, lower-paid work, especially migrant women (Australian Multicultural Women's Alliance & Settlement Services International, 2026; Ziersch et al., 2022).

Many IMGs report experiences of discrimination. In a survey by the Australian Medical Council (2024), IMGs reported feeling there was a preference in Australia for Australian-trained doctors, while many female IMGs reported experiences of sexism. Further, they also felt the moratorium on overseas graduates that requires they work in priority areas for their first 10 years of registration was an instance of institutional discrimination that isolated them professionally and socially.

IMGs also reported that their past training or experience in their country of origin was often not recognised. Similarly, opportunities to address skills gaps needed for working in rural communities were also limited (O'Sullivan et al. 2026). This reflects general lack of training opportunities in Australia for specialists including those trained in Australia (Breadon et al., 2025). Further, many also reported experiences of racism as a major challenge for themselves and their families when working in rural areas (Australian Medical Council Ltd., 2024). In MCWH's research with migrant and refugee women, participants shared their own observation that overseas doctors were experiencing institutional discrimination or bias:

> *"Because we have doctors in [her country of origin]. If we apply here in Australia, they don't accept the doctors from [her country of origin], there is racism for that, that's why all our doctors going to nurses because nurses are acceptable here than the doctors." (Labra-Odde et al., 2025, p. 33)*

IMGs possess important skills that are worth harnessing in Australia's multilingual and multicultural society. In our own research, many migrant and refugee women spoke favourably of their experiences with specialists from the same community as them (as will be explored in TOR e). However, they too noted that migrant specialists face barriers to accessing secure and long-term employment, especially when working in regional areas. While Australia's immigration strategy currently offers priority processing for health professionals committed to regional work (e.g. Subclass 482 Temporary Skill Shortage and Subclass 494), this is dependent on securing employment, which requires both regional funding and employers to recognise the value of migrant and refugee practitioners (Labra-Odde et al., 2025, p. 34). As one participant shared:

> *"I've noticed, [name of the hospital] is not recognising the certain doctors or the surgeons to keep them in [name of the state] so they are leaving [name of the state].I actually did speak to [a surgeon] last week who is actually leaving [date)... So we have a lack of doctors and anaesthetics and all that, but just because they can't give an employment contract to get into their visas, they're leaving [name of the regional city]." (Labra-Odde et al., 2025, p. 33)*

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.

Australia's healthcare system is complex, fragmented and often difficult to navigate, with health information and services rarely offered in languages other than English (Multicultural Centre for Women's Health, 2021; Sullivan et al., 2020; C. Vaughan et al., 2016). Even for those fluent in English, Australia's specialist pathways have been described as confusing, with many reporting the lack of transparency around costs (Faux, 2025).

Australia's referral-based system for specialist care also varies considerably from many international models of specialist access that migrant and refugee women may have experienced in their country of origin. Similarly, experiences of gendered racism and medical misogyny can also limit migrant and refugee women's pathways to specialist care. For issues, such as female genital mutilations/circumcision (FGM/C), primary care providers often lack the expertise to refer migrant and refugee women to the care they need. For some women, poor accessibility to specialist care in Australia made them seek specialist healthcare in their country of origin where care was perceived to be cheaper, more comprehensive and more accessible to them.

Lack of transparency in referral pathways and referral information

Across MCWH's work, migrant and refugee women consistently shared that lack of accessible, tailored and in-language referral information remained a barrier to referral to specialist care. Without guidance from primary care practitioners or formal public health channels, many rely on informal networks to access information related to often complex and bureaucratic referral pathways that frequently change. International students, in particular, have reported being confused and frustrated about the lack of accessibility when negotiating and seeking support from the healthcare and service systems in host countries (Vakkai et al., 2020). In our own work, one participant shared with us:

> *"When I first came here, I didn't know how to search for information, and I felt that it was quite complicated. People would talk about things like a GP referring you to specialists, which was complicated for me. So I relied on my friends, asking if they had any relevant experience ... when I wanted to see a ... [language other than English]-speaking specialist, doctor, GP, dentist, etc., I would search on ... [overseas based social platform] for that." (Labra-Odde et al., 2025, p. 28)*

In MCWH's research elsewhere on access to mental health support, a service provider reflected that even when multilingual information was made available by governments, these resources were not communicated to migrant and refugee communities through active outreach.

> *"I think Victorian government is providing them [migrant and refugee communities] multi-language information if you want to read, but only on websites. If you are from overseas and you don't even know what website exists, how do you go there and read?." (Tran et al., 2023)*

While Australia follows a strict gatekeeper model, with specialist care only available through referral by a primary care provider, many other countries including Greece, India and Austria allow patients to directly access specialist care without a referral (Reibling & Wendt, 2012; Sagayam et al., 2025). In MCWH's research, migrant and refugee women reflected on how Australian referral processes were different from their country of origin, but that these differences were poorly communicated and that familiarity with Australian referral systems was assumed in health information and by health practitioners. As a participant shared:

"I have to go through these steps, which are different from the process in … [her country of origin). But why aren't there clear, step-by-step instructions in… [participant's preferred language]? This information should be easily accessible" (Labra-Odde et al., 2025, p. 28)

Discrimination, gender and racial bias

In Australia's gatekeeper model of specialist care, if a primary practitioner does not believe a woman's own testimony of her symptoms or pain, specialist referral may be denied. In Australia, gender bias in the health system remains a persistent problem. In the national #EndGenderBias survey, two thirds of respondents reported that they experienced gender bias in health care. Further polling from the Australia Institute found that women were far less likely to feel that their GP took their medical concerns seriously and that they were believed (Predavec, 2026).

For migrant and refugee women, gender discrimination often intersects with racial discrimination. For example, conditions such as endometriosis have been historically viewed by doctors as a condition experienced by white women only, an inaccurate association that persists in treatment today (Bougie et al., 2022). In MCWH's research, participants consistently shared experiences of being dismissed, disbelieved, disempowered and denied treatment.

One participant shared her experience of seeking specialist support for respiratory symptoms. Her concerns were dismissed on the basis of race and her request for further diagnostics was denied:

"I asked him if I might have Long COVID and if I could get my lungs checked. He told me that, usually, they don't conduct lung checks here, and that my concern was a Chinese way of thinking." (Labra-Odde et al., 2025, p. 43)

Migrant and refugee women also shared their experiences of their pain not being taken seriously by doctors, especially when related to gynaecological conditions such as endometriosis. Participants in our survey conducted for the Victorian Women's Pain Inquiry shared how their pain conditions weren't taken seriously by doctors for many years, while one health professional from a migrant background shared the ways that migrant and refugee women's pain is often dismissed on the basis of racial assumptions. They shared:

"The healthcare system and hospitals are designed with a certain white, ablebodied, cis gender normative and operate with stereotyping everyone outside of this. There is an assumption that women of colour (should) have a high pain tolerance and when they ask for pain support, they are often labelled - for example as "an Indian princess" or that it's just "Asian show" or "difficult". This makes for a very poor health experience resulting in detrimental physical and mental health outcomes." (Multicultural Centre for Women's Health, 2024, p. 31)

Further, when it came to seeking referrals for mental health support, migrant women feared experiencing discrimination that could threaten their families, visa, or livelihoods. As one participant shared:

"...someone who lived for a long time in Australia said to me do not go to see any psychiatrist because the government would take your children if they knew you are not mentally stable."" (Multicultural Centre for Women's Health, 2023, p. 12)

Unfortunately, for many migrant and refugee women, fear of adverse consequences of seeking support is a legitimate concern. In MCWH's research on discrimination in the healthcare system, one migrant woman shared her experience of seeking specialist psychiatric care for her child who was then arrested, detained and assaulted by police (Labra-Odde et al., 2025, p. 50). These experiences of gender and racial bias and discrimination from primary care providers can prevent migrant and refugee women from accessing specialists and can diminish trust in the healthcare system more broadly.

On top of gendered racism towards heterosexual and cisgender women, gender diverse migrants and refugees also experience discrimination, limiting their access to specialist care. In general, gender diverse people report that they often encounter primary care providers who are discriminatory or unfamiliar with pathways to provide referrals for gender affirming specialist care. Gender diverse people also shared that endocrinologists and specialist surgeons able to provide gender affirmative care were in short supply, and that the costs and wait times for gender-affirmative care were often prohibitive, especially as many treatments are excluded from Medicare (Strauss et al., 2022). At present, there is a major gap on the experiences of migrants and refugees' experiences of navigating specialist referral pathways. However, existing research on LGBTQIA+ migrants and forcibly displaced people general health access describes significant barriers including lack of access to GPs, cost barriers often caused by Medicare exclusion, and significant experiences of discrimination based on race, immigration status, sexuality and gender (Cochrane et al., 2023; Pallotta-Chiarolli, 2016). Further community-led research is needed to understand the experiences and issues faced by migrant and refugee gender diverse people's attempts to access specialist care.

FGM/C and specialist referral

Female Genital Mutilation/Cutting ("FGM/C") refers to a range of procedures that alter or injure the external female genitals for non-medical reasons. While it is primarily practiced in parts of Africa, the Middle East and Asia, women and girls who have experienced FGM/C live in many countries, including Australia (MCWH, 2026). However, both community, primary and specialist health practitioners still lack the capacity to properly support and treat migrant and refugee women who have experienced FGM/C. As part of MCWH's SWIFT (Supporting Workers in FGM/C Training) project, our needs analysis highlighted substantial gaps in referral systems for women who have experienced FGM/C to access specialist care, including specialist gynaecological and de-infibulation services. In Australia de-infibulation and reconstructive surgery access is often limited due to a shortage of appropriately trained practitioners. Further, access is often concentrated within maternity services, leaving those who require the procedure outside of pregnancy with limited options. Primary health workers often also had limited awareness referral pathways or knowledge of what referrals were appropriate.

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.

In Australia, about one-third of specialist care is provided by public clinics that provide free services to Medicare eligible patients, though wait-times for these services are often a significant barrier to access for all (Breadon et al., 2025), including for migrants and refugees. For the two-thirds of those who rely on private access to specialists, costs, including fees and diagnostic costs, have risen and rapidly outpaced Medicare subsidies (Breadon et al., 2025). Among nations with universal healthcare systems, Australia stands alone as the only one without effective price or cost control mechanisms over private specialist fees (Zhang et al., 2026).

The cost of specialist care can be especially prohibitive for migrant and refugee women who experience significant socio-economic disadvantage. Migrant and refugee women face higher levels of unemployment, and those who are able to find work are often concentrated in casual or precarious work and in 'feminised industries' where wages are often low (Multicultural Centre for Women's Health & Ethnic Communities Council of Victoria, 2021).

This can lead to exorbitant out-of-pocket costs when compared to income, placing essential services entirely out of reach for migrant and refugee women. In a research study on the experiences of GPs in western Sydney, a cultural hub with a high population of migrants and refugees, GPs noted how financial barriers faced by their patients meant that many were prevented from attending private specialists, creating greater onus for GPs to provide more specialised care or find more affordable options (Reath et al., 2019).

For migrant and refugee women, high costs of specialists are often compounded by a number of other institutional factors related to Australia's public and private health insurance regimes including Medicare exclusion for temporary migrants, gender bias in the Medicare Benefits Scheme (MBS), and lack of appropriate coverage under private health insurance.

Medicare ineligibility and private health insurance coverage

As of February 2024, around 1.7 temporary visa holders (excluding tourists and New Zealand citizens) lived in Australia (Faulkner et al., 2025), most of whom are excluded from Medicare and thus are subject to enormous costs for specialist care. In Australia, one-third of specialist care is provided through public specialist clinics for free to those with Medicare (Breadon et al., 2025). However, these clinics often do not provide services for those not covered by Medicare, or services offered are extremely expensive for those without Medicare. For example, Peter Mac Cancer Centre in Melbourne only provides treatment to patients holding a current Medicare card with some minor exceptions (Peter Mac, 2026), while the Royal Women's Hospital does offer care to those who are ineligible for Medicare, but the out-of-pocket cost for uninsured mothers seeking a maternity package is $19,750 (The Royal Women's Hospital, 2026).

While temporary migrants can take out private health insurance, this insurance often does not provide the same coverage as Medicare despite costly premiums. For example, international students covered by the Overseas Health Cover Deed are only entitled to private health insurance

benefits equal to 85% of the Medicare Benefits Scheme. Further, research has found that holding private health insurance was associated with an increased odds of far higher direct out-of-pocket costs for cancer care, with patients with private health insurance paying as much as double compared to those who relied solely on Medicare (Bygrave et al., 2021). Further, private health insurance coverage for women's health issues like pregnancy and abortion is often limited – either being entirely excluded from coverage or subject to waiting periods for migrants on certain visas (e.g. PALM scheme workers and international students who take out coverage for less than one year) (Kanan, 2025; Multicultural Centre for Women's Health, 2025).

In MCWH's research on international students' experiences seeking help after experiencing sexual or intimate partner violence, one participant shared her experiences of speaking specialist mental health care in Victoria:

> *It's extremely expensive, like one appointment is $500. It is just the initial appointment and if I don't have any Medicare and then I just have a student health insurance, so how I can afford it? [Insurance] just covers for some accidental injuries... It's very challenging for [international] students like us"(Tran et al., 2025)*

Research on the experiences of PALM scheme workers also reflect the high costs migrants face when attempting to access healthcare. Workers shared that private health insurance did not often cover medical costs, noting the trade-offs they had to make between accessing healthcare in Australia or sending money to their families (G. Vaughan et al., 2026). They further shared that this would not be a worry if they had access to Medicare. Many also underscored the unfairness they faced in having to pay taxes in Australia while being denied Medicare and working in high-risk industries where injury is not uncommon (G. Vaughan et al., 2026, p. 7).

Workers also expressed frustration at the complex and often unpredictable nature of the private health insurance rebate system. For example, one worker shared how their private health insurance provider would not cover services provided for an infection on the basis that the infection began overseas, even though the worker noticed symptoms while in Australia (G. Vaughan et al., 2026, p. 7). Women working through the PALM scheme have also shared their fears about seeking reproductive healthcare due to cost (Kanan, 2025). Indeed, there is a lack of clarity surrounding what sexual and reproductive healthcare PALM scheme workers are entitled to under (compulsory) private health insurance in Australia.

Gender bias in diagnostics and specialist care

In a submission made by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, MBS items were identified as having a distinctly gendered bias (Khot, 2024). For example, rebates for pelvic ultrasounds for women were lower than scans of the scrotum, despite the fact that pelvic ultrasounds involve assessment of multiple organs (uterus, urinary bladder, bowel, ovaries, etc) in comparison to the single organ (the testes) in the scrotal ultrasound. Further, this gap also extends to contraceptive rebates.

For women without Medicare, out-of-pocket costs for sexual and reproductive healthcare are also prohibitive. Pregnancy and termination related care often involves many specialists, including anaesthetists, obstetricians and gynaecologists. In a study on sexual and reproductive access for

women on temporary visas in Australia, researchers found the average cost of a payment plan for pregnancy and birth care can be up to AUD $3,232 (Shannon, 2021). Further, termination costs ranged from between $470 to $7,700 according to a 2017 study, (Shankar et al., 2017).

In MCWH's research on international students' experiences of help-seeking after experiencing violence, one participant recalled the impact these costs had on her when she sought termination after an assault, saying:

> *I did not have much money, and I had to spend a lot of money on bills, pretty much on doctor [hospital/medical] bills because I had to go to the emergency room, and I was pregnant. The bill that I received was $2,000 ... economically it was very hurtful." (Tran et al., 2025, p. 2586)*

Migrant and refugee women report unfamiliarity with the Australian healthcare system, social inequality and financial constraints, visa constraints, social isolation and limited transport options, and lack of culturally and linguistically appropriate services as key barriers to accessing crucial specialist care for reproductive health, including antenatal healthcare (Billett et al., 2022; Bradford et al., 2024; Mengesha et al., 2016; Olcoń et al., 2023). For example, maternity clinic fees for antenatal care at Tasmanian public hospitals are free for people who have a Medicare card, while for those who do not have Medicare, appointments at antenatal clinics are charged at $329 for each occasion of service with a health care specialist (Shannon, 2021).

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

In Australia, one in five people delay or skip accessing specialist care due to high costs and long waits (Breadon et al., 2025). This is no different for migrant and refugee women, who often experience additional barriers to specialist care. In one study on the experiences of South Asian migrants, many reported experiences of long wait-times in the public system, with some feeling they were forced into the private system at significant cost, fearing the impact wait times had on them and their loved ones' health (Adhikari et al., 2021). Further, another study found that many migrants postponed necessary treatments due to the high cost of specialist and dental care (Nisar et al., 2025).

In Australia, many migrants arrive with better health profiles than the Australian-born non-Indigenous population, largely due to the migration system preferencing those who are healthier, able-bodied and of working age. However, across the life-course, health outcomes deteriorate over time a due to factors including settlement stress, decreased access to positive social determinants of health and barriers to healthcare access (Huang et al., 2026; Khatri & Assefa, 2022). Lack of access to specialist care forms part of this problem. Further, many refugees and asylum seekers face significant health problems stemming from their migration and pre-settlement experiences leading to health problems such as Post-Traumatic Stress Disorder (PTSD) or micronutrient deficiencies that may be exacerbated without access to affordable, appropriate specialist care (Khatri & Assefa, 2022).

Across MCWH's work, we have observed the ways lack of specialist care impacts migrant and refugee women, especially in the areas of maternal and child health, sexual and reproductive health, chronic disease and pain management, and cancer. The impact of timely care goes beyond the health of individual migrant and refugee women, with many reporting impacts on their families and communities as well. Faced with these barriers, many migrants and refugees forego pursuing specialist care in Australia, with many reporting that they prefer to access treatment in their country of origin. However, this may further delay important treatment and care.

Perinatal, maternal and child health impacts

In Australia, one third of people giving birth are migrants, with the majority coming from mainly non-English speaking countries (AIHW, 2026). The impact of delayed, or denied, access to specialist care has severe impacts on migrant and refugee women's experiences in the perinatal period -- the period from conception to the first year of a child's life (Centre for Perinatal Excellence, 2023). The World Health Organisation recommends that women receive specialist care in the antenatal period (period of pregnancy before childbirth) at least four times, with the first antenatal visit to occur within the first ten weeks of pregnancy. Further, the Department of Health and Pregnancy Care Guidelines recommends a schedule of ten visits for a person's first pregnancy even when there are no complications (Department of Health 2020). This is because antenatal care is associated with far better maternal and child health outcomes, including the likelihood of effective health interventions. In Australia, research has found that migrant and refugee women have a lower uptake of antenatal care due to many of the abovementioned barriers to specialist care (AIHW, 2026).

This can lead to serious consequences for the health, wellbeing and lives of migrant and refugee women and their children. For example, cost of specialist care and diagnostics, especially when faced with an unpredictable private health insurance regime, lead to migrant and refugee women skipping important testing and screening (Vazquez Corona et al., 2025). Limited diagnostic access and specialist care during the antenatal period can have devastating consequences for mothers and children. For example, in August 2025, the CDC declared syphilis a Communicable Disease of National Significance. While syphilis can remain unnoticed for months and even years in adults, infections during later pregnancy increase the risk of mother-to-child transmission. Congenital syphilis can lead to stillbirth, miscarriage, premature birth and lifelong health damage. From 2010 – 2021 Australia reported 74 cases of congenital syphilis. 43% of mothers who had given birth to infants with congenital syphilis had not received antenatal care and 22% of these infants were stillborn (Bond & Chen, 2024). If detected in early pregnancy, early treatment can radically reduce the risks of congenital syphilis. More generally, migrant and refugee women's birth outcomes reflect lower levels of timely maternity care, with higher rates of stillbirth, poorer outcomes for gestational diabetes and higher rates of instrumental birth and caesarean (Multicultural Centre for Women's Health, 2021).

Lack of adequate access to specialist care during birth and the post-partum period can even result in death in extreme cases, both for mother and babies. In 2019, a Vietnamese woman Gia Lam, died of sepsis after medical staff failed to diagnose and treat her for a UTI while she remained in postnatal medical care. While Gia Lam was seen by multiple specialists prior to, during and after birth, an accredited interpreter was not engaged, limiting her practical access to the care of specialists. In 2026, the coroners' court found that Ms Lam should have been offered an interpreter by her

medical team (May, 2026). In 2020, Chaitali and Yoginkumar Patel's baby Siya died just 23 days after she was born in a Melbourne Hospital from a brain injury that a Victorian coroner deemed preventable. Siya, despite being born in Australia, was not eligible for Medicare meaning that her parents were not able to access routine subsidised postnatal outpatient services. While Siya's parents had lived in Australia for three years, they only had 'international visitor' private health insurance which did not cover standard postnatal reviews (Press, 2024). Babies born in Australia are not automatically eligible for Medicare and need at least one parent who is eligible for Medicare to also be eligible.

While Gia and Siya's cases are tragic and extreme, in MCWH's research on bias in healthcare, migrant and refugee women consistently reported how the lack of access to specialist care led to them experiencing birth trauma (Labra-Odde et al., 2025, p. 45). Further, existing evidence has found that migrant and refugee parents, including those arriving to Australia with young children are often not formally notified of maternal and child health services. As a result, there are disparities in service utilisation of paediatric specialist services by migrant parents (Guo et al., 2020).

Other sexual and reproductive health impacts

Medical specialists such as sexual health physicians, infectious disease physicians, gynaecologists and obstetricians make up a key part of sexual health services in Australia. However, migrant and refugee women face significant barriers to accessing specialist care for sexual and reproductive health. On top of pregnancy and birth-related impacts, lack of access to specialist SRH services can lead to migrant and refugee women facing increased risks of contracting STIs and blood-borne viruses such as HIV. In Australia, notifications for HIV have reduced significantly, however notifications for those who speak a language other than English at home have increased between 2012 to 2019 (King et al., 2022, p. 10).

In particular, notifications have increased for women born in Asia, while late diagnosis among women who report heterosexual sex as an exposure risk was higher among those born in Sub-Saharan Africa, followed by East Asia , and then Australia (King et al., 2022, p. 13). Research on why migrant and refugee women are more likely to be diagnosed later is scant in Australia, however it is likely attributable to relatively low testing rates among heterosexual women in general and the barriers migrant and refugee women face in accessing specialist sexual and reproductive health services.

Lack of access to sexual and reproductive healthcare among PALM scheme workers has also led to higher rates of STI transmission among workers. Recent research has found that PALM scheme workers experience higher rates of chlamydia with positive treponemal serology that may reflect higher rates of untreated STIs (Seymour et al., 2025). Leaving STIs untreated not only increases the spread of infection but increase the risk of further health complications. For example, chlamydia can lead to the development of pelvic inflammatory disease, a painful condition that can result in ectopic pregnancy, infertility and chronic pelvic pain (Manavi, 2006) .

Chronic pain and disease management

Poorer treatment for chronic pain and chronic disease due to delays in or lack of access to specialist care have serious and compounding impacts for migrant and refugee women. Migrants and refugees experience higher rates of chronic illness including diabetes, kidney disease and cardiovascular

disease (Australian Institute of Health and Welfare, 2023). However, many migrants and refugees still face barriers to accessing specialist care and diagnostics to manage these conditions.

For example, migrants have been found to be 60% less likely to seek help for chest pain within the first hour of symptoms (Wechkunanukul et al., 2022). Additionally, cost and the lack of culturally and linguistically appropriate information have been identified as barriers preventing migrants and refugees from accessing critical care for stroke (Kaur et al., 2026). As a result, patients who spoke a language other than English often faced poorer clinical outcomes for stroke treatment specifically (Rezania et al., 2021).

Persistent inequities also exist across the cancer care continuum for migrants and refugees in Australia. For instance, data shows that fewer people from migrant and refugee communities take part in cancer screening compared to the Australian-born population (Aminisani et al., 2012; Anaman et al., 2017; Australian Institute of Health and Welfare, 2026), highlighting the need for reliable in-language health information and education. Migrant and refugee cancer patients also reported having diminished understandings and explanations about cancer, treatment and the roles of specialists specifically due to health services expectation of English proficiency and familiarity with the health system (Scanlon et al., 2021; Shaw et al., 2013). Another study found medical clinicians tended to refer migrant and refugee patients to allied health or multicultural health workers, thus limiting access to specialist oncology clinicians (Broom et al., 2019). Beyond screening, barriers across the cancer care continuum have meant migrant and refugee cancer patients often had poorer cancer journeys resulting in worse health outcomes.

Impact on work, care, families and communities

Across MCWHs research, migrant and refugee women reported the long-term and far-reaching impacts of lack of specialist care on themselves and their communities. In particular, participants shared how they were unable to access treatment for chronic pain, leading to their conditions worsening and impacting their work, study, caregiving responsibilities and ability to engage in social activities. As one participant shared:

> *"It was both mental and physical pain I suffered years and years... It was muscular and joint pain accompanied with other symptoms, which seemed unrelated… When I am mentally down, it was worsen or vice versa. Then some good doctor finally diagnosed it, Fibromyalgia! ... My family life impacted, I stopped socialising, I have missed many workdays, I missed many days of language classes. I couldn't look after my kids, they were always seeing me as a sick mum in the bed."" (Multicultural Centre for Women's Health, 2024, p. 15)*

Migrant and refugee women also shared their perception that there were many in their communities with chronic health conditions who have not been diagnosed because of barriers to healthcare access, including specialist access. They further shared the ways that chronic disease and chronic pain affected patient's mental health and the wellbeing of their whole families. Participants noted:

"In the [ethno-specific community], there are many chronic patients ... They have not been diagnosed yet, it has been 14, 15, 16, 17 years or more. Those patients have been suffering from that pain ... And another family member also has to stay with him to take care of him ... he has to stop working, and after leaving work, there is no income ... Guilt is felt, and because of that one chronic patient, the whole family is affected, and they are also affected economically. And after that financial impact, various misunderstanding starts at home. Things like I am the only one earning, you all are staying at home. The patient cannot do anything. How can they survive if only one person earns? And family destruction starts. Violence can also occur. It can end up negatively and, in the end, it can even lead to suicide." (Labra-Odde et al., 2025, p. 49)

"When health becomes poor, self-confidence also decreases because a person loses their hope of being cured. When this chronic condition becomes a severe condition day by day, in their mind, they do not feel like going to the house of any friend, brother, or relative." (Labra-Odde et al., 2025, p. 50)

Preference for overseas specialist support

Faced with multiple barriers to specialist care, including cost, discrimination, waiting times, and lack of specialists who can provide linguistically and culturally appropriate care, many migrant and refugee women said they preferred to access care from doctors in their country of origin, either online or by travelling overseas. As one participant shared:

"I always use online consultations from doctors in [country of origin] for other health issues as I have to wait so long to see the specialist doctors, and the price are so expensive. I have to see doctor online and even go back to [country of origin]. Much cheaper and much quicker. When I go back to see doctor in [country of origin], I feel like I'm their first priority while when I book and see doctor here, still feel sense of discrimination." (Tran et al., 2023)

While another shared:

I feel like I can't get good medical resources here, but if I go back to [my country of origin], we can find, for example, a specialist clinic for just [~$50 AUD Equivalent] and you can get excellent medical resources. Based on my own experience, I think it's better that way. Everything here is slow ... I'd rather go back to [name of country] to get things done. Like when I needed to get a gastroscopy done, I just bought a ticket for the next day and flew back, got it done, and then came back. It felt so much faster." (Labra-Odde et al., 2025, p. 32)

Research on PALM scheme access to healthcare also reflects this, with workers expressing a preference to wait until they could return home for medical treatment. Participants shared that costs of healthcare in Australia often exceed the cost of flights back to their countries of origin (G. Vaughan et al., 2026).

While financially pragmatic, migrant's reliance on overseas medical specialists is an indictment on Australia's health system. The reliance on overseas services may lead to delays in treatment which can place migrants and refugees at higher risk of experiencing poorer health outcomes.

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

There are significant opportunities to improve access to specialist care for migrant and refugee women, many of which stem from the enormous diversity of Australia's healthcare workforce. At present, over 40% of Australia's health workforce are migrants (Islam et al., 2026). In recognising and harnessing skills of migrants and refugees, especially women and gender-diverse people, we can strengthen our health systems to provide more appropriate, responsive care for all. There is a strong appetite among international medical graduates to work in Australia, able to fill skill shortages in many medical specialties. Similarly, specialist clinics tailored and co-designed by migrant and refugee women are a promising model for providing specialist and culturally and linguistically appropriate care. But further, many other migrants and refugees have been using their significant linguistic, cultural, health and educational skills as bilingual health educators in programs such as MCWH's Health in My Language (HiML) program. Bilingual health educators help migrants and refugees navigate the health system and Australia's specialist referral pathways. However, they also play a crucial role in providing preventative health education on a range of topics including sexual and reproductive health, and cancer screening. Engaging migrants and refugees effectively in preventative health can reduce the need for future specialist medical intervention.

Recognising and harnessing the skills of specialist international medical graduates

Although many migrants and refugees make up a large part of Australia's medical workforce, many specialist international medical graduates (SIMGs) face barriers to practice, such as discrimination and lack of employment security. In 2025, there was a 30% increase in SIMGs seeking pathways to practice indicating a strong appetite to work in Australia (Medical Board of Australia, 2026). Australia's National Medical Workforce Strategy currently recognises a need to provide international medical graduates with "necessary cultural safety training", however, it does not recognise the international skills and knowledge IMGs bring to Australia (Australian Government Department of Health, 2021). Doctors from the global south often bring a wealth of knowledge to Australia about how to provide healthcare in complex, regional and remote areas, with experience managing high density workloads, often with limited access to specialists or expensive diagnostics (Sharma & Cotton, 2022).

Further, in a country with such high levels of cultural diversity, international medical graduates play an important role in providing culturally responsive care for migrant and refugee women and gender diverse people. Culturally responsive care refers to the ability to engage, respect and respond to the needs of migrants and refugees. It looks beyond concepts of 'cultural competency' that focus on cultural difference, towards understanding how dominant systems, structures, or practices in Australia may need to be adjusted to respond to the needs of migrants and refugees. In our own research at MCWH, migrant and refugee women often shared the ways that medical practitioners who had a similar cultural background provided culturally responsive care, often by providing healthcare in their own languages and in ways that were tailored to their needs. For example, one participant shared that she felt lucky that she could see a doctor from a similar cultural background due to their cultural and linguistic familiarity, noting:

Most of us we are used to go to a doctor who we really know and we feeling comfortable with and to talk with. We are of [ethnicity] so we prefer to see a doctor [of the same ethnicity] so we can tell all the symptoms clearly ... they know if there's anything which is specific to our background, because they are used to knowing what we eat ... they can simply say so we're comfortable with that and we're really lucky. (Labra-Odde et al., 2025)

Further, another participant in MCWH's research on mental health shared:

"My GP is of the same cultural background and she referred me to a psychiatrist who was able to understand where I came from and which culture I belong to."" (Tran et al., 2023, p. 12)

Participants also shared how migrant doctors understood financial barriers to health care and provided pathways to remedy them. As one participant shared:

"In the second visit the doctor was [of migrant background] so she saw my documents, everything, and she found that I don't have Medicare and she asked me do you want to apply for a waiver? And she showed me every documents and she told me everything, how can I apply, after that she gave me the form, I filled that form, and I applied. And after that I learnt about the waiver… it's like same as the Medicare so I didn't pay after that. Fortunately, I had that doctor." (Labra-Odde et al., 2025)

While doctors of all backgrounds can provide culturally responsive care, international medical graduates are often already equipped with the skills needed to provide such care. These skills include proficiency in languages other than English and familiarity with overseas medical systems and other norms that may impact health.

Co-designed and community led specialist clinics

As described above, migrant and refugee women often experienced poorer pregnancy and birth outcomes, often stemming from poorer access to specialist care that is responsive to their needs. However, specialist clinics and services that are co-designed by and for migrant and refugee women have shown strong results in improving migrant and refugee women's experiences of maternal health, such as African women's clinics and dedicated maternal and child health services (Billett et al., 2022). These services were valued by women for their appointment flexibility and for providers' understanding of their needs. MCWH's experience working with women who have experienced FGM/C echo these findings. For example, the African women's clinic at the Royal Women's Hospital in Victoria not only provides maternal and child support, but also support for women who have experienced FGM/C. This clinic provides a model of care on bringing together specialist clinical expertise, culturally responsive practice and multidisciplinary support.

Bilingual health educators as system navigators

There is strong evidence in Australia supporting the effectiveness of community and bilingual health educators who support migrant and refugee women to access and navigate health services in Australia, including specialist services (Cvetanovska et al., 2025; Mistry et al., 2023). This research

has called for peer health navigation to be sustainably supported and embedded within Australia's health system, for navigators to be supported with training and capacity building, and for navigation support to be tailored for the diverse needs of migrant and refugee cohorts.

MCWH's Health in My Language (HiML) program provides tailored, in-language health education to migrant and refugee women in Australia on how to navigate Australia's health system, with over 17,000 migrant and refugee women attending sessions in 2026 (Multicultural Centre for Women's Health, 2026). The program, through partnership with community health services across Australia, provides bilingual health educators with accredited training, continuous development support and access to a growing suite of bilingual health education material. The program has had enormous success in improving migrant and refugee women's understanding and confidence navigating Australia's health system (Multicultural Centre for Women's Health, 2026). In 2026, 80% of participants rated their knowledge of health services as 'high' after a health education session, compared to just 4% before the session. Further, 98% of participants shared that they intended to share their learnings with others after the session. As one participant shared:

> *Before I started the HiML sessions, I was anxious and overwhelmed whenever I thought about using the healthcare system… I had no idea how to ask for help or navigate the health system… the knowledge I gained gave me the courage to overcome my past hesitations and encouraged me to go to the clinic"*

Sessions are delivered through outreach directly to migrant and refugee women, with sessions taking place in workplaces, schools, community centres and places of worship. Childcare is offered at sessions to support mothers attending, while sessions themselves are delivered by trusted members of the community, and in the preferred language of participants. As one participant shared:

> *As a migrant and a single mother of two teenagers, I have struggled to settle into a new country, and navigating complex systems, including healthcare, has been challenging. Learning how to maintain mental wellbeing and identifying where to access professional support has been very helpful to me*

There is considerable potential for Australia's existing bilingual health education workforce to be engaged to deliver targeted system navigation education and services in relation to specialist care and be better embedded within healthcare settings. So far, the Health in My Language (HiML) and MCWH's broader health education program has delivered health education that has assisted migrant and refugee women to understand how to navigate Australian mental health, sexual and reproductive health, and cancer diagnostic and referral pathways.

Migrant and refugee women consistently share their desire for community-led, outreach forms of health information. As one participant shared in MCWH's research:

"Information sharing sessions, supporting migrants, these kinds of projects is really, really important, because the health system is totally different, the literacy level that migrants have from Australians is very, very different, how we manage our health systems, is very, very different, so we need more, more information sessions or these kinds of supports from the government if it's possible." (Labra-Odde et al., 2025, p. 28)

Public health and prevention approaches

Demand for specialist care may be reduced with more effective public health and prevention approaches. At present, migrant and refugee women report lower access to preventative health screening, services and information in areas such as sexual and reproductive health, cardiovascular health, and cancer (Allida et al., 2025; Hawkey et al., 2022a; Scanlon et al., 2021). However, in each of these areas, earlier interventions can reduce need for extended specialist care, especially in the case of sexual and reproductive health where early interventions are often low cost and effective.

However, public health and prevention efforts often implicitly exclude migrant and refugee women. Programs may be delivered in places that migrant and refugee women rarely attend, information may be only delivered in English or only relevant to those with a Medicare card, or in certain cases, screening itself may not be available for those without Medicare access. Further, some prevention initiatives are designed with certain migrant or refugee groups in mind. For example, earlier intervention to support women in the perimenopause period may be needed as cardiovascular risk tend to increase during that period. However, the median age of perimenopause ranges significantly depending on region with median age for women in Asia being from 42 – 49, in comparison to 50 – 52 in Europe (Palacios et al., 2010), with Australian research showing that Asian-born women may enter perimenopause earlier. Nevertheless, advice to GPs tends to focus on 'normal menopause' onset being above 45 (Spencer & Newman, 2026). This may mean that women who experience menopause in their early 40s may miss the window for effective treatment to prevent cardiovascular disease (Multicultural Centre for Women's Health, 2024).

Expanding prevention approaches to be tailored, community-led, and accessible to migrant and refugee women can both improve health outcomes, reduce the risk of severe illness, and reduce pressure on Australia's hospital systems and specialist services.

MCWH has been providing health information to migrant and refugee women in their preferred languages for over 40 years. Participants who engage in our programs consistently share improved understandings of how to remain healthy and engage with the health system to detect issues before worsening. As a *Health in My Language* (HiML) participant shared:

Preventive health checks or cancer screenings are not something people talk about openly…after attending the HIML session, I became much more conscious about my own health, [and] the session encouraged me to seriously think about doing the cervical screening test myself"

Migrant and refugee communities have a strong appetite for health prevention and community-led health education projects. In a study on cardiovascular disease prevention, migrants shared their preference for group-based, participatory health information and education programs provided in

their language (Allida et al., 2025). While other research has also found that migrant women spoke of group education sessions as their preferred approach to receive sexual and reproductive health prevention information and stressed their desire for information to be available in their own languages (Hawkey et al., 2022b).

Recommendations

1. Support the expansion and sustainability of the national bilingual health education workforce and efforts like the ***Health in My Language (HiML) Program***. A national bilingual health education workforce should be supported to:
    - Provide service navigation support to migrant and refugee women and gender diverse people in their own languages to support their access to specialist services. This can be done through the embedding of bilingual health educators in Australia's healthcare systems, including at clinics, hospitals and other first points of contact.
    - Provide preventative health education and support to migrant and refugee women wherever they are to promote health outcomes and reduce need for specialist support. Effort should be made to support outreach efforts and the development of further infrastructure to make bilingual health education more accessible, such as the development of drop-in bilingual health education centres in multicultural hubs.
2. Fund multicultural women's health organisations to develop tailored information on navigating the Australian health system and accessing specialist care in languages other than English, including information on potential cost for those without Medicare.
3. Invest in, support, and value Australia's interpreting workforce including by:
    - Funding specialist interpreter training for complex medical topics like pregnancy related care and sexual and reproductive health.
    - Improving employment security for Australian interpreters who remain a highly casualised workforce.
    - Provide subsidies for longer health appointments when an interpreter is needed.
4. Commission and support community-led research on:
    - Migrant and refugee women and gender diverse people's health system navigation, including existing pathways, available services, and promising practice.
    - Gender diverse migrant and refugees' access to healthcare, including specialist care.
5. Invest in strengthening FGM/C (Female Genital Mutilation/Cutting) workforce capability and expanding access to specialist healthcare services. This should include training specialist practitioners to provide appropriate clinical care, including deinfibulation and reconstructive surgery where clinically indicated, improving access to specialist multidisciplinary services outside maternity settings, and strengthening primary healthcare practitioners' knowledge of FGM/C and appropriate referral pathways. This could be supported through further investment in national workforce development initiatives such as **MCWH's Supporting Workers in FGM/C Training (SWIFT) Program**.
6. Expand access to Medicare to all in Australia to ensure that everyone can access affordable specialist care in Australia regardless of visa status. Ensure that public specialist clinics are available to all, regardless of visa status.

7. Support all health practitioners to develop their capacity to provide culturally responsive, trauma-informed and non-discriminatory care for migrant and refugee women and gender diverse people including by training primary health practitioners to be aware of the way Australia's gatekeeper specialist healthcare access model may differ from specialist access models in other countries.
8. Improve pathways to secure practice for Specialist International Medical Graduates by:
    - Providing consistent pathways to permanency and secure long-term employment contracts to ensure practitioners can stay in the workforce, including in regional and rural areas.
    - Reduce barriers to employment like lack of recognition of overseas experience and improve opportunities for specialist international medical graduates to build their capacity to provide care in the Australian health system.
9. Support the development of free and affordable multicultural women's health clinics, like the Victorian Royal Women's Hospital's African Women's Clinic which provides tailored, culturally responsive specialist support to migrant and refugee women.
10. Improve access to sick and carers leave for all workers by:
    - Strengthening enforcement of casual and contractual employment definitions to reduce the contractualization and casualisation of work, including for migrant and refugee women and gender diverse people who are often concentrated in highly casualised industries.
    - Improve access to carer and sick leave for those employed in casual and contractual work such as through schemes similar to Victoria's pandemic Sick Pay Guarantee.
11. Improve support to specialist healthcare for migrants and refugees in regional and remote areas including through:
    - Advocating to expand state-based regional and rural health transport schemes that cover the cost of transport to specialist healthcare to be eligible for all regardless of visa status or Medicare eligibility.
    - Ensure that employers who employ migrant workers in remote locations (such as PALM scheme workers, working holiday makers) make reasonable efforts to ensure that workers can access healthcare, for example by providing time-off to attend appointments, information on how to access services, a means of contacting services and support to access transport to services.

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